No. 23-12155

In the United States Court of Appeals for the Eleventh Circuit

AUGUST DEKKER, BRIT ROTHSTEIN, SUSAN DOE, by and through her parents and next friends, JANE DOE and JOHN DOE, and K.F., by and through his parent and next friend, JADE LADUE,

Plaintiffs-Appellees,

v.

SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *et al.*,

Defendants-Appellants.

On Appeal from the U.S. District Court for the Northern District of Florida, No. 4:22-cv-00325, Honorable Robert L. Hinkle, District Judge

APPELLEES' APPENDIX
VOLUME 6 OF 10 (Tabs 178-11 – 183-20)

Jennifer Altman
Shani Rivaux
PILLSBURY WINTHROP SHAW PITTMAN, LLP
600 Brickell Avenue, Suite 3100
Miami, FL 33131
(786) 913-4900

Catherine McKee
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27514
(919) 968-6308

Simone Chriss
Chelsea Dunn
SOUTHERN LEGAL COUNSEL, INC.
1229 NW 12th Avenue
Gainesville, FL 32601
(352) 271-8890

Abigail Coursolle
NATIONAL HEALTH LAW PROGRAM
3701 Wilshire Boulevard Suite 315
Los Angeles, CA 90010
(310) 736-1652

Omar Gonzalez-Pagan
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, NY 10005
(212) 809-8585

Katy DeBriere
FLORIDA HEALTH JUSTICE PROJECT
3900 Richmond Street
Jacksonville, FL 32205
(352) 278-6059

Counsel for Plaintiffs-Appellees
(Additional counsel listed on inside cover.)

William C. Miller
Gary J. Shaw
PILLSBURY WINTHROP
SHAW PITTMAN, LLP
1200 17th Street, NW
Washington, DC 20036
(202) 663-8000

Karen L. Loewy
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
1776 K Street, NW, 8th Floor
Washington, DC 20006
(202) 804-6245

Counsel for Plaintiffs-Appellees

TABLE OF CONTENTS

Tab/Docket No.

VOLUME 1 OF 10

VOLUME 2 OF 10

VOLUME 3 OF 10

VOLUME 4 OF 10

VOLUME 5 OF 10

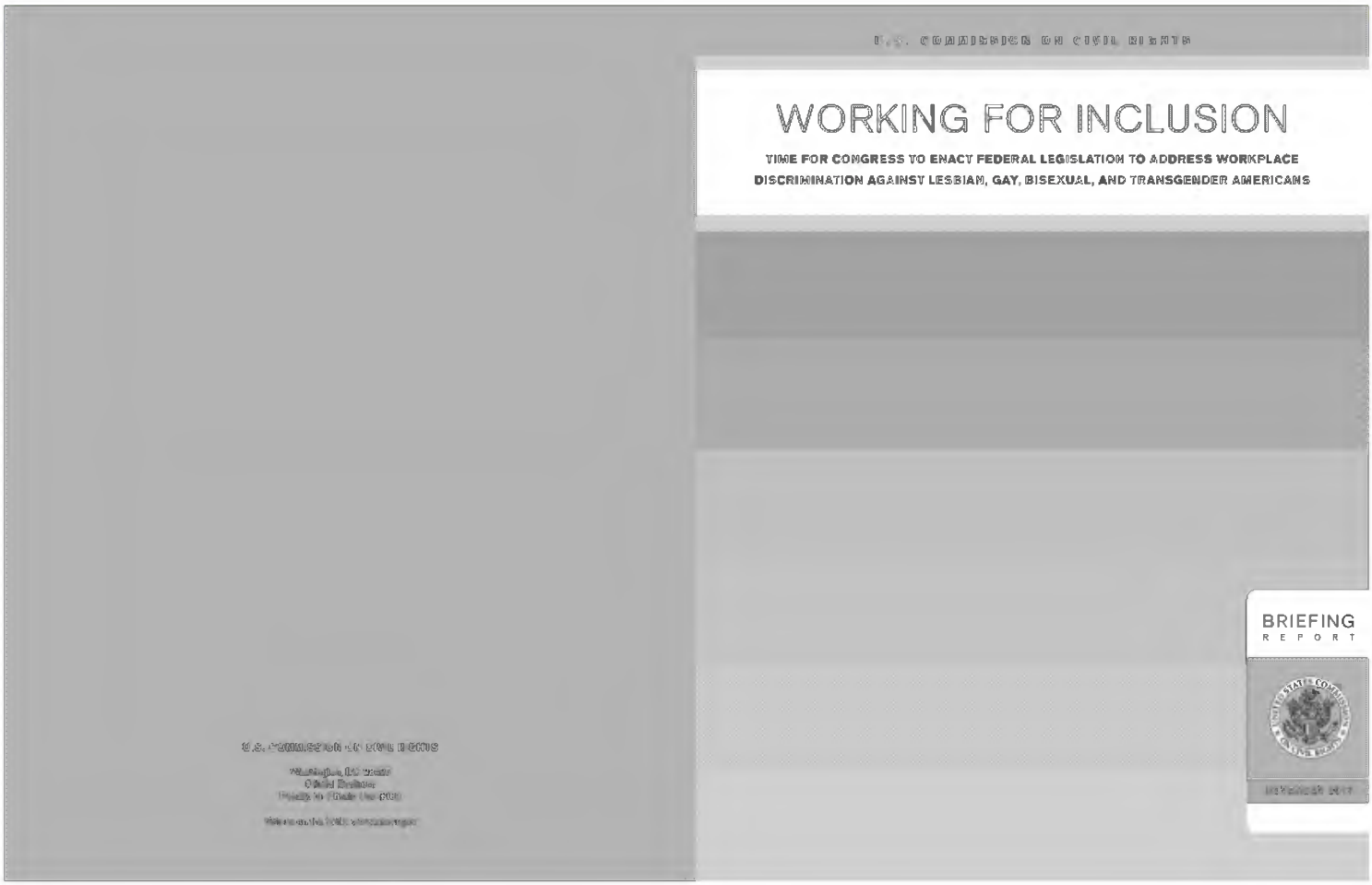
VOLUME 6 OF 10

VOLUME 7 OF 10

VOLUME 8 OF 10

VOLUME 9 OF 10

TAB 178-11



Pl. Trial Ex. 131

U.S. COMMISSION ON CIVIL RIGHTS

The U.S. Commission on Civil Rights is an independent, bipartisan agency established by Congress in 1957. It is directed to:

- Investigate complaints alleging that citizens are being deprived of their right to vote by reason of their race, color, religion, sex, age, disability, or national origin, or by reason of fraudulent practices.
- Study and collect information relating to discrimination or a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, age, disability, or national origin, or in the administration of justice.
- Appraise federal laws and policies with respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, disability, or national origin, or in the administration of justice.
- Serve as a national clearinghouse for information in respect to discrimination or denial of equal protection of the laws because of race, color, religion, sex, age, disability, or national origin.
- Submit reports, findings, and recommendations to the President and Congress.
- Issue public service announcements to discourage discrimination or denial of equal protection of the laws.

MEMBERS OF THE COMMISSION

Catherine E. Lhamon, *Chairperson*
Patricia Timmons-Goodson, *Vice Chairperson*
Debo P. Adegbile
Gail L. Heriot
Peter N. Kirsanow
David Kladney
Karen Narasaki
Michael Yaki

Mauro Morales, *Staff Director*

U.S. Commission on Civil Rights
1331 Pennsylvania Avenue, NW
Washington, DC 20425
(202) 376-8128 voice
TTY Relay: 711

www.usccr.gov

Working for Inclusion: Time for Congress to Enact Federal Legislation to Address Workplace Discrimination Against Lesbian, Gay, Bisexual, and Transgender Americans

Briefing Before
The United States Commission on Civil Rights
Held in Washington, DC

Briefing Report

[*This page intentionally left blank*]

UNITED STATES COMMISSION ON CIVIL RIGHTS

1331 PENNSYLVANIA AVE., NW • SUITE 1150 • WASHINGTON, DC 20425
WWW.USCCR.GOV

Letter of Transmittal

President Donald J. Trump
Vice President Mike Pence
Speaker of the House Paul Ryan
Senate Majority Leader Mitch McConnell

On behalf of the United States Commission on Civil Rights ("the Commission"), I am pleased to transmit our briefing report, *Working for Inclusion: Time for Congress to Enact Federal Legislation to Address Workplace Discrimination Against Lesbian, Gay, Bisexual, and Transgender Americans*. The report is also available in full on the Commission's website at www.usccr.gov.

The report examines the main social and economic arguments made for and against enacting federal legislation to provide federal nondiscrimination workplace protections for lesbian, gay, bisexual, and transgender (LGBT) employees.

The majority of the Commission voted for key findings including that LGBT workers have faced a long, serious, and pervasive history of official and unofficial employment discrimination by federal, state, and local governments and private employers. Such discrimination persists and has wide-ranging, damaging implications for the quality of life for many LGBT Americans, their children and families, and communities. An inconsistent and irreconcilable patchwork of state laws against LGBT workplace discrimination and federal court decisions interpreting existing federal law render LGBT employees insufficiently protected from workplace discrimination.

Our primary recommendation is directed to Congress: In order to effectively and consistently protect LGBT employees from workplace discrimination, Congress should immediately enact a federal law explicitly banning discrimination in the workplace based on sexual orientation and gender identity. We also make particular recommendations that federal agencies should issue and —where relevant—reaffirm specific guidance for federal and private employers outlining protections for LGBT individuals in the workforce, including specifically enumerating

protections for transgender persons; federal agencies should also collect workplace discrimination data about LGBT employees.

We at the Commission are pleased to share our views, informed by careful research and investigation, to help ensure that all Americans enjoy civil rights protections to which we are entitled.

For the Commission,

Catherine E. Lhamon

Chair

TABLE OF CONTENTS

EXECUTIVE SUMMARY

American employees spend a large part of our awake hours at work. At the same time, the majority of lesbian, gay, bisexual, and transgender (LGBT)[1] workers live in states that do not offer explicit LGBT-specific nondiscrimination protections in employment. The briefing testimony and written materials submitted to the Commission, along with extensive social science research and surveys, reflect the reality that many LGBT Americans are forced to deal with prejudice and discrimination every day in the workplace. Over the past several decades, there has been increasing national support for extending equal protections to LGBT individuals. According to a 2013 poll released by Project Right Side and Americans for Workplace Opportunity, a majority of people (88 percent), regardless of political affiliation, agreed that LGBT individuals should be judged based on their performance in the workplace.[2] Congress has not enacted federal antidiscrimination workplace protections for LGBT employees. This report highlights the main social and economic arguments made by proponents and opponents for enacting federal legislation and makes findings and recommendations regarding civil rights status for LGBT employees.

Over the past forty years, Congress has introduced multiple iterations of legislation that would prohibit workplace discrimination against LGBT Americans, but has not passed such legislation. On March 16, 2015, the Commission held a briefing to examine workplace discrimination against LGBT Americans.[3] The purpose of the briefing was to gather information about existing state, local, and federal laws and policies, and the impacts of discrimination on LGBT employees. The Commission also sought to hear from multiple perspectives in support of and against enacting federal legislation to address workplace discrimination against LGBT employees.[4]

---

[1] This report uses the acronym of LGBT to include individuals who are lesbian, gay. bisexual, or transgender. At times, this report refers to "LGB" to refer only to those individuals because, for example, the particular study being discussed may have been limited to that sub-group.

[2] Alex Lundry, "ENDA National Poll Results," (TargetPoint Consulting, September 16, 2013), http://images.politico.com/global/2013/09/29/enda_poll_2013-09-08_natl_memo.html, p. 1; *see also* http://images.politico.com/global/2013/09/29/enda_poll_2013-09-08_50_states.html.

[3] U.S. Commission on Civil Rights. *Briefing: Examining Workplace Discrimination Against LGBT Americans,* (Washington, DC, March 16, 2015), http://www.usccr.gov/calendar/trnscrpt/Discrimination_LGBT_03-16-2015.pdf (*hereinafter cited* as Briefing Transcript).

[4] During the briefing, the Commission heard from three panels of experts. These experts discussed 1) the federal government's compliance with laws, regulations, and presidential Executive Orders that prohibit discrimination against LGBT Americans; 2) the impacts for LGBT employees who reside in states that do not have specific state nondiscrimination protections; and 3) policy issues, including whether Congress should pass federal legislation and the appropriate language for such federal legislation. *Ibid.*

Proponents in favor of a national law that specifically forbids discriminating against employees based on their sexual orientation[5] or gender identity[6] contend that federal legislation is necessary to provide LGBT workers equal rights and equal dignity in the workplace similar to other workers. Proponents of federal legislation further argue that although the federal government, states, corporations, and businesses are increasingly creating and enforcing LGBT-inclusive policies, this progress is at best sporadic and uneven. As these policies are enacted separately and independently, the lack of national legal protections leaves many to hide who they are for fear of discrimination—including termination—in the workplace. They also assert that while the nation has experienced some great strides in LGBT equality over the past several years, widespread discrimination and animus towards LGBT communities is still prevalent. Additionally, researchers have found that LGBT individuals who live in jurisdictions without worker protections also experience poverty at higher rates than heterosexuals in those jurisdictions. At the same time, lesbians and gay men living in jurisdictions that do offer employment protections were less likely to be impoverished compared to heterosexuals.[7] These findings suggest anti-discrimination protections and a social climate of acceptance may mitigate disparities.

Proponents further note that existing state and federal laws leave many LGBT employees unprotected from workplace discrimination.[8] Recently, the Equal Employment Opportunity Commission (EEOC) interpreted existing federal law prohibiting sex discrimination (Title VII of the Civil Rights Act) to include claims of discrimination based on sexual orientation and gender identity.[9] The U.S. Court of Appeals for the Seventh Circuit is currently the sole Circuit to hold that sexual orientation falls within the existing language of Title VII.[10] Yet, other Circuit Courts

---

[5] Sexual orientation may be defined as "one's emotional or physical attraction to the same and/or opposite sex." Office of Personnel Management, U.S. Equal Employment Opportunity Commission, U.S. Office of Special Counsel, and Merit Systems Protection Board, *Addressing Sexual Orientation and Gender Identity Discrimination in Federal Civilian Employment: A Guide to Employment Rights, Protections, and Responsibilities*, rev. June 2015, http://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/addressing-sexual-orientation-and-gender-identity-discrimination-in-federal-civilian-employment.pdf, p. 2.

[6] Gender identity may be defined as "one's inner sense of one's own gender, which may or may not match the sex assigned at birth. Different people choose to express their gender identity differently. For some, gender may be expressed through, for example, dress, grooming, mannerisms, speech patterns, and social interactions. Gender expression usually ranges between masculine and feminine, and some transgender people express their gender consistent with how they identify internally, rather than in accordance with the sex they were assigned at birth." *Ibid.*

[7] M.V. Lee Badgett, Laura E. Durso, and Alyssa Schneebaum, "New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community," Williams Institute, June 2013, https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf, pp. 2–3, 4, 8–9.

[8] Sarah Warbelow and Breanna Diaz, "2016 State Equality Index," Human Rights Campaign Foundation, 2016, http://assets.hrc.org//files/assets/resources/SEI-2016-Report-FINAL.pdf?_ga=2.163800255.1465071743.1510103868-576800549.1507751318, p. 14.

[9] *See, Baldwin v. Foxx,* EEOC Doc No. 0120133080, 2015 WL 4397641 (EEOC Jul. 16, 2015) (discussing Title VII, Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq*).

[10] *Hively v. Ivy Tech Comty. Coll. of Ind.*, 853 F.3d 339, 350-51 (7th Cir. 2017). At the time of publication, this question was also pending before the U.S. Court of Appeals for the Second Circuit. See discussion *infra* in Chapter 2.

have held that Title VII does not include such protections.[11] In practice, this means that employees may or may not have access to a federal forum to hear their allegations of discrimination based on sexual orientation and gender identity. Additionally, twenty-eight states do not have state law protections prohibiting workplace discrimination based on sexual orientation, and thirty states do not have state law protections for being transgender or gender-nonconforming.[12] Proponents of federal legislation argue:

> Today, it's possible for a lesbian couple to get legally married on Saturday and then be fired on Monday for putting a wedding picture on their desk.[13]

> [D]iscrimination has no place in our nation and yet right now in 2015 in many states, like Florida, a person can be fired simply for being lesbian, gay, bisexual or transgender. As a result, millions of LGBT Americans go to work every day fearing that without any warning they could lose their jobs not because of their work performance but simply because of who they are or who they love . . . . Passing ENDA[14] would eliminate the patchwork of differing state and often absurd state legislation and provide consistent workplace protections across the country.[15]

Opponents to enactment of a specific federal non-discrimination law question whether the Constitution allows Congress to legislate non-discriminatory workplace protections for LGBT workers and argue that these protections, if any, should be governed by localities and businesses. They argue that federal legislation protecting sexual orientation and gender identity would infringe upon business owners' First Amendment rights and not permit them to run organizations that are consistent with their values.[16] Further, they argue that while all individuals should be respected, federal antidiscrimination legislation is bad policy because it is inconsistent with free-market principles protecting the freedom of contract and against overregulation by the government.[17] Ryan Anderson of the Heritage Foundation argues that a "fundamental principle" guiding American labor law is the "doctrine of 'at will' employment" that permits employers to dismiss employees

---

[11] *See infra* note 134 (collecting cases).

[12] Movement Advancement Project, "Non-Discrimination Laws", http://www.lgbtmap.org/equality-maps/non_discrimination_laws/ (data current as of 10/19/17).

[13] Selisse Berry, Founder and CEO at Out and Equal Workplace Advocates, testimony, Briefing Transcript, pp. 158–59.

[14] As discussed in more detail later in this chapter, the Employment Non-Discrimination Act (ENDA) was the federal nondiscrimination legislation pending at the time of the Commission's briefing in 2015.

[15] Gina Duncan, Transgender Inclusion Director at Equality Florida, testimony, Briefing Transcript, pp. 213–14.

[16] For example, *see* Family Research Council, "The Employment Non-Discrimination Act (ENDA): A Threat to Free Markets and Freedom of Conscience and Religion," October 2013, http://downloads.frc.org/EF/EF13J68.pdf.

[17] For example, *see* Ryan Anderson, "Sexual Orientation and Gender Identity (SOGI) Laws Threaten Freedom," Heritage Foundation, November 2015, http://www.heritage.org/civil-society/report/sexual-orientation-and-gender-identity-sogi-laws-threaten-freedom, p. 2.

at any time.[18] He argues that antidiscrimination laws would threaten this principle and negatively affect the business community. Hans Bader of the Competitive Enterprise Institute claims that "[s]ince American business seldom discriminates based on sexual orientation, the potential benefits of ENDA [the Employment Non-Discrimination Act] are limited, at best. But ENDA would impose real and substantial costs on business, and it could trigger conflicts with free speech and religious freedom."[19] Bader contends that the principles of free-market competition will offer enough protections to LGBT employees, since many private companies have already prohibited discrimination on the basis of sexual orientation, and to appear anti-gay may be perceived as bad for business.[20] Finally, opponents also raise concerns about the potential for increased legal costs and workplace disruptions that they believe such federal legislation would cause.[21]

After examining the current state of LGBT workplace protections, the Commission highlights the following findings and recommendations, discussed in full in Chapter 4:

Highlighted findings:

- Historians, researchers, and courts have extensively documented that lesbian, gay, bisexual, and transgender (LGBT) workers have faced a long, serious, and pervasive history of official and unofficial employment discrimination by both federal, state, and local governments and private employers.
- Federal data sources do not effectively capture rates of LGBT employment or rates of LGBT employment discrimination.
- An inconsistent and irreconcilable patchwork of state laws against anti-LGBT workplace discrimination and federal court decisions interpreting existing federal law render LGBT employees insufficiently protected from workplace discrimination.

Highlighted recommendations:

- In order to effectively and consistently protect LGBT employees from workplace discrimination, Congress should immediately enact a federal law explicitly banning discrimination in the workplace based on sexual orientation and gender identity.
- In addition to Congressional action, federal agencies including the Departments of Justice and Labor, the Equal Employment Opportunity Commission, and the Office of Personnel Management should issue and—where relevant—reaffirm specific guidance for federal

---

[18] *Ibid.* at 6.

[19] Hans Bader, "Employment Non-Discrimination Act Makes as Little Sense as Chemotherapy for a Cold," *OpenMarket Blog*, Competitive Enterprise Institute, June 2012, https://cei.org/blog/employment-non-discrimination-act-makes-little-sense-chemotherapy-cold.

[20] *Ibid.*

[21] For example, *see* Ryan Anderson, William E. Simon Fellow at the Heritage Foundation, testimony, Briefing Transcript, p. 276 ("[Nondiscrimination federal legislation] will expose employers to unimaginable liability").

and private employers outlining protections for LGBT individuals in the workforce, including specifically enumerating protections for transgender persons.

- Workplace discrimination data should be collected through the inclusion of sexual orientation and gender identity questions in population-based surveys of the workforce such as the Census, American Community Survey, and surveys fielded by the Bureau of Labor Statistics and other agencies.

[*This page intentionally left blank*]

CHAPTER 1: INTRODUCTION TO LGBT EMPLOYMENT IN AMERICA

This introductory chapter: 1) seeks to quantify the number of LGBT employees in the United States, 2) discusses the extent and impact of workplace discrimination against LGBT employees, 3) lists the existing state laws addressing LGBT employees, and 4) discusses the prior efforts to enact federal legislation.

Number of Lesbian, Gay, Bisexual, and Transgender Employees

The exact number of individuals who self-identify as LGBT is not known. Historically, many national surveys have not included questions exploring sexual orientation or gender identity.[22] In fact, early estimates of LGBT couples were made by examining U.S. Census responses identifying households with cohabitating unmarried couples of the same sex.[23] Most recently, the U.S. Census Bureau sent a draft of the 2020 Census and American Community Survey collection report to Congress in March 2017.[24] It appeared that the Census Bureau was going to collect LGBT demographic information, but later that same day, the Census Bureau stated that it mistakenly included those categories for collection.[25] Advocates have argued that alongside adding LGBT questions to the Census, the American Community Survey and surveys fielded by the Bureau of Labor Statistics should include questions on sexual orientation and gender identity.[26]

A 2013 survey conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics found that 3.4 percent of Americans identify themselves as gay or lesbian (1.6 percent), bisexual (0.7 percent) or other (1.1 percent).[27] More recently, a 2017 Gallup survey found

---

[22] Berry testimony, Briefing Transcript, p. 176 ("[W]e're not being counted. We're not being asked to self-identify who we are within companies or within workplaces at all.").

[23] Jaime Grant, "How Big is the LGBT Community? Why Can't I Find This Number?", National Gay and Lesbian Task Force, 2010, http://www.thetaskforce.org/static_html/downloads/release_materials/tf_lgbt_community.pdf, p. 3.

[24] U.S. Census Bureau, "Subjects Planned for the 2020 Census and American Community Survey," March 2017, https://www2.census.gov/library/publications/decennial/2020/operations/planned-subjects-2020-acs.pdf.

[25] Hansi Lo Wang, "U.S. Census to Leave Sexual Orientation, Gender Identity Questions Off New Surveys," *NPR*, March 29, 2017, https://www.npr.org/sections/thetwo-way/2017/03/29/521921287/u-s-census-to-leave-sexual-orientation-gender-identity-questions-off-new-surveys70329. The Administration for Community Living of the U.S. Department of Health and Human Services also proposed to delete a question on sexual orientation from the National Survey of Older Americans Act Participants, but decided to retain the question after many groups and individuals objected to the change. Revision of Currently Approved Collection for National Survey of Older Americans Act Participants (NSOAAP), 82 Fed. Reg. 28491 (Jun. 22, 2017).

[26] Statement of Stacey Long Simmons, Director of Public Policy & Government Affairs at National LGBTQ Task Force, U.S. Commission on Civil Rights, *Briefing: Examining Workplace Discrimination Against LGBT Americans,* (Washington, DC, March 16, 2015) at 5 (*hereinafter cited* as Simmons Statement).

[27] Brian W. Ward, James M. Dahlhamer, Adena M. Galinsky, Sarah J. Joestl, "Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013," National Center for Health Statistics, 2014, https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf, p. 1. The National Health Interview Survey of 34,557 adults aged

that the portion of American adults who identified as LGBT increased from 3.5 percent in 2012 to 4.1 percent in 2016.[28] According to Gallup, these figures are from "the largest representative sample of LGBT Americans collected in the U.S."[29] This means there are an estimated 10 million adults who now identify as LGBT in the U.S., which is approximately 1.75 million more individuals than in 2012. This increase is largely due to millennials (defined as those born between 1980 and 1998) being more than twice as likely as previous generations to self-identify as LGBT.[30]

Population estimates of LGBT communities may be non-inclusive due to several factors, because of the multiple dimensions of sexuality.[31] First, self-identification is only one aspect of measuring sexual orientation and gender identity. For example, research shows that when surveys are inclusive of the complex dynamics of identity, behavior, attraction, and relationships, these surveys yield very different (and often larger) population estimates compared to those that only utilize self-identification measures.[32] Other studies suggest that sexual orientation and gender identity are on a continuum (*i.e.*, not static) for some individuals, therefore, they do not self-identify with categories that traditionally appear on surveys.[33] Thus, depending on which definition(s) and measure(s) a researcher chooses, estimates may vary. These disparate results can also be due to "how comfortable and confident survey respondents feel about the confidentiality and privacy of data collected."[34]

Based on these estimates (and considering the likelihood of underreporting, as mentioned above), it is fair to say that LGBT Americans comprise a significant portion of private and public sector employees.[35] In addition to the difficulties described above, the exact number of LGBT employees

---

18–64 added questions on sexual orientation in 2013 to create an "ongoing collection of information on sexual orientation" to enable a "more consistent, long-term monitoring" of the goal of "improving the health, safety, and well-being of LGB persons." The "other" category represents the "something else" response, "don't know" response, or respondent refused to answer. *Ibid.* at 2.

[28] Gary J. Gates, "In US, More Adults Identifying as LGBT," Gallup, January 11, 2017, http://www.gallup.com/poll/201731/lgbt-identification-rises.aspx.

[29] *Ibid.* Results are based on telephone interviews with a random sample of 1,626,773 U.S. adults, 18 and older, living in all 50 states and D.C., collected from June 1, 2012 through December 30, 2016.

[30] *Ibid.*

[31] Grant, *supra* note 23, at 4-5.

[32] Identity, behavior, attraction, and relationships all capture related dimensions of sexual orientation and gender identity, but none of these measures completely address the concepts. *See* Gary Gates, "How many people are lesbian, gay, bisexual, and transgender?", Williams Institute, April 2011, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf, p. 2.

[33] *Ibid.* Judith Bradford and Jocelyn C. White, "Lesbian Health Research," in *Women and Health* (San Diego, Calif.: Academic Press, 2000), 64–78. Edward O. Laumann, John H. Gagnon, Robert T. Michael, Stuart Michaels, *The Social Organization of Sexuality: Sexual Practices in the United States* (Chicago, Ill: University of Chicago Press, 1994). Laura Dean, Ilan H. Meyer, Kevin Robinson, Randall L. Sell, Robert Sember, Vincent M.B. Silenzio, Deborah J. Bowen, et al., "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns," *Journal of the Gay and Lesbian Medical Association*, 4:3 (2000), p. 101, https://doi.org/10.1023/A:1009573800168.

[34] Gates, *supra* note 28.

[35] Crosby Burns, Kate Childs Graham, and Sam Menefee-Libey, "Gay and Transgender Discrimination in the Public Sector: Why It's a Problem for State and Local Governments, Employees and Taxpayers," Center for American

is also not fully known due to fear of coming out at work which could subject individuals to harassment or discrimination by colleagues or their employer. According to a survey from the Pew Research Center, "only one-third of employed LGBT adults say all or most of the people they closely work with are aware of their sexual orientation or gender identity."[36] Further, over a third of respondents say no one at work knows their sexual orientation or gender identity.[37] Only approximately 5.8 percent of self-identified bisexual survey respondents were generally open about their sexual orientation to their coworkers.[38] A 2014 report authored by the Human Rights Campaign found that most (53 percent) of LGBT employees are open about their sexuality with only a few people or are entirely "closeted" at work.[39]

Nevertheless, the best available data suggests a general range of 5.4 million to 8.2 million for estimating employees who self-identify as LGBT. The National LGBTQ Taskforce estimates there are 5.4 million LGBT workers in the United States.[40] For the upper-range, the 2015 Williams Institute report[41] estimates that up to 9.5 million adults self-identify as LGBT[42] and the 2017 Gallup poll estimates 10 million adults, or 4.1 percent of U.S. adults.[43] This puts the LGBT workforce at approximately over eight million LGBT employees. As of September 2009, state and local governments employed approximately 19.7 million workers.[44] This estimate includes about 5.2 million state employees and 14.5 million local government employees.[45] The Williams Institute

---

Progress, September 2012, https://cdn.americanprogress.org/wp-content/uploads/2012/08/LGBTPublicSectorReport1.pdf, p. 6.

[36] Pew Research Center, "A Survey of LGBT Americans: Attitudes, Experiences and Values in Changing Times," June 13, 2013, http://assets.pewresearch.org/wp-content/uploads/sites/3/2013/06/SDT_LGBT-Americans_06-2013.pdf, p. 59.

[37] Brad Sears & Christy Mallory, The Williams Institute, Documented Evidence of Employment Discrimination & Its Effects on LGBT People (2011), *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/Sears-Mallory-Discrimination-July-20111.pdf; Gary J. Gates, "Sexual Minorities in the 2008 General Social Survey: Coming Out and Demographic Characteristics," October 2010.

[38] *Ibid.*

[39] Deena Fidas and Liz Cooper, "The Cost of the Closet and the Rewards of Inclusion: Why the Workplace Environment for LGBT People Matters to Employers," Human Rights Campaign Foundation, May 2014, http://assets.hrc.org//files/assets/resources/Cost_of_the_Closet_May2014.pdf?_ga=1.25864509.1225877603.1490017176, p. 9.

[40] Stacey Long Simmons, Director of Public Policy and Government Affairs for the National LGBTQ Task Force, testimony, Briefing Transcript, p. 80. *See also* Simmons Statement, *supra* note 26, at 2.

[41] The Williams Institute is a nationally recognized think tank housed at the UCLA School of Law that specializes in research on sexual orientation and gender identity law, and public policy. It was founded in 2001 and is a respected, independent research institute that is often cited and influential in policy change, media, and nonprofit advocacy work regarding LGBTQ communities.

[42] Lauren Jow, "9.5M LGBT Adults Nationwide Would Be Protected under New Comprehensive Non-Discrimination Bill," Williams Institute, July 2015, *available at* https://williamsinstitute.law.ucla.edu/press/press-releases/9-5m-lgbt-adults-nationwide-would-be-protected-under-new-comprehensive-non-discrimination-bill/, Gary J. Gates, "LGBT Demographics: Comparisons among population-based surveys," Williams Institute, 2014, http://williamsinstitute.law.ucla.edu/wp-content/uploads/lgbt-demogs-sep-2014.pdf, p. 1.

[43] Gates, *supra* note 28.

[44] Burns, *supra* note 35, at 6.

[45] *Ibid.*

estimates that as of 2009 slightly more than 4 percent of municipal employees (585,000) and slightly more than 8 percent of state employees (418,000) are LGBT.[46] In addition, as shown in Table 1 below, data from the U.S. Bureau of Labor Statistics and the Williams Institute reflect that approximately 7 million private-sector employees—roughly 85 percent of the total LGBT workforce—are LGBT.

Table 1 Number of Gay and Transgender Employees by Secto

	Number of LGBT Employees (Est.)	Total Number of Employees	Percent out of total LGBT Workforce (Est.)
Local	585,000	14,516,000	7.13
State	418,000	5,155,000	5.09
Federal	200,000	2,829,000	2.44
Total Public	1,203,000	22,500,000	14.67
Total Private	7,000,000	107,234,000	85.33
Total Public and Private	8,203,000	129,734,000	100

Source: Crosby Burns, Kate Childs Graham, and Sam Menefee-Libey, "Gay and Transgender Discrimination in the Public Sector: Why It's a Problem for State and Local Governments, Employees and Taxpayers," Center for American Progress, September 2012, https://cdn.americanprogress.org/wp-content/uploads/2012/08/LGBTPublicSectorReport1.pdf, p. 6 (noting that the source of its data is the Williams Institute and U.S. Bureau of Labor Statistics), *accessed at* https://www.americanprogress.org/wp-content/uploads/2012/08/LGBTPublicSectorReport1.pdf, USCCR staff provided calculations for third (totals) column.

In 2012, the Office of Personnel Management (OPM) began asking federal employees to self-identify whether they are LGBT on its annual survey of federal workers.[47] As of 2015, OPM estimates that 3 percent of the federal civilian workforce is LGBT.[48] With regard to military service, the University of Southern California estimates that nearly 71,000 LGBT service members were serving in the military, or 2.8 percent of the total work force of the United States military as of 2016.[49] The Williams Institute estimates that nearly 150,000 transgender military personnel have served or are currently serving in the military.[50]

---

[46] Brad Sears, Nan D. Hunter, Christy Mallory, "Documenting Discrimination on the Basis of Sexual Orientation and Gender Identity in State Employment," Williams Institute, September 2009, https://williamsinstitute.law.ucla.edu/wp-content/uploads/1_LGBTWorkforce1.pdf, p. 1.

[47] U.S. Office of Personnel Management, "2012 Federal Employee Viewpoint Survey Results: Employees Influencing Change," 2012, https://www.fedview.opm.gov/2012files/2012_Government_Management_Report.pdf, p. 21.

[48] U.S. Office of Personnel Management, "Federal Employee Viewpoint Survey Results: Employees Influencing Change," 2015, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF, p. 38.

[49] Jeremy T. Goldbach and Carl Andrew Castro, "Lesbian, Gay, Bisexual, and Transgender (LGBT) Service Members: Life After Don't Ask, Don't Tell," *Current Psychiatry Reports*, 18:56 (2016), p. 1, http://cir.usc.edu/wp-content/uploads/2016/04/GoldbachCastro-LGBT-Military.pdf.

[50] Gary J. Gates and Jody L. Herman, "Transgender Military Service in the United States," Williams Institute, May 2014, http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf, p. 1. *See also* Agnes Gereben Schaefer, Radha Iyengar, Srikanth Kadiyala, Jennifer Kavanagh, Charles C. Engel, Kayla

Extent of Discrimination Against LGBT Employees

Studies have found that discrimination in the workplace has a negative effect on LGBT employees.[51] LGBT individuals often face lower wages, increased difficulty in finding jobs, promotion denials, and/or job terminations due to their sexual orientation or gender identity. Studies have found that anywhere from 21 to 47 percent of LGBT adults faced employment discrimination because they were gay or transgender.[52] A summary of numerous studies of LGBT employee survey respondents showed that ten to 28 percent reported receiving negative performance evaluations or were passed over for promotion because they were gay or transgender, and seven to 41 percent experienced verbal and/or physical abuse in the workplace.[53] More staggering is that 90 percent of transgender employees report experiencing some form of harassment or mistreatment on the job.[54] For instance, 23 percent of employed transgender workers reported mistreatment such as "being forced to use a restroom that did not match their gender

---

M. Williams and Amii M. Kress, "Assessing the Implications of Allowing Transgender Personnel to Serve Openly," RAND Corporation, 2016, https://www.rand.org/pubs/research_reports/RR1530.html (finding that somewhere between 1,320 and 6,630 transgender individuals then served in the military and a more precise estimate was not possible given current data limitations).

[51] *See e.g.,* Deborah Vagins, "Working in the Shadows: Ending Employment Discrimination for LGBT Americans," American Civil Liberties Union, September 2007, https://www.aclu.org/files/pdfs/lgbt/enda_20070917.pdf; Sears, *supra* note 37; Jennifer C. Pizer, Brad Sears, Christy Mallory, and Nan D. Hunter, *Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People: The Need for Federal Legislation Prohibiting Discrimination and Providing for Equal Employment Benefits*, 45 Loy. L.A. L. Rev. 715 (2012), *available at* http://williamsinstitute.law.ucla.edu/wp-content/uploads/Pizer-Mallory-Sears-Hunter-ENDA-LLR-2012.pdf.

[52] Movement Advancement Project, Center for American Progress, and Human Rights Campaign, "A Broken Bargain: Discrimination, Fewer Benefits and More Taxes for LGBT Workers," June 2013, http://www.lgbtmap.org/file/a-broken-bargain-full-report.pdf, p. 27 (estimating that 38% of LGBT employees who were "out at work" had experienced discrimination or harassment); Preston Mitchum, "Workplace Discrimination Series: Brooke Waits," Center for American Progress, Aug. 5, 2013, *available at* http://www.americanprogress.org/issues/lgbt/news/2013/08/05/71447/workplace-discrimination-series-brooke-waits/; Burns, *supra* note 35, at pp. 7–8 (collecting data from four different surveys that reflected that, at the low end, 13 percent of gay public-sector workers "reported being denied a promotion or receiving a negative job evaluation" to, at the high end, 47% of respondents in on a survey on transgender Americans reported experiencing "some sort of adverse job outcome"). Michigan Department of Civil Rights, *Report on LGBT Inclusion Under Michigan Law, With Recommendations for Action,* 43–44, (Jan. 28, 2013,) *available at* https://www.michigan.gov/documents/mdcr/MDCR_Report_on_LGBT_Inclusion_409727_7.pdf; Hon. Jared Polis, U.S. Representative of Second District of Colorado, testimony, Briefing Transcript, p. 257 (stating that "[f]orty-two percent of LGBT Americans have experienced mistreatment of harassment on their job just due to their sexual orientation").

[53] M.V. Lee Badgett, Holning Lau, Brad Sears, Deborah Ho, "Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination," Williams Institute, 2007, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Badgett-Sears-Lau-Ho-Bias-in-the-Workplace-Jun-2007.pdf, p. 2.

[54] U.S. Department of Labor, "DOL Policies on Gender Identity: Rights and Responsibilities," July 2013, https://www.dol.gov/oasam/programs/crc/20130712GenderIdentity.htm (citing Jaime M. Grant, Lisa A. Mottet, and Justin Tanis, "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, p. 3).

identity, being told to present in the wrong gender in order to keep their job, or having a boss or coworker share private information about their transgender status without their permission."[55]

Discrimination against LGBT employees can begin with the job application process. Researchers found discrimination against LGBT employee applicants, for example, in a study when researchers sent two sets of matched resumes to major employers, where one resume suggested the applicant was gay (*e.g.*, by disclosing leadership experience at an LGBT student organization), employers were far less likely to positively receive "gay" applicants than "straight" ones. Results revealed that those with indications of being LGBT received approximately 30 percent fewer callbacks.[56]

Discrimination against LGBT employees affects all occupations. LGBT individuals across the country and in a variety of professions report being discriminatorily terminated from their jobs. As with all discrimination claims, there may be conflicting narratives between employee and employer. Pointing to either administrative (*i.e.*, EEOC) or court rulings to determine rates of discrimination is also difficult: the EEOC only recently ruled that people claiming discrimination on the basis of sexual orientation or gender identity have the right to sue under Title VII. As discussed in more detail below, only one Circuit has held that sexual orientation claims may be brought under Title VII, and the Circuit courts are divided on whether claims of gender identity fall under Title VII.

At the same time, there is evidence that discrimination is occurring. Every year (since January 2013 when the EEOC began collecting data), there has been a steady increase in the number of merit resolutions rulings and reasonable cause claims reported to the EEOC for LGBT plaintiffs (see Table 2). While the EEOC does not publish their decisions, these numbers suggest that these cases had favorable outcomes to LGBT plaintiffs alleging discrimination or the EEOC determined that there was reasonable cause to believe discrimination occurred based upon investigation.

Results from the 2008 General Social Survey (GSS)[57] found that 42 percent of LGB employees experienced at least one form of employment discrimination at some point in their lives.[58] Moreover, the survey found 25 percent of LGB-identified respondents employed by federal, state, or local governments reported having experienced workplace discrimination due to their sexual orientation in the prior five years.[59]

---

[55] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi, "The Report of the 2015 U.S. Transgender Survey," National Center for Transgender Equality, December 2016, http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf, p. 10–11.

[56] Emma Mishel, Discrimination against Queer Women in the U.S. Workforce: A Résumé Audit Study, *Socius*, p. 6, (2016), http://journals.sagepub.com/doi/pdf/10.1177/2378023115621316.

[57] The GSS is conducted by the National Opinion Research Center at the University of Chicago, and has been a reliable source for monitoring social and demographic changes in the United States since 1972.

[58] Pizer, *supra* note 51, at 722-23.

[59] *Ibid.* at 723.

Table 2 LGBT-Based Sex Discrimination Charges				
	FY 2013*	**FY 2014**	**FY 2015**	**FY 2016**
Receipts	808	1,100	1,412	1,768
Resolutions	337	846	1,135	1,649
Resolutions By Type				
Settlements	31	71	96	118
	9.2%	8.4%	8.5%	7.2%
Withdrawals w/Benefits	17	46	57	74
	5.0%	5.4%	5.0%	4.5%
Administrative Closures	69	164	203	282
	20.5%	19.4%	17.9%	17.1%
No Reasonable Cause	216	544	737	1,114
	64.1%	64.3%	64.9%	67.6%
Reasonable Cause	4	21	42	61
	1.2%	2.5%	3.7%	3.7%
Successful Conciliations	1	13	13	26
	0.3%	1.5%	1.1%	1.6%
Unsuccessful Conciliations	3	8	29	35
	0.9%	0.9%	2.6%	2.1%
Merit Resolutions	52	138	195	253
	15.4%	16.3%	17.2%	15.3%
Monetary Benefits (Millions)	**$0.9**	**$2.2**	**$3.3**	**$4.4**

*The data for FY 2013 is for the last three quarters only. EEOC began tracking information on charges filed alleging discrimination related to gender identity and/or sexual orientation for charges received on or after January 1, 2013. Note: Charges may have multiple allegations under multiple statutes, so totals will not tally with breakdowns of specific bases or issues and are subject to updates. Monetary benefits include amounts which have been recovered exclusively or partially on non-LGBT claims included in the charge.
Source: Jeanne Goldberg (Senior Attorney Advisor, Office of the Legal Counsel, EEOC), in discussion with USCCR staff, April 17, 2017.

According to the Williams Institute, in 2008 approximately 38 percent of LGB people who were open about their sexual orientation in the workplace have experienced discrimination or harassment in the workplace.[60] Seven percent of LGB Americans report losing jobs because of their sexual orientation.[61] According to the National Center for Transgender Equality and the National Gay and Lesbian Task Force, for transgender employees the statistics are significantly higher, with 90 percent reporting experiencing harassment, mistreatment, or discrimination at

[60] *Ibid.*
[61] *Ibid.*

work, or taking actions to avoid it (*e.g.*, hiding their identity), due to their gender identity.[62] In addition, 2013 data from the Pew Research Center indicates that 21 percent of LGBT Americans feel that an employer has treated them unfairly due to their sexual orientation or gender identity.[63]

Employment discrimination also significantly affects LGBT youth and their long-term career opportunities. Bill Bettencourt from the Center for the Study of Social Policy explained that "[t]he lack of sufficient supportive career options for LGBT young people unfortunately leads to a path that impacts our criminal system and society as a whole."[64] According to a 2011-2012 Williams Institute survey, approximately 40 percent of homeless youth are LGBT.[65] Respondents most frequently cited family rejection of their sexual orientation or gender identity as a factor leading to their homelessness,[66] and 32 percent indicated abuse from their families as a reason cited for leaving.[67] Bettencourt argued that "[n]o matter what kinds of system improvements we put in place to support these young people in achieving some independence and becoming responsible citizens, without workplace supports we are doomed to fail them. Even when they can get jobs, if they cannot be themselves in the workplace, too often their productivity is impacted, as well as their ability to keep a job."[68]

ECONOMIC IMPACTS FROM WORKPLACE DISCRIMINATION

Workplace discrimination against LGBT communities can cause job instability and high turnover, resulting in greater unemployment and poverty rates as well as substantial wage gaps between LGBT and heterosexual workers. On average gay men earn from ten to 32 percent less than similarly qualified heterosexual males.[69] Older gay and lesbian adults experience higher poverty rates than their heterosexual counterparts.[70] In the 2015 U.S. Transgender Survey released by the

---

[62] Grant, *supra* note 54, at 51.

[63] Pew Research Center, *supra* note 36, at 1. Pew Research Center surveyed "a nationally representative sample of 1,197 self-identified lesbian, gay, bisexual, and transgender adults 18 years of age or older. The sample comprised 398 gay men, 277 lesbians, 479 bisexuals, and 43 transgender adults." *Ibid.* at 3.

[64] Public Comment of Bill Bettencourt, Senior Associate, Center for the Study of Social Policy, U.S. Commission on Civil Rights, *Briefing: Examining Workplace Discrimination Against LGBT Americans* (Washington, DC, March 16, 2015) (submitted March 11, 2015).

[65] Laura E. Durso and Gary J. Gates, "Serving Our Youth: Findings from a National Survey of Services Providers Working with Lesbian, Gay, Bisexual, and Transgender Youth Who Are Homeless or At Risk of Becoming Homeless," Palette Fund, True Colors Fund, and Williams Institute, July 2012, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Durso-Gates-LGBT-Homeless-Youth-Survey-July-2012.pdf, p. 3.

[66] *Ibid.* at 4 (finding that 46% of respondents cited this factor, the highest of any factor cited by the youth).

[67] *Ibid.*

[68] Bettencourt Comment, *supra* note 64.

[69] Lee Badgett, *supra* note 53, at 1.

[70] Movement Advancement Project Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders, and Center for American Progress, "LGBT Older Adults: Falling Through the Safety Net," September 2010, https://cdn.americanprogress.org/wp-content/uploads/issues/2010/09/pdf/lgbt_safetynet.pdf, p. 1. Randy Albelda, M.V. Lee Badgett, Alyssa Schneebaum, Gary J. Gates, "Poverty in the Lesbian, Gay, and Bisexual Community."

National Center for Transgender Equality, transgender individuals were three times as likely to be unemployed and more than twice as likely to live in poverty compared to general rates in the U.S.[71] Nearly 30 percent of respondents in the survey reported being homeless.[72] The National Commission on Employment Policies estimated that discrimination against LGBT employees can be quantified as causing a $47 million loss in annual profits, attributable to training expenditures and unemployment benefits. Others have estimated that hostile work environments cost companies $1.4 billion in lost output per year due to a decline in productivity.[73]

Financially, discrimination also creates a large burden on national economic growth. Discrimination can lead to increased turnover for a business. For instance, approximately 53 percent of LGBT employees are "closeted."[74] Closeted LGBT employees "who felt isolated at work" are 73 percent more likely than their heterosexual counterparts to leave a position within three years.[75] Due to direct and indirect costs (*e.g.*, exit interviews, severance pay, temporary staffing, loss of productivity, training new employees) replacing employees can be quite costly.[76] Replacing employees due to discrimination can cost anywhere from $5,000 to $10,000 for an hourly worker, and between $75,000 to $211,000 for an executive who makes $100,000 a year.[77] Another analysis found the annual cost of employee turnover due to various forms of workplace discrimination could cost U.S. employers upwards of $64 billion annually.[78] There are also legal costs associated with discrimination for all businesses. Employers who find themselves tied up in discrimination lawsuits can experience significant financial costs. In 2010, the Annual Workplace Class Action Litigation Report found that the cost of the top-ten private plaintiff employment discrimination lawsuits totaled $346.4 million, which increased from $84.4 million just a year

---

Williams Institute, March 2009, *available at*: http://escholarship.org/uc/item/2509p8r5; Crosby Burns and Jeff Krehely, "Gay and Transgender People Face High Rates of Workplace Discrimination and Harassment: Data Demonstrate Need for Federal Law," Center for American Progress, May 2011, *available at* https://cdn.americanprogress.org/wp-content/uploads/issues/2011/06/pdf/workplace_discrimination.pdf.

[71] James, *supra* note 55, at 3.

[72] *Ibid.*

[73] Kenneth A. Kovach and Peter E. Millspaugh, *Employment Non Discrimination Act: On the Cutting Edge of Public Policy*, 39 Bus. Horizon 65, 70 (1996). *See also* Jeremy S. Barber, Comment, Re-Orienting Sexual Harassment: Why Federal Legislation is Needed to Cure Same-Sex Sexual Harassment Law, 52 AM. U. L. REV. 493, 531 & n. 238 (2002).

[74] Fidas, *supra* note 39, at 2. HRC Staff, "HRC Study Shows Majority of LGBT Workers Closeted at the Workplace," Human Rights Campaign, HRC Blog, May 7, 2014, *available at* http://www.hrc.org/blog/entry/hrc-study-shows-majority-of-lgbt-workers-closeted-on-the-job.

[75] Pizer, *supra* note 51, at 14.

[76] Heather Boushey and Sarah Jane Glynn, "There Are Significant Business Costs to Replacing Employees," Center for American Progress, November 2012, https://cdn.americanprogress.org/wp-content/uploads/2012/11/16084443/CostofTurnover0815.pdf, p. 5.

[77] Gail Robinson and Kathleen Dechant, "Building a business case for diversity," *The Academy of Management Executive*, 11.3: 21, August 1997, http://cursos.itam.mx/sastre/casos%20y%20ejercicios/diversidadrobinsonydechant97.pdf, p. 23.

[78] The Level Playing Field Institute, "The Corporate Leavers Survey," January 2007. http://www.workforcediversitynetwork.com/docs/corporate-leavers-survey.pdf, p. 4.

before.[79] In 2013, the cost of the top-ten private plaintiff employment discrimination lawsuits totaled $638 million.[80]

Studies have found that policies protecting against discrimination on the basis of sexual orientation and/or gender identity have a positive impact on businesses in terms of employee morale, the work environment, and profits. Utilizing data from the Organization for Economic Co-operation and Development (OECD), Out Now Global estimates that—as a nation—the U.S. could save $8.93 billion if LGBT workers felt comfortable being out at work.[81] They argue these savings would be the result of LGBT workers being able to be out to all of their colleagues without fear of harassment or discrimination. Further, the report estimates that businesses would have a direct benefit as well. Out Now Global found that for businesses with 10,000 employees their savings could be between $127 thousand and $944 thousand; for businesses with 50,000 employees, their savings estimated between $633 thousand and $4.7 million; businesses with 100,000 employees, $1.3 million and $9.4 million; and for those with 250,000 employees, $3.2 million and $23.6 million in savings.[82]

Businesses have also cited that having a diverse staff positively affects office operations. Such benefits include: recruitment and retention, ideas and innovation, customer service, productivity, customer base, and employee relations and morale.[83] Additionally, nondiscrimination policies have positive effects on LGBT workers, including high job satisfaction, high commitment to the company, high life satisfaction, high psychological adjustment, and less conflict between work

---

[79] Seyfarth Shaw LLP, "Annual Workplace Class Action Litigation Report," January 2011, http://www.seyfarth.com/dir_docs/publications/2016WCARfinal.pdf.

[80] Chris DiMarco, "Top 10 most expensive discrimination settlements of 2013," *Corporate Counsel*, July 8, 2014, http://www.insidecounsel.com/2014/07/08/top-10-most-expensive-discrimination-settlements-o.

[81] Ian Johnson and Darren Cooper, "LGBT Diversity: Show Me The Business Case," Out Now, February 2015, http://www.outnowconsulting.com/media/13505/Report-SMTBC-Feb15-V17sm.pdf, p. 47 (data source: Out Now Global LGBT 2020 Study). This calculation uses the midpoint between the Center for American Progress' estimate of 16.1% of annual salary to replace low-skilled employees and Oxford Economics' estimate of 120% of annual salary to replace average to high-skilled employees. Boushey, *supra* note 76, at p. 2; Oxford Economics, "The Cost of Brain Drain: Understanding the financial impact of staff turnover," February 2014, http://www.oxfordeconomics.com/my-oxford/projects/264283. The calculation is for moving the "out to none" population to being "out to all" for the national full time workforce, with 38% of U.S. respondents stating they are currently "out to all," assuming that the LGBT community comprises 6% of the adult population. Lukenbill, G, "Untold millions: Positioning your business for the gay and lesbian consumer revolution" Harper Collins: New York; U.S. Census Bureau, "Annual estimates of the population by five-year age groups and sex for the United States," May 2007.

[82] The achievable savings for companies of the sizes indicated where the lower amount is if all workers are defined as low-skilled (Boushey, *supra* note 76, at 2), and the upper level in the calculation is the average figure found in 2014 as the costs to replace staff (Oxford Economics, *supra* note 81).

[83] Brad Sears and Christy Mallory, "Economic Motives for Adopting LGBT-Related Workplace Policies," Williams Institute, October 2011, http://williamsinstitute.law.ucla.edu/wp-content/uploads/Mallory-Sears-Corp-Statements-Oct2011.pdf, p. 2–3.

and home.[84] A 2014 Human Rights Campaign report found that one in four LGBT employees reported staying at a job specifically because of its inclusive environment.[85]

Implementing these policies affects employee morale and satisfaction, thereby affecting productivity. Of the top 50 Fortune 500 companies that implemented nondiscrimination policies, a majority of those companies stated that these policies increased overall profitability.[86] When polled, a majority of small business owners believe laws that prohibit discrimination against LGBT employees can improve their bottom line.[87] Further, more than two-thirds of small business owners believe there should be a federal law prohibiting employment discrimination against LGBT individuals.[88]

INTENSIFIED DISCRIMINATION AGAINST TRANSGENDER INDIVIDUALS

Due to the lack of cultural awareness on transgender issues and stigma, many transgender workers face particular difficulty obtaining jobs, retaining jobs, and receiving promotions. Mara Keisling, Executive Director of the National Center for Transgender Equality, offered testimony to the Commission explaining some of the hardships that the transgender community faces:

> [W]hat I think is important for everybody to understand -- that right now in 2015, more than at any time in my 15-year career -- in this moment, transgender people are traumatized. They are traumatized economically, they are traumatized culturally and they are very much traumatized physically. . . . We are really a resilient and determined people. You have to be when you are as marginalized as transgender people are, and . . . our testimony shows how transgender people are under siege and traumatized economically with an unemployment rate twice the national average or four times [more] likely than non-trans people to live on less than $10,000 a year.[89]

The Commission also received testimony that showed how these difficulties are "exacerbated for transgender people who are also members of other vulnerable communities, such as being a person

---

[84] Kristin Griffith and Michelle Hebl, "The Disclosure Dilemma for Gay Men and Lesbians: 'Coming Out' at Work," *Journal of Applied Psychology*, 87(6):1191–99 (2002), pp. 1195–96.
[85] Fidas, *supra* note 39, at 23.
[86] U.S. Congress, Joint Economic Committee Democratic Staff, "Economic Consequences of Discrimination Based on Sexual Orientation and Gender Identity", November 2013, p. 2.
[87] Small Business Majority, "Opinion Poll: Small Businesses Support Workplace Nondiscrimination Policies," June 4, 2013, https://www.smallbusinessmajority.org/sites/default/files/research-reports/060413-workplace-nondiscrimination-poll-report.pdf, p. 4.
[88] *Ibid.*
[89] Mara Keisling, Executive Director of the National Center for Transgender Equality, testimony, Briefing Transcript, pp. 215–16.

of color; undocumented; living with HIV/AIDS; or a senior or youth."[90] A survey by the National Center for Transgender Equality and the National Gay and Lesbian Task Force found that 44 percent of transgender employees were passed over for a job, 23 percent were denied a promotion, and 26 percent were fired due to their gender identity.[91] Respondents, who reported having lost a job due to bias, further reported being currently unemployed at much higher percentages than the general population (26 to seven percent respectively).[92] This finding suggests that transgender individuals struggle to regain employment after they have been discriminatorily terminated.

Transgender individuals are unemployed at three times the rate of the general population,[93] and transgender people of color are jobless at up to four times the rate of the general population, according to the National Transgender Discrimination Survey.[94] The same survey found that employment discrimination negatively affects transgender workers in many ways. These issues include hiring, retention, promotion, and suffering from underemployment. Further, many transgender workers report experiencing hostile work environments where they are often mistreated, harassed, physically or sexually assaulted, forced to present as a gender they do not identify with, asked inappropriate questions, and deliberately taunted by the use of incorrect pronouns by their coworkers.[95] Due to the increased stigma of being transgender and these barriers listed above, unemployment is particularly detrimental to transgender individuals. Further, many transgender individuals consider themselves underemployed because they are overqualified for their position. For example, transgender people report often taking such jobs because of difficulties of being hired. According to a 2011 report, transgender respondents who were unemployed have nearly double the rate of engaging in survival sex work, four times the rate of homelessness, and 85 percent more incarceration compared to those who were employed.[96] In addition, they are disproportionately more likely to be HIV positive, smoke, use drugs or drink heavily, and have multiple suicide attempts.[97]

---

[90] Statement of Ilona Turner, Legal Director at Transgender Law Center, U.S. Commission on Civil Rights, *Briefing: Examining Workplace Discrimination Against LGBT Americans,* (Washington, DC, March 16, 2015) at 2 (*hereinafter cited* as Turner Statement).

[91] Grant, *supra* note 54, at 53.

[92] *Ibid.*

[93] James, *supra* note 55, at 140.

[94] Grant, *supra* note 54, at 55.

[95] *Ibid.* at 56-62. *See, e.g., Bost v. Sam's East, Inc.*, E.E.O.C. Charge Number 430-2014-01900, Determination (Aug. 4, 2017), *available at* http://transgenderlegal.org/media/uploads/doc_729.pdf. In this case, the EEOC issued a determination that a transgender employee of Sam's Club "was subjected to a hostile work environment because of her sex," after the evidence demonstrated that the employee "was harassed in that [employer] officials repeatedly referred to [the employee] by using masculine pronouns when speaking with her or providing her written correspondence. Despite [the employee's] complaints to have this behavior stopped, the derogatory masculine references continued."

[96] Grant, *supra* note 54, at 65.

[97] *Ibid.*

Data released in 2016 from the largest national survey of transgender Americans by the National Center for Transgender Equality show:[98]

1. In the past year, 30 percent of respondents who had a job claimed they were fired, denied a promotion, or experienced other forms of mistreatment (*e.g.*, verbal harassment, physical or sexual assault at work) due to their gender identity; 13 percent of respondents claimed a lost job.
2. In the past year, 15 percent of respondents were verbally harassed, physically attacked, and/or sexually assaulted while at work.
3. 77 percent of respondents who had a job in the past year hid their gender identity, delayed their transition, or quit their job, due to fear of negative repercussions.
4. Due to perceived bias in employment, 20 percent of those surveyed felt forced to have to work in the "underground economy" (*e.g.*, sex work or dealing drugs).

Kylar Broadus, a transgender man and the Senior Public Policy Counsel with the National LGBTQ Task Force, presented some of these findings along with his personal experiences of discrimination before the United States Senate in 2012 and again at the March 2015 briefing of the U.S. Commission on Civil Rights. After announcing his transition to coworkers, Broadus reported that he was harassed daily, forbidden from talking to certain individuals, and heavily monitored by his supervisor, despite the fact that his work performance had not suffered. Six months later, Broadus lost his job. He was unemployed for a year before finding another job and suffered post-traumatic stress disorder because of the negative treatment at work.[99] Fifteen years later, he stated that he is still dealing with the financial repercussions due to extended underemployment and has not been able to pay off his student loans.[100]

As a part of the National LGBTQ Task Force, he seeks to ensure that there are clear directives to employers regarding protections for LGBT Americans. In his own words:

> [W]hile we worked hard, all of us, to provide protections there are not enough protections and they're slim, particularly for transgender individuals, and [] there are unclear directives. And as we've seen with past laws enacted in the United States, when there are unclear directives to employers then the laws that are there become very murky . . . We

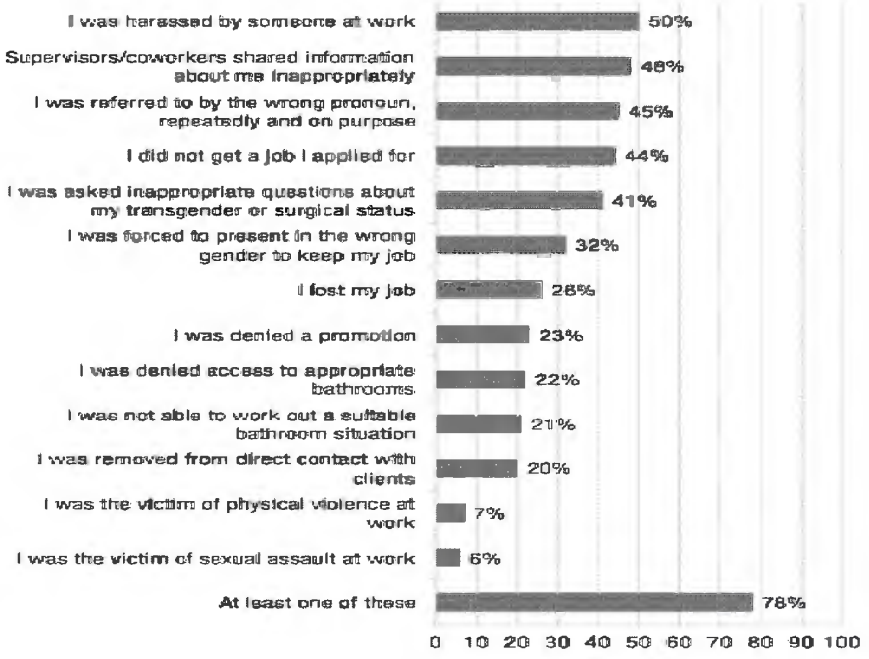
---

[98] James, *supra* note 55, at 10-11.
[99] Statement of Kylar W. Broadus, Senior Public Policy Counsel of the Transgender Civil Rights Project at the National LGBTQ Task Force, U.S. Commission on Civil Rights, *Briefing: Examining Workplace Discrimination Against LGBT Americans,* (Washington, DC, March 16, 2015) at 4-5 (*hereinafter cited* as Broadus Statement).
[100] *Ibid.*

need clear expressed federal protections for transgender Americans. After all, we are people and we are human beings and we deserve the right to make a living.[101]

Broadus' experiences are not unique; many transgender individuals have reported enduring similar mistreatment in the workplace (Figure 1). Further, they report feeling forced to take jobs for which they are overqualified and to make significantly less money compared to cisgender[102] individuals. Figure 2 shows the large disparity in the percentage of transgender individuals with household incomes less than $10,000 compared to the general population.

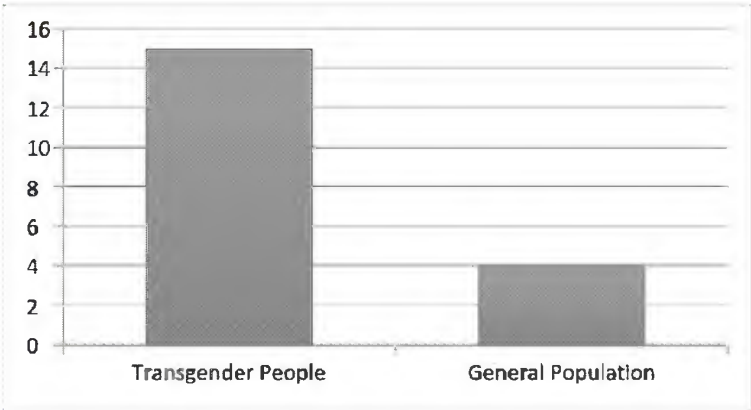
Figure 1. Transgender Workers—Mistreatment and Workplace Discrimination



Source: Jaime M. Grant, Lisa A. Mottet, and Justin Tanis. "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011, http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, p. 56.

[101] Kylar W. Broadus, Senior Public Policy Counsel of the Transgender Civil Rights Project at the National LGBTQ Task Force, testimony, Briefing Transcript, pp. 225–26.
[102] Cisgender is a term referring to individuals whose gender identity is congruent with the sex they were assigned at birth.

FIGURE 2. Percent of People with Household Incomes under $10,000



Source: Jaime M. Grant, Lisa A. Mottet, and Justin Tanis, "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, p. 51.

Recently, additional issues transgender individuals face in the workplace have become more prominent in national media. These news accounts cover efforts from transgender individuals to be treated fairly and have their gender identities recognized, which includes the use of their correct names and pronouns as well as being allowed to adhere to the appropriate dress code.[103] OPM encourages federal agencies to eliminate "gender-specific dress and appearance rules" to ensure that all employees are comfortable.[104] Additionally, many advocates are fighting for employer-provided healthcare benefits to include sex reassignment surgery, counseling, and hormone therapy.[105]

Existing State Laws for LGBT Employees

Most states use Title VII of the Civil Rights Act of 1964 as the model for state anti-discrimination laws. Accordingly, most states have enacted legislation to prohibit discrimination on the basis of

---

[103] Ellen Chang, "Transgender Employees Seeking Greater Workplace Protection," *The Street*, July 27, 2017, https://www.thestreet.com/story/13157435/1/transgender-employees-seeking-greater-workplace-protection.html.
[104] U.S. Office of Personnel Management, "Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace Diversity and Inclusion," Diversity & Inclusion: Reference Materials, https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/gender-identity-guidance/.
[105] R. Nick Gorton, "Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma," *Sexuality Research and Social Policy*, December 2007, Vol 4(4): 81-91, *available at* http://www.deanspade.net/wp-content/uploads/2010/08/gorton.pdf; Human Rights Campaign Foundation, "Corporate Equality Index 2017: Rating Workplaces on Lesbian, Gay, Bisexual and Transgender Equality," http://assets.hrc.org//files/assets/resources/CEI-2017-FinalReport.pdf?_ga=1.92925597.1225877603.1490017176, pp. 24–27; Jennifer Wong, *Recasting Transgender-Inclusive Healthcare Coverage: A Comparative Institutional Approach to Transgender Healthcare Rights*, 31 Law & Ineq. 471 (2013), *available at*: http://scholarship.law.umn.edu/lawineq/vol31/iss2/6.

race, sex, and religion along with other protections provided by federal law. Some states have adopted protections against discrimination based on sexual orientation and/or gender identity, but a sizable minority of states have not extended any anti-discrimination protections to LGBT individuals. Where they exist, these state protections may be in the form of a state statute, a state executive order, an administrative order, or state policy for state employees. Such legislation or orders vary between states. Local jurisdictions (such as cities or counties) may also have passed ordinances. Twenty states plus the District of Columbia have state laws that offer employment protections for all LGBT employees.[106] An additional two states have laws prohibiting sexual orientation discrimination, but exclude transgender protections.[107] Eight states have an executive order, administrative order, or a state policy that protects only LGBT state employees. An additional three states offer LGB protections to state employees, but do not address transgender employees. And 17 states offer no protections on the basis of sexual orientation or gender identity, but cities and local municipalities may offer their own protections (see Table 3).[108]

Table 3 Employment Protection Laws by State

Sexual Orientation & Gender Identity Statute (LGBT)*	Sexual Orientation Only (LGB)**	Executive Order for State Employees	Administrative Order for State Employees	Government Policy for State employees	No LGBT protections
California	New Hampshire	Arizona (LGB)	Alaska (LGB)	Indiana (LGBT)	Alabama
Colorado	Wisconsin	N.C. (LGBT)***			Arkansas
Connecticut		Kentucky (LGBT)			Florida
Delaware		Michigan (LGBT)			Georgia
District of Columbia		Missouri (LGB)			Louisiana
Hawaii		Montana (LGBT)			Idaho
Illinois		Ohio (LGBT)			Mississippi
Iowa		Pennsylvania (LGBT)			Nebraska
Maine		Virginia (LGBT)			Kansas
Maryland					North Dakota
Massachusetts					Oklahoma

[106] Movement Advancement Project, "Non-Discrimination Laws: Employment," data current as of October 19, 2017, http://www.lgbtmap.org/equality-maps/non_discrimination_laws; Human Rights Campaign, "State Maps of Laws & Policies: Employment," updated April 25, 2017, http://www.hrc.org/state-maps/employment.

[107] *Ibid.*

[108] Movement Advancement Project, "Non-Discrimination Laws: Employment," data current as of October 19, 2017, http://www.lgbtmap.org/equality-maps/non_discrimination_laws.

Minnesota					South Carolina
Nevada					South Dakota
New Jersey					Tennessee
New Mexico					Texas
New York					West Virginia
Oregon					Wyoming
Rhode Island					
Utah					
Vermont					
Washington					

Source: Movement Advancement Project, "Non-Discrimination Laws: Employment," data current as of October 19. 2017, http://www.lgbtmap.org/equality-maps/non_discrimination_laws; Human Rights Campaign, "State Maps of Laws & Policies: Employment," updated April 25, 2017, http://www.hrc.org/state-maps/employment. Table created by USCCR staff.
* "LGBT" indicates that the state offers both sexual orientation and gender identity protections.
** "LGB" indicates that the state offers only sexual orientation protections. ***N.C.'s Ex. Or. does not protect transgender bathroom acessibility.

Failed Efforts to Enact Federal Legislation

Since 1974, seven separate pieces of legislation to prohibit LGBT employment discrimination on the basis of actual or perceived sexual orientation or gender identity have been introduced in Congress. Table 4 below summarizes introduced LGBT workplace protection legislation from 1974 through 2017 (see Appendix A for full explanation and language of the various legislation). The first two iterations of this federal legislation—frequently dubbed the Employment Non-Discrimination Act (ENDA) or the Equality Act—prohibited employment discrimination on the basis of sexual orientation alone.[109] In 2009, gender identity protections were added and if enacted, the legislation would offer protections for all LGBT individuals.[110] These proposed bills sought to provide employment protections to LGBT workers as well as to offer a legal avenue for employees to file formal complaints alleging sexual orientation and gender identity discrimination in the workplace.[111] Closely modeled after existing civil rights legislation such as Title VII of the Civil Rights Act and the Americans with Disabilities Act, the various incarnations of these bills sought to enhance protections beyond those provided by local policies and state laws.[112]

[109] Equality Act, H.R. 14752, 93rd Cong. (1974), *available at* https://www.congress.gov/bill/93rd-congress/house-bill/14752; Employment Non-Discrimination Act of 1994, H.R. 4636, 103rd Cong. (1994), *available at* https://www.congress.gov/bill/103rd-congress/house-bill/4636.
[110] Employment Non-Discrimination Act of 2009, H.R. 3017, 111th Cong. (2009), *available at* https://www.congress.gov/bill/111th-congress/house-bill/3017.
[111] *Id.*
[112] Seth Althauser and Sarah Greenberg, "FAQ: Employment Non-Discrimination Act: What You Need to Know," Center for American Progress, July 2011, https://www.americanprogress.org/issues/lgbt/news/2011/07/19/9988/faq-the-employment-non-discrimination-act/#r1.

No version has ever successfully passed both the House and the Senate (see Table 4).[113] The failure of these bills can be attributed to opponents against enacting new federal legislation, and after the Supreme Court's *Hobby Lobby* decision, some prominent LGBT activist organizations opposed the breadth of the exemptions afforded to religious groups.[114] For instance, some opponents to enacting federal legislation prohibiting employment discrimination argue that the expansion of these laws would constitute another example of government overreach against private businesses.[115] In his testimony to the Commission, Roger Clegg of the Center for Equal Opportunity stated his opposition to ENDA on the premise that:

> [p]eople should be able to use their private property the way that they want to use their private property—and that employers should be able to make personnel decisions without interference from the government . . . . And there should be a presumption against the government, at any level, stepping in and saying . . . we know better than you whom you should hire and whom you should promote. And there should be an especially strong presumption against the federal government passing a law that second guesses employers in this regard.[116]

Others argue that passing federal legislation prohibiting sexual orientation and gender identity discrimination creates a new protected class on the basis of someone's choice. For instance, at the 2009 House Education and Labor Committee Hearing, Rep. John Kline of Minnesota argued that it would create "an entirely new protected class that is vaguely defined and often subjective . . . . Attempting to legislate individual perceptions is truly uncharted territory and it does not take a legal scholar to recognize that such vaguely defined protections will lead to an explosion in litigation and inconsistent judicial decisions."[117]

In response to the 2015 version of the bill, some LGBT groups such as the National LGBTQ Task Force withdrew support because they felt that the religious exemptions were too broad. Other

---

[113] Jerome Hunt, "History of the Employment Non-Discrimination Act: It's Past Time to Pass This Law," Center for American Progress, July 2011, *available at* https://www.americanprogress.org/issues/lgbt/news/2011/07/19/10006/a-history-of-the-employment-non-discrimination-act/.

[114] Ed O'Keefe, "Gay Rights groups withdraw support of ENDA after Hobby Lobby decision," *The Washington Post*, July 8, 2014, https://www.washingtonpost.com/news/post-politics/wp/2014/07/08/gay-rights-group-withdrawing-support-of-enda-after-hobby-lobby-decision/?utm_term=.004df929e6bf.; Tierney Sneed, "Why LGBT Groups Turned on ENDA," *U.S. News*, July 9, 2014, https://www.usnews.com/news/articles/2014/07/09/why-lgbt-groups-turned-on-enda?int=news-rec.

[115] Walter Olson, "Against ENDA," *Cato At Liberty Blog*, November 1, 2013, https://www.cato.org/blog/against-enda.

[116] Roger Clegg, President and General Counsel at the Center for Equal Opportunity, Briefing Transcript, pp. 107-08.

[117] For example, *see* H.R. 3017, Employment Non-Discrimination Act of 2009, Hearing Before the House Comm. on Ed. and Labor, 111th Congress (2009), *transcript available at* https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg52242/pdf/CHRG-111hhrg52242.pdf.

groups such as the American Civil Liberties Union (ACLU), Lambda Legal, the National Center for Lesbian Rights, and the Transgender Law Center all raised similar concerns and wanted the bill to offer the same amount of protections given to other minority groups (*e.g.*, minority races, religions).[118] Ian Thompson, a legislative representative at the ACLU, stated that "[i]n none of those other categories is there this kind of broad, sweeping religious exemption that gives a stamp of legitimacy to discrimination, and we feel adamantly that there should not be for this type of discrimination against LGBT people."[119]

Table 4 Summary of Introduced LGBT Employment Non-Discrimination Legislation[a]

		Protected Classes		Protected Venues	
	Congressional Actions	**LGB**	**Gender Identity***	**Workplace**	**Other**
1974 Equality Act	Not voted out of committee Reintroduced 1975–1991	Sex, Marital status, Sexual orientation	No	Yes, including: Employers, Employment agencies, Labor unions, Joint labor-management committees Exempt: < 15 employees	Public accommodations, Public facilities, Federally assisted programs
1994 ENDA	Not voted out of committee. Reintroduced in 1996, then failed Senate 49–50. Not voted upon in House Same version reintroduced 1997-2004 Not introduced in 2005-2006	Yes	No	As above. Exempt: Faith-based organizations Armed forces	
2007 ENDA	Passed House 235–184 Not introduced in Senate	Yes	Yes, but removed from voted-upon House bill	As above	No preferential treatment, No quotas
2009 ENDA	Not voted out of committee	Yes	Yes	As above	

[118] Sneed, *supra* note 114.
[119] *Ibid.*

Table 4 Summary of Introduced LGBT Employment Non-Discrimination Legislation[a]					
		Protected Classes		Protected Venues	
	Congressional Actions	LGB	Gender Identity*	Workplace	Other
2013 ENDA	Passed Senate 64–32 Not voted upon in House	Yes	Yes	As above.	
2015 Equality Act	Introduced 7/23/15	Yes	Yes	As above. Religious exemption changes to incorporate existing Title VII exemption.	Public accommodations, federally funded programs, housing, federal jury service, credit
2017 Equality Act	Reintroduced 5/2/17	Yes	Yes	As above.	As above.

[a] LGB = lesbian, gay, bisexual. ENDA = Employment Non-Discrimination Act. *Gender Identity = Transgender, Gender Non-conforming or pertaining to anyone who does not adhere to the gender binary. Source: U.S. Commission on Civil Rights staff

In May 2017, 241 Democratic members of Congress reintroduced the Equality Act in both the Senate and House.[120] If this bill passes, it would include broad societal protections on the basis of sex (including pregnancy and childbirth), sexual orientation, and gender identity in employment, housing, public accommodations, federal jury service, and public education.[121] One of the co-sponsors of the bill, Rep. David Cicilline of Rhode Island, stated: "The Equality Act represents a simple idea that everyone, including members of the LGBT community, is entitled to equal treatment under the law, and the right to live free of discrimination."[122] Unlike other iterations of this bill, this version does not have religious exemptions. The bill states that the Religious Freedom Restoration Act (RFRA) cannot be used to block protections against discrimination. The bill states: "The Religious Freedom Restoration Act of 1993 (42 U.S.C. 2000bb et seq.) shall not provide a claim concerning, or a defense to a claim under, a covered title, or provide a basis for challenging the application or enforcement of a covered title."[123] A more detailed discussion on the advantages and disadvantages of federal legislation can be found in Chapter 3.

---

[120] Equality Act, H.R. 2282, 115th Cong. (2017). *available at* https://www.congress.gov/bill/115th-congress/house-bill/2282; Equality Act, S. 1006, 115th Cong. (2017), *available at* https://www.congress.gov/bill/115th-congress/senate-bill/1006.

[121] *Id.*

[122] Jeff Taylor, "241 members of Congress just announced their support for full LGBT equality," *LGBTQ Nation*, May 2, 2017, https://www.lgbtqnation.com/2017/05/democrats-take-stand-lgbtq-rights-reintroducing-equality-act/.

[123] Equality Act, H.R. 2282, 115th Cong. (2017), *available at* https://www.congress.gov/bill/115th-congress/house-bill/2282; Equality Act, S. 1006, 115th Cong. (2017), *available at* https://www.congress.gov/bill/115th-congress/senate-bill/1006.

[*This page intentionally left blank*]

CHAPTER 2: EXISTING FEDERAL NON-DISCRIMINATION LAW

Title VII of the Civil Rights Act and LGBT Employees

Title VII of the Civil Rights Act of 1964 states: "It shall be an unlawful employment practice for an employer (1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin."[124] As discussed below, the question for LGBT employees is whether discrimination based on sexual orientation or gender identity falls within Title VII's prohibition against discriminating on the basis of "sex."

The EEOC's "congressionally mandated role is to enforce Title VII of the Civil Rights Act of 1964, as well as the other federal employment non-discrimination laws."[125] Employees who believe that they have been discriminated against can file claims for discrimination with the EEOC. The EEOC has authority to issue administrative decisions and resolve charges of discrimination. While the EEOC receives all claims, the Department of Justice (DOJ) enforces Title VII in cases involving state or local government employees.[126] In January 2013, the EEOC began tracking information on filed claims alleging discrimination on the basis of sexual orientation or gender identity.[127] The data for claims (or charges) based on LGBT discrimination filed with the EEOC FY 2013-2016 can be found above in Chapter 1.

Title VII contains a religious exemption that recognizes the right of religious organizations to preferentially hire individuals of a particular religion.[128] The Supreme Court recognized in *Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-day Saints v. Amos*

---

[124] 42 U.S.C. § 2000e-2(a). Of note, Title VII's protections do not apply to all employers. Congress exempted employers with 15 or fewer employees, 42 U.S.C. § 2000e(a), and certain religious employers from Title VII. 42 U.S.C. § 2000e-1(a).

[125] Jeanne Goldberg, Senior Attorney Advisor, Office of Legal Counsel at EEOC, testimony, Briefing Transcript, p. 10.

[126] U.S. Department of Justice, Laws Enforced by the Employment Litigation Section, https://www.justice.gov/crt/laws-enforced-employment-litigation-section (last updated Oct. 25, 2017).

[127] Mary Beth Maxwell, Principal Deputy Assistant Secretary for Policy at the Department of Labor, testimony, Briefing Transcript, p. 30.

[128] Title VII states its provisions do not apply to "a religious corporation, association, educational institution, or society with respect to the employment of individuals of a particular religion to perform work connected with carrying on of the corporation, association, educational institution, or society of its activities." 42 U.S.C § 2000e-1(a). Under the statute, religion is defined to include "all aspects of religious observance and practice, as well as belief." 42 U.S.C § 2000e(j). The EEOC defines religious practices "to include moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." 29 C.F.R. § 1605.1.

that the scope of this exemption is not limited to jobs that might be considered primarily religious, but includes "all activities of religious employers."[129]

In *Hosanna-Tabor v. E.E.O.C.*, the Supreme Court also recognized that the "ministerial exception" to antidiscrimination laws is required by the Religious Clauses of the First Amendment.[130] The Supreme Court ruled that having to "accept or retain an unwanted minister, or punishing a church for failing to do so," would infringe on the Free Exercise Clause, which "protects a religious group's right to shape its own faith and mission through its appointments," and the Establishment Clause, "which prohibits government involvement in such ecclesiastical decisions."[131] Determining whether the ministerial exception applies in a particular case requires a fact-specific analysis, but *Hosanna-Tabor* makes clear that it is not limited to only those who meet the popular conception of clergy.[132]

"Because of Sex" Court and Administrative Decisions

TITLE VII AND SEXUAL ORIENTATION

In April 2017, the Seventh Circuit held that claims of discrimination based on sexual orientation could be brought under the existing language of Title VII.[133] Until then, all federal circuit courts of appeals that had considered the question had uniformly rejected claims that workplace actions based upon sexual orientation constitute discrimination under Title VII.[134] In May 2017, in *Zarda*

---

[129] 483 U.S. 327, 339 (1987).

[130] *Hosanna-Tabor Evangelical Lutheran Church and School v. E.E.O.C.*, 565 U.S. 171, 188 (2012).

[131] *Id.* at 188-89.

[132] *See id.* at 192-95. For more discussion about the religious exemptions, please see the Commission's report on the subject. U.S. Commission on Civil Rights, "Peaceful Coexistence: Reconciling Nondiscrimination Principles with Civil Liberties," September 2016, http://www.usccr.gov/pubs/Peaceful-Coexistence-09-07-16.PDF. In October 2017, Attorney General Jeff Sessions issued guidance "interpreting religious liberty protections in federal law," pursuant to President Trump's Executive Order No. 13798 (May 4, 2017). Attorney General, Memorandum for All Executive Departments and Agencies re Federal Law Protections for Religious Liberty, Oct. 6, 2017, *available at* https://www.justice.gov/opa/press-release/file/1001891/download.

[133] *Hively*, 853 F.3d at 350-51 (holding that "the logic of the Supreme Court's decisions, as well as the common-sense reality that it is actually impossible to discriminate on the basis of sexual orientation without discriminating on the basis of sex" meant that discrimination on the basis of sexual orientation is actionable under Title VII.). The employer in the *Hively* case has not asked the Supreme Court to review the Seventh Circuit's decision, and the time for seeking a petition of *certiorari* has passed.

[134] *See, e.g., Christiansen v. Omnicom Group, Inc.*, 852 F.3d 195, 199 (2d Cir. 2017) (declining to revisit past circuit precedent that holds sexual orientation discrimination does not fall under Title VII); *Evans v. Georgia Regional Hospital*, 850 F.3d 1248, 1255 (11th Cir. 2017) ("[T]here is no sexual orientation action under Title VII."); *Vickers v. Fairfield Med. Ctr.*, 453 F.3d 757, 764 (6th Cir. 2006) ("[R]ecognition of Vickers' claim would have the effect of *de facto* amending Title VII to encompass sexual orientation as a prohibited basis for discrimination."); *Medina v. Income Support Div., New Mexico*, 413 F.3d 1131, 1135 (10th Cir. 2005) ("Title VII"s protections . . . do not extend to harassment due to a person's sexuality."); *Bibby v. Phila. Coca Cola Bottling Co.*, 260 F.3d 257, 261 (3d Cir. 2001) (affirming decision of district court granting summary judgment to defendant where plaintiff claimed he was harassed on the basis of his sexual orientation); *Higgins v. New Balance Athletic Shoe, Inc.*, 194 F.3d 252, 259 (1st Cir. 1999) ("Title VII does not proscribe harassment simply because of sexual orientation."); *Hopkins v. Balt. Gas &*

v. Altitude Express, the U.S. Court of Appeals for the Second Circuit voted to review *en banc* whether Title VII protects against discrimination on the basis of sexual orientation.[135] Even where courts rejected sexual orientation claims, in some courts, allegations based on gender non-conformity were deemed actionable.[136] Those courts that have held that discrimination based on gender non-conformity is actionable have generally relied on the rationale that discrimination based on "sex stereotyping" is actionable, as the Supreme Court found in *Price Waterhouse v. Hopkins*. In *Price Waterhouse v. Hopkins*, the Supreme Court held that sex discrimination includes employment decisions based upon a woman's failure to conform to "sex stereotypes."[137] Hopkins was a female senior manager whose firm denied her partnership because the partners believed she did not act sufficiently feminine. The firm advised Hopkins she would have a better chance at being elected partner if she would, among other things, "take a course at charm school," "walk more femininely," "talk more femininely," and "wear makeup."[138]

In an earlier decision, the Supreme Court held that "[i]n forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes."[139] The Supreme Court therefore reasoned that "[a]n employer who objects to aggressiveness in women but whose positions require this trait places women in an intolerable and impermissible catch 22: out of a job if they behave aggressively and out of a job if they do not. Title VII lifts women out of this bind."[140] "[W]e are beyond the day," concluded the Court, "when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group."[141] In 1998, the Supreme Court also held that Title VII sexual harassment of an employee by a person of the same sex is actionable, regardless of the victim's or harasser's sex.[142]

Elec. Co., 77 F.3d 745, 751 (4th Cir. 1996) ("Title VII does not prohibit conduct based on the employee's sexual orientation[.]"); *Williamson v. A.G. Edwards & Sons, Inc.*, 876 F.2d 69, 70 (8th Cir. 1989) ("Title VII does not prohibit discrimination against homosexuals."); *DeSantis v. Pacific Tel. & Tel Co., Inc.*, 608 F.2d 327, 329-30 (9th Cir. 1979) (Title VII does not prohibit discrimination based upon homosexuality), *overruled on other grounds by Nichols v. Azteca Restaurant Enterprises, Inc.*, 256 F.3d 864, 875 (9th Cir. 2001); *Blum v. Gulf Oil Corp.*, 597 F.2d 936, 938 (5th Cir. 1979) ("Discharge for homosexuality is not prohibited by Title VII[.]").

[135] *Zarda et al. v. Altitude Express et al.*, Case No. 15-3775, Dkt. 271 (2nd Cir. May 25, 2017).

[136] *See, e.g., Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000), discussed *infra*.

[137] 490 U.S. 228, 251 (1989).

[138] *Id.* at 235 (internal quotation marks omitted).

[139] *Id.* at 251 (*quoting Los Angeles Dept. of Water and Power v. Manhart*, 435 U.S. 702, 707 n. 13 (1978)) (further citations omitted).

[140] *Id.* at 251.

[141] *Id.*

[142] *Oncale v. Sundowner Offshore Servs., Inc.*, 523 U.S. 75, 79-80 (1998). The plaintiff in *Oncale* worked on an oil platform crew, and was forcibly subjected to sex-related humiliating actions by co-workers in the presence of the rest of the crew. The Court focused on "whether members of one sex are exposed to disadvantageous terms or conditions of employment to which members of the other sex are not exposed." *Id.* at 80 (quoting *Harris v. Forklift Sys., Inc.*, 510 U.S. 17, 25 (1993) (Ginsburg, J., concurring)). Justice Scalia, writing for the Court, recognized this ruling expanded the textual meaning of "sex" beyond what the sponsors of the law may have intended:

In practice, some courts have found that the distinctions among sex stereotyping, sexual orientation, gender non-conformity, same-sex harassment, and gender identity are confusing, difficult to apply, and depending on the facts, not necessarily distinct.[143] "The challenge facing the lower courts since *Price Waterhouse* is finding a way to protect against the entire spectrum of gender stereotyping while not protecting against the stereotype that people should be attracted only to those of the opposite gender."[144] The Seventh Circuit recently described the efforts of courts to sort through the distinction between sexual orientation discrimination versus gender non-conformity discrimination as follows:

> [C]ourts have gone about this task in different ways—either by disallowing any claims where sexual orientation and gender non-conformity are intertwined, (and, for some courts, by not allowing claims from lesbian, gay, or bisexual employees at all), or by trying to tease apart the two claims and focusing only on the gender stereotype allegations. In both methods, the opinions tend to turn circles around themselves because, in fact, it is exceptionally difficult to distinguish between these two types of claims.[145]

In 2015, the Equal Employment Opportunity Commission concluded that a person's claim alleging sexual orientation discrimination falls within Title VII on the basis of alleged sex discrimination.[146] The practical impact of the EEOC's ruling is that all employees covered by EEOC jurisdiction may now file administrative claims under Title VII before the agency alleging discrimination based on sexual orientation. The EEOC's decision is not binding on courts, however courts may, and often do, defer to the EEOC. In its decision, the EEOC identified the following three legal bases for recognizing sexual orientation discrimination under Title VII:

- First, the EEOC concluded that "sexual orientation is inherently a 'sex-based consideration,' and an allegation of discrimination based on sexual orientation is necessarily an allegation of sex discrimination under Title VII."[147] The very concept of sexual orientation is based upon a person's sexual attractions, and cannot be defined or

---

> As some courts have observed, male-on-male sexual harassment in the workplace was assuredly not the principal evil Congress was concerned with when it enacted Title VII. But statutory prohibitions often go beyond the principal evil to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed.

Id. at 79.

[143] *See, e.g.*, *Videckis et al. v. Pepperdine University*, Case No. 2:15-CV-00298, Dkt. 41 (C.D. Cal. Dec. 15, 2015), *available at* http://documents.latimes.com/judge-pregerson-ruling-sexual-orientation-discrimination/.

[144] Brian Soucek, Perceived Homosexuals: Looking Gay Enough for Title VII, 63 Am. U. L. Rev. 715, 726 (2014).

[145] *Hively v. Ivy Tech Cmty. Coll.*, 830 F.3d 698, 705 (7th Cir. 2016), *overruled by Hively*, 853 F.3d at 350-51.

[146] *Baldwin v. Foxx*, EEOC Doc No. 0120133080, 2015 WL 4397641 (EEOC Jul. 16, 2015).

[147] 2015 WL 4397641 at *5 (quoting *Price Waterhouse*, 490 U.S. at 242).

understood without reference to "sex." Therefore, sexual orientation is "inseparable from and inescapably linked to sex."[148]

- Second, the EEOC determined that sexual orientation discrimination is associational discrimination on the basis of sex. "For example, a gay man who alleges that his employer took an adverse employment action against him because he associated with or dated men states a claim for sex discrimination under Title VII; the fact that the employee is a man instead of a woman motivated the employer's discrimination against him."[149] In other words, "an employee alleging discrimination on the basis of sexual orientation is alleging that his or her employer took his or her sex into account by treating him or her differently for *associating* with a person of the same sex."[150] The EEOC compared such discrimination to associational race discrimination courts have long recognized.[151]
- Third, the EEOC clarified that there is little to no distinction between sexual orientation discrimination and gender stereotype discrimination (which is actionable under *Price Waterhouse*). According to the EEOC, gender stereotypes involve more than assumptions about over-masculine or feminine behavior: "Sexual orientation discrimination and harassment '[are] often, if not always, motivated by a desire to enforce heterosexually defined gender norms.'"[152]

TITLE VII AND GENDER IDENTITY

Courts' view of claims based on sex stereotyping and gender identity have changed over time, with some courts allowing these claims to proceed under Title VII and some finding that Title VII does not cover these claims. For its part, the EEOC held in 2012 that claims based on gender identity may be brought under Title VII's prohibition against discrimination "because of sex."[153] In 2017, Attorney General Jeff Sessions withdrew guidance issued by Attorney General Eric Holder in 2014 and stated that going forward the Department of Justice would take the position that Title VII "encompasses discrimination between men and women but does not encompass discrimination based on gender identity *per se*, including transgender status."[154]

In the late 1970s and early 1980s, the first circuit courts to consider Title VII claims brought by plaintiffs seeking protection from discrimination based on their gender identities adopted the

---

[148] *Id.*
[149] *Id.* at *6.
[150] *Id.* (emphasis in original).
[151] *Id.* (citing *Floyd v. Amite Cnty. School Dist.*, 581 F.3d 244, 249 (5th Cir. 2009); *Holcomb v. Iona Coll.*, 521 F.3d 130, 138 (2d Cir. 2008)).
[152] *Id.* at *8 (quoting *Centola v. Potter*, 183 *F. Supp.* 2d 403, 410 (D. Mass. 2002)) (alteration in original).
[153] *Macy v. Holder*, EEOC Doc No. 0120120821, 2012 WL 1435995 (EEOC Apr. 20, 2012).
[154] Attorney General, Memorandum re Revised Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964, Oct. 4, 2017.

position that the plain meaning of the term "sex" did not extend to discrimination based on "transsexualism."[155] In *Holloway*, an employee of Arthur Andersen who was assigned male at birth brought suit under Title VII, alleging her employer discharged her after she began her transition from living as a man to living as a woman.[156] The Ninth Circuit held that "[a] transsexual individual's decision to undergo sex change surgery does not bring that individual, nor transsexuals as a class, within the scope of Title VII."[157]

Similarly, in the *Sommers* case—where a transgender woman was discharged because she "misrepresented herself as an anatomical female when she applied for the job"[158]—the Eighth Circuit viewed "the major thrust of the 'sex' amendment was towards providing equal opportunities for women."[159] The Eighth Circuit court held, "[b]ecause Congress has not shown an intention to protect transsexuals, we hold that discrimination based on one's transsexualism does not fall within the protective purview of the Act."[160] Thus, the focus of these early cases was on what Congress intended the scope of the term "sex" to encompass.

As discussed above, in 1989, in *Price Waterhouse*, the Supreme Court held that sex discrimination includes employment decisions based upon a woman's failure to conform to "sex stereotypes."[161] Of importance here, in *Price Waterhouse*, the Supreme Court used the terms "sex" and "gender" interchangeably.[162] With regard to congressional intent, the Supreme Court stated that "Congress' intent to forbid employers to take *gender* into account in making employment decisions *appears on the face of the statute*."[163]

After *Price Waterhouse*, courts began analyzing gender identity discrimination claims under Title VII in two ways. The first approach recognizes open identification as a member of the opposite sex as a deviation from preconceived gender norms. This category is an extension of the *Price Waterhouse* framework whereby it is unlawful to discriminate against an individual for failing to conform to sex stereotypes. An example of cases falling into the first category is the Ninth Circuit's decision in *Schwenk v. Hartford*.[164] The Ninth Circuit relied on the "logic and language of *Price*

---

[155] *See Holloway v. Arthur Andersen & Co.*, 566 *F.2d* 659, 663 (9th Cir. 1977); *Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 750 (8th Cir. 1982).
[156] *Holloway*, 566 F.2d at 661.
[157] *Id.* at 664.
[158] *Sommers*, 667 F.2d at 748.
[159] *Id.* at 750 (citations omitted).
[160] *Id.*
[161] *Price Waterhouse*, 490 U.S. at 248-51.
[162] In concluding an employer cannot discharge an employee for deviations from "sex stereotypes," the Supreme Court held "an employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of *gender*." *Id. at* 250 (emphasis added). Likewise, the Supreme Court viewed the words "because of . . . *sex*" to mean "*gender* must be irrelevant to employment decisions." *Id.* at 240 (emphasis added).
[163] *Id.* at 239 (emphasis added).
[164] 204 F.3d at 1187.

Waterhouse" to conclude that openly expressing one's identity as a member of the opposite sex is therefore no different from the failure to conform with sex stereotypes in *Price Waterhouse*.[165]

Under the second approach, courts have continued to analyze cases using the pre-*Price Waterhouse* view of differentiating between "sex" and "gender," and associating transgender status with one or the other. The cases interpreting "sex" to include "gender identity" hold transgender status is protected, whereas the cases interpreting "sex" to mean biological sex hold it is not. The Tenth Circuit followed this approach in *Etsitty v. Utah Transit Auth.*:

> [T]here is nothing in the record to support the conclusion that the plain meaning of "sex" encompasses anything more than male and female. In light of the traditional binary conception of sex, transsexuals may not claim protection under Title VII from discrimination based solely on their status as a transsexual.[166]

The court did suggest, without deciding, that an actionable claim may arise based on discrimination against a transgender individual for failing to conform to the gender stereotypes of his or her biological sex.[167] More recently courts have, even while differentiating between "sex" and "gender," held the analysis employed by *Etsitty* to be too narrow.[168]

Currently, six federal circuit courts of appeals have adjudicated the merits of a Title VII claim asserted by transgender individuals. The Sixth, Ninth, and Eleventh Circuits all hold Title VII prohibits discrimination against a transgender employee on the basis of the reasoning announced in *Price Waterhouse*.[169] In contrast, the Seventh, Eighth, and Tenth Circuits have held there is no Title VII protection for transgender individuals.[170]

---

[165] *Id.* at 1201-02. *See also Smith v. City of Salem*, 378 F.3d 566, 574 (6th Cir. 2004); *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011) ("'The very acts that define transgender people as transgender are those that contradict stereotypes of gender-appropriate appearance and behavior.' There is thus a congruence between discriminating against transgender and transsexual individuals and discrimination on the basis of gender-based behavioral norms.") (quoting Ilona M. Turner, *Sex Stereotyping Per Se: Transgender Employees and Title VII*, 95 Cal. L. Rev. 561, 563 (2007)) (alteration and internal citations omitted).

[166] 502 F.3d 1215, 1222 (10th Cir. 2007).

[167] *Id.* at 1224.

[168] For example, the court in *Fabian v. Hosp. of Cent. Conn.* reasoned the definition of "sex" extends beyond the biological distinctions between male and female, but also to the social and cultural manifestations associated with a particular biological sex. 172 F.Supp.3d 509, 526 (D. Conn. 2016). An unlawful adverse employment action is also made "because of . . . sex" when motivated by a recent gender reassignment surgery. *Schroer v. Billington*, 577 F.Supp.2d 293, 308 (D.D.C. 2008) ("[T]he Library's refusal to hire Schroer after being advised that she planned to change her anatomical sex by undergoing sex reassignment surgery was *literally* discrimination 'because of . . . sex.'") (emphasis in original).

[169] *See Smith*, 378 F.3d at 574; *Schwenk*, 204 F.3d at 1201-02; *Glenn*, 663 F.3d at 1316.

[170] *See Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081, 1084 (7th Cir. 1984); *Sommers*, 667 F.2d at 750; *Etsitty*, 502 F.3d at 1222. Both the *Ulane* and *Sommers* decisions, however, were decided pre-*Price Waterhouse*, and the continued force of those opinions is therefore uncertain.

NON-DISCRIMINATION AND RELIGIOUS BELIEFS

The right to be free of discrimination at work may conflict with other protected rights of co-employees and/or employers. For example, in *Cruzan v. Special Sch. Dist. No. 1*, a female employee alleged the employer's policy allowing a transgender woman to use the women's restroom created a hostile work environment and discriminated against her on the basis of religion.[171] The court upheld the lower court's grant of summary judgment to the employer because the evidence was not sufficient to show a hostile work environment and because the employee did not notify the employer of her religious objections.[172]

More recently, a district court in the Eastern District of Michigan granted summary judgment to a funeral home that terminated a transgender woman who was willing to comply with the female, but not the male, dress code. The court held enforcement of Title VII in these circumstances was not allowed because under the Religious Freedom Restoration Act, it imposed a substantial burden on the owner's sincerely held religious belief that a person's sex is a "God-given gift" and people should not deny or attempt to change their sex.[173]

Additional Legal Protections for LGBT Employees in the Federal Workplace

Multiple federal departments have responsibilities for ensuring non-discrimination against LGBT employees working within the federal government. For instance, the Department of Labor has made efforts to protect LGBT employees from discrimination and remove barriers for the LGBT workforce through policy, education, and training.[174] To this end, the Office of Diversity and Inclusion within OPM has issued publications regarding the treatment of LGBT employees in the federal workplace. Additionally, same-sex marriage benefits in federal employment are addressed in agency-specific EEO policies following the *U.S. v. Windsor* and *Obergefell v. Hodges* decisions to ensure equal benefits for same-sex married couples. For instance, the Department of Labor changed its policies to ensure implementation and compliance where necessary.[175]

---

[171] 294 F.3d 981, 982-83 (8th Cir. 2002).
[172] *Id.* at 984.
[173] *EEOC v. R.G. & G.R. Harris Funeral Homes*, 201 F.Supp.3d 837, 856 (E. D. Mich. 2016), *appeal docketed*, No. 16-2424 (6th Cir. Oct. 13, 2016). For more discussion about the Religious Freedom Restoration Act, please see the Commission's report. Peaceful Coexistence, *supra* note 132.
[174] Maxwell testimony, Briefing Transcript at 22–23.
[175] *Ibid.* at 21-23.

PRESIDENTIAL EXECUTIVE ORDERS

Since the late 1960s, Presidents have issued Executive Orders to address workplace discrimination within the executive branch and/or by federal contractors and subcontractors. Presidents use executive orders "to achieve policy goals, set uniform standards for managing the executive branch, or outline a policy view intended to influence the behavior of private citizens."[176] Executive orders provide a uniform policy for the federal government, but generally are not enforceable in courts.

In 1969, President Nixon issued Executive Order 11,478, which required all executive department and agencies to adopt an affirmative program to prohibit employment discrimination.[177] In 1998, President Clinton amended Nixon's Executive Order to include "sexual orientation."[178] On the same day, President Clinton issued a caveat noting that the amended Executive Order "does not and cannot create any new enforcement rights (such as the ability to proceed before the Equal Employment Opportunity Commission)."[179] The Clinton Executive Order did play a significant role toward employment equality within federal agencies.[180] For example, it directed agencies to revise their policies to ensure that employment decisions for federal civilian employees are not made on the basis of sexual orientation.

In 2014, President Obama issued Executive Order 13,672, reaffirming non-discrimination against employees in all aspects of federal employment, including upgrades, demotions, promotions, transfers, recruitment, recruitment advertising, layoff, termination, pay and other forms of compensation, and selection for various types of training.[181] This Executive Order added "gender identity" to the list of categories already protected from employment discrimination and thus

---

[176] Vivian S. Chu and Todd Garvey, "Executive Orders: Issuance, Modification and Revocation," Congressional Research Service, April 16, 2014 at Summary, *available at* http://fas.org/sgp/crs/misc/RS20846.pdf.

[177] Exec. Order No. 11,478, Equal Employment Opportunity in the Federal Government, 3 C.F.R. § 803 (Aug. 8, 1969) (stating "[i]t is the policy of the Government of the United States to provide equal opportunity in Federal employment for all persons, to prohibit discrimination in employment because of race, color, religion, sex, national origin, handicap, or age, and to promote the full realization of equal employment opportunity through a continuing affirmative program in each executive department and agency.").

[178] Exec. Order No. 13,087, Further Amendment to Executive Order 11478, Equal Employment Opportunity in the Federal Government, 3 C.F.R. § 30097.

[179] William J. Clinton, *Statement on Signing an EO on Equal Employment Opportunity in the Federal Government*, May 28, 1998, Gerhard Peters and John T. Woolley, eds., American Presidency Project, *available at* http://www.presidency.ucsb.edu/ws/?pid=56040.

[180] U.S. Equal Employment Opportunity Commission (EEOC), *Discrimination Based on Sexual Orientation, Status as a Parent, Marital Status and Political Affiliation*, (Fact Sheet, Dec. 29, 2009), *available at* http://www.eeoc.gov/federal/upload/otherprotections.pdf.

[181] E.O. 13,672, July 21, 2014, Further Amendment to Executive Order 11,478, Equal Employment Opportunity in the Federal Government, and Executive Order 11,246, Equal Employment Opportunity, July 21, 2014, *available at* https://obamawhitehouse.archives.gov/the-press-office/2014/07/21/executive-order-further-amendments-executive-order-11478-equal-employmen. *See also* Remarks by the President at Signing of Executive Order on LGBT Workplace Discrimination, July 21, 2014, *available at* https://obamawhitehouse.archives.gov/the-press-office/2014/07/21/remarks-president-signing-executive-order-lgbt-workplace-discrimination.

clarified that protections extend protection to transgender individuals.[182] In support of the Executive Order, the White House issued a statement saying that prohibiting LGBT employment discrimination is not only critical to promoting equality, but also plays an important role in supporting businesses and strengthening the economy.[183]

Additionally, the Obama Executive Order prohibits federal contractors from engaging in discrimination on the bases of both gender identity and sexual orientation.[184] The Department of Labor enforces this provision, and in 2014, the Office of Federal Contract Compliance Programs issued a regulation governing non-discrimination by federal contractors and subcontractors.[185] To satisfy their obligations under the final rule, federal contractors or federally assisted contractors must: 1) include an updated equal opportunity clause in new or modified subcontracts and purchase orders, 2) ensure that applicants and employees are not discriminated against by reason of their sexual orientation and gender identity, 3) update the equal opportunity language in job solicitations, and 4) post updated notices.[186] Only federal contracts entered into after April 8, 2015, are impacted by the Final Rule.[187]

The development of the Obama Executive Order was criticized by several religious organizations, which fought for inclusion of a religious exemption.[188] While the Obama Executive Order did not specifically grant exemptions to religious contractors, it did not amend President Bush's Executive Order 13,279, which protects the right of faith-based social service programs receiving federal funding to limit "employment of individuals [to] a particular religion."[189]

Further, opponents of extending federal legislation were supportive of President Trump's Executive Order that revoked President Obama's Executive Order 13,673, also known as the Fair Pay and Safe Workplaces order, which required federal contracting agencies to consider violations of federal and state labor laws when considering contract rewards.[190] In 2016, the Department of Labor regulations implementing Executive Order 13,673 required companies seeking federal contracts to report workplace law violations, including Title VII violations, which the Department

---

[182] *Id.*
[183] White House, Office of the Press Secretary, FACT SHEET: Taking Action to Support LGBT Workplace Equality Is Good for Business.
[184] *Id.*
[185] DOL, Office of Federal Contract Compliance Programs, Implementation of Executive Order 13672 Prohibiting Discrimination by Contractors and Subcontractors (Washington DC: GPO, 2014), 79 Fed. Reg. 72985 (Dec. 9, 2014).
[186] 41 C.F.R. Parts 60-1, 60-2, 60-4, and 6-50.
[187] *Id.*
[188] Julie Hirschfeld Davis and Erik Eckholm, "Faith Groups Seek Exclusion from Bias Rule," *New York Times,* July 8, 2014, http://www.nytimes.com/2014/07/09/us/faith-groups-seek-exclusion-from-bias-rule.html?_r=0.
[189] E.O. 13,672 *supra* note 181; E.O. 13,279, Equal Protection of the Laws for Faith-Based and Community Organizations, 3 C.F.R. §§ 77141–77144 (Dec. 12, 2002).
[190] Exec. Order No. 13,673, 79 Fed. Reg. 45309 (Jul. 31, 2014).

had previously interpreted as banning discrimination based on sexual orientation and gender identity.[191] Camilla Taylor, Senior Counsel for Lambda Legal, argued that while President Trump did not specifically overturn the order that protected LGBT employees who work for federal contractors, he made the policy increasingly difficult to enforce.[192]

TRANSGENDER GUIDANCE FOR FEDERAL AGENCIES

In March 2015, OPM issued "Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace," which defines terms and addresses questions agencies may have related to the employment of transgender individuals within the Federal workforce:

> The guidance outlines a series of core concepts including gender identity, transgender, and transition and defines common terms related to the transition process. The guidance also provides information on issues such as employee confidentiality and privacy, dress and appearance, sanitary and related facilities, recordkeeping, and insurance benefits.[193]

OFCCP has also issued guidance stating that the current laws banning discrimination on the basis of sex should include transgender workers.[194] At the Commission's briefing, Mary Beth Maxwell, Principal Deputy Assistant Secretary for Policy at the DOL, stated that former Secretary Thomas Perez directed DOL to update enforcement protocols and antidiscrimination guidance to clarify that "we provide the full protection of the federal nondiscrimination laws that we enforce to transgender individuals."[195]

---

[191] Guidance for Executive Order 13673, "Fair Pay and Safe Workplaces," 81 Fed. Reg. 58653 (Aug. 25, 2016), *available at* https://www.federalregister.gov/documents/2016/08/25/2016-19678/guidance-for-executive-order-13673-fair-pay-and-safe-workplaces.

[192] Mary Emily O'Hara, "LGBTQ Advocates Say Trump's New Executive Order Makes Them Vulnerable to Discrimination," *NBC News*, Mar. 29, 2017, https://www.nbcnews.com/news/us-news/lgbtq-advocates-say-trump-s-news-executive-order-makes-them-n740301.

[193] Statement, U.S. Office of Personnel Management at 1, March 25, 2015 (*hereinafter* OPM Statement); U.S. Office of Personnel Management, Diversity & Inclusion Reference Materials: Guidance Regarding the Employment of Transgender Individuals in the Federal Government, http://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/gender-identity-guidance/.

[194] U.S. Department of Labor, DOL Policies on Gender Identity: Rights and Responsibilities, http://www.dol.gov/oasam/programs/crc/20130712GenderIdentity.pdf.

[195] Adam Edelman, "Labor Department to update discrimination protection guidance for federal transgender workers," *New York Daily News*, July 1, 2014, http://www.nydailynews.com/news/politics/labor-department-update-anti-discrimination-protection-guidance-federal-transgender-workers-article-1.1851248; *see also* Maxwell testimony, Briefing Transcript at 23.

FEDERAL AGENCIES' EMPLOYMENT POLICIES INCLUSIVE OF GENDER IDENTITY AND SEXUAL ORIENTATION

Federal agencies' Equal Employment Opportunity (EEO) policies and No Fear Act statements generally list prohibitions of discrimination based on race, color, sex, religion, national origin, age, disability, marital status, or political affiliation. Many federal agencies now also specifically include gender identity or sexual orientation.

Of the ten federal agencies with the largest numbers of employees, all have gender identity and/or sexual orientation language within their EEO policies. OPM guidance encourages federal agencies to update their EEO statements and policies to include prohibitions against discrimination based on sexual orientation and gender identity.[196]

Table 5 depicts information regarding EEO and No Fear Act policies of the ten largest federal agencies by number of employees. The Notification and Federal Antidiscrimination and Retaliation Act of 2002 (No Fear Act) was implemented in October 2003. The EEOC states that the Act "imposes additional duties upon Federal agency employers intended to reinvigorate their longstanding obligation to provide a work environment free of discrimination and retaliation."[197]

Table 5 EEO/No Fear Language Ten Largest Federal Departments by Number of Employees

Department	EEO Policy/No Fear Act Contains Gender Identity or Sexual Orientation Language	Language Listed in Policy	Additional Findings
Justice	Yes, Both[198]	Discrimination on the basis of sex, gender identity, sexual orientation	N/A
Agriculture	Yes, Both[199]	Discrimination on the basis of sex, gender identity, sexual orientation	Policy states that not all prohibited bases will apply to all programs and/or employment activities

[196] Office of Personnel Management, *supra* note 5.
[197] U.S. Equal Employment Opportunity Commission, "No FEAR Act," https://www.eeoc.gov/eeoc/statistics/nofear/qanda.cfm.
[198] U.S. Department of Justice, "U.S. Department of Justice Equal Employment Opportunity Policy," https://www.justice.gov/jmd/file/790081/download, *available from* https://www.justice.gov/jmd/policy (last updated Oct. 31, 2015).
[199] U.S. Department of Agriculture, "Non Discrimination Statement," https://www.usda.gov/non-discrimination-statement (last visited Nov. 12, 2017).

Table 5 EEO/No Fear Language—Ten Largest Federal Departments by Number of Employees			
Department	**EEO Policy/No Fear Act Contains Gender Identity or Sexual Orientation Language**	**Language Listed in Policy**	**Additional Findings**
Veterans Affairs	Yes, Both[200]	Discrimination on the basis of sex, gender identity, sexual orientation, transgender status	N/A
Homeland Security	Yes, Both[201]	Discrimination on the basis of sex, sexual orientation and gender identity	N/A
Treasury	Yes, Both[202]	Discrimination on the basis of sex (including gender identity, sexual orientation, and pregnancy)	
Health & Human Services	Yes, Both[203]	Discrimination on the basis of sex, gender identity, sexual orientation	N/A
Interior	Yes, Both [204]	Discrimination on the basis of sex, gender, sexual orientation, gender identity	
Transportation	Yes, Both[205]	Discrimination on the basis of sex, sexual orientation, gender identity and transgender	N/A

[200] U.S. Department of Veterans Affairs, "EEO, Diversity and Inclusion, No FEAR, and Whistleblower Rights and Protection Policy Statement," Jul. 5, 2017, https://www.diversity.va.gov/policy/statement.aspx.
[201] U.S. Department of Homeland Security, "Revised DHS Anti-Discrimination Policy Statement," Jun. 12, 2014, https://www.dhs.gov/sites/default/files/publications/DHS%20Anti-Discrimination%20Policy%20Statement%20-%206.12.14_1.pdf.
[202] U.S. Department of the Treasury, "EEO and Civil Rights Policies," May 31, 2017, https://www.treasury.gov/about/organizational-structure/offices/Mgt/Documents/FY%202017.EEO%20Policy%20FY2017%20Draft%203.30.17.pdf.
[203] U.S. Department of Health and Human Services, "Department of Health and Human Services Equal Employment Opportunity Policy," Apr. 29, 2016, https://www.hhs.gov/about/agencies/asa/eeo/policy/index.html.
[204] U.S. Department of the Interior, "Employment Complaints and Adjudication Division," https://www.doi.gov/pmb/eeo/Complaints-Processing.
[205] U.S. Department of Transportation, "DOT Discrimination Policy—Complaint Process," Oct. 4, 2016, https://www.transportation.gov/civil-rights/complaint-resolution/equal-employment-opportunity-complaint-process.

Table 5 EEO/No Fear Language—Ten Largest Federal Departments by Number of Employees			
Department	**EEO Policy/No Fear Act Contains Gender Identity or Sexual Orientation Language**	**Language Listed in Policy**	**Additional Findings**
Labor	Yes, Both[206]	Discrimination on the basis of sex (including gender identity) and sexual orientation.	
Defense	Yes, Both[207]	Discrimination on the basis of sex, sexual orientation and gender identity	N/A

Source: Compiled by U.S. Commission on Civil Rights staff.

Private Workplace Protections for LGBT Employees

Many private companies have adopted and implemented workplace policies or practices that prohibit discrimination on the basis of sexual orientation and/or gender identity.[208] According to written testimony by The Leadership Conference on Civil and Human Rights to the Senate, by 2012, 86 percent of Fortune 500 companies prohibited sexual orientation discrimination and more than 50 percent also prohibited discrimination based on gender identity.[209]

For the past fifteen years, the Human Rights Campaign has released a list that ranks the Fortune 500, Fortune 1000, and the top 200 revenue-grossing law firms on the basis of the "best places to work for LGBT equality."[210] The ranking is based on what they call the "corporate equality index" (CEI) that utilizes several criteria.[211] First, businesses are rated if they have equal employment opportunity policies that include: sexual orientation and gender identity for all operations (domestic and global), and contractor/vendor standards that include sexual orientation and gender identity. The second set of criteria is based on employment benefits that are equivalent to spousal and partner benefits such as equivalent medical benefits (*e.g.*, dental, vision, legal dependent

[206] U.S. Department of Labor, "U.S. Department of Labor Policy on Equal Employment Opportunity," Feb. 24, 2015, https://www.dol.gov/oasam/programs/crc/crc-internal/2015EEOPolicy.pdf.
[207] U.S. Department of Defense, "Directive 1020.02E: Diversity Management and Equal Opportunity in the DoD," Nov. 29, 2016, http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/102002e_dodd_2015.pdf.
[208] Human Rights Campaign Foundation, *supra* note 105, at 2.
[209] Senate Hearing 112-915, "Equality at Work: The Employment Non-Discrimination Act," Hearing of the Committee on Health, Education, Labor, and Pensions, June 2012, *available at* https://www.gpo.gov/fdsys/pkg/CHRG-112shrg92383/html/CHRG-112shrg92383.htm.
[210] Human Rights Campaign Foundation, *supra* note 105, at 10. Commission staff is unaware of other reports that are as comprehensive and robust as the HRC's CEI reports regarding the inclusive private employers' policies, practices, and benefits for LGBT employees in the United States. Started in 2002, these reports are nationally recognized benchmarks for businesses to gauge their level of LGBT workplace inclusion against competitors.
[211] *Ibid.* at 16-18. A tool established by the Human Rights Campaign that rates U.S. businesses on their treatment of gay, lesbian, bisexual, and transgender employees, consumers, and investors.

coverage, COBRA) and other "soft" benefits (*e.g.*, bereavement leave, employer-provided supplemental life insurance for partner, adoption assistance, qualified joint and survivor annuity for partners).

Regarding transgender protections specifically, the Human Rights Campaign rates corporations on the basis of providing transgender employees equal health coverage. This includes use of insurance contracts and/or policy documentation that are based on the World Professional Association for Transgender Health Standards of Care, use of documentation that clearly communicates inclusive insurance options, and whether such coverage is readily available to employees. They state that benefits should include services related to gender transition (*e.g.*, medically necessary services related to sex affirmation/reassignment such as short-term medical leave, pharmaceutical coverage, coverage for medical visits, coverage for reconstructive surgical procedures related to sex reassignment, and coverage for routine non-transition services).[212]

According to the Human Rights Campaign 2017 CEI report, as of 2016, 92 percent of Fortune 500 companies included sexual orientation and 82 percent included gender identity in their non-discrimination policies.[213] Half of these Fortune 500 companies offer transgender-inclusive health care benefits, including surgical procedures. For the 2017 CEI report, the 327 Fortune 500 companies that submitted surveys had an average score of 91 out of a possible 100. However, when analyzing the scores of all Fortune 500 companies, it found substantially lower scores. The average score for all Fortune 500 companies (reporting and non-reporting) was 66; and those companies that did not respond to the survey had an average score of 14 (see Table 6).[214]

Table 6 Equality at Fortune-Ranked Companies

	All Fortune 500	Fortune 500 Participants	Fortune 500 Non-Responders
Sexual Orientation in U.S. Non-Discrimination Policy	92%	99%	75%
Gender Identity in U.S. Non-Discrimination Policy	82%	98%	49%
Domestic Partner Benefits	61%	81%	19%
Transgender-Inclusive Benefits	50%	74%	0%
Organizational LGBT Competency	57%	83%	0%
Public Commitment to the LGBT Community	47%	69%	0%

[212] *Ibid.* at 14.
[213] *Ibid.* This report discusses the 2017 CEI report. The Human Rights Campaign recently published the 2018 CEI report, which is available at https://www.hrc.org/campaigns/corporate-equality-index.
[214] *Ibid.* at 7.

Source: Human Rights Campaign Foundation, Corporate Equality Index 2017, http://assets.hrc.org//files/assets/resources/CEI-2017-FinalReport.pdf?_ga=1.92925597.1225877603.1490017176

Some question whether the high percentages of the United States' largest companies having antidiscrimination policies evidences nondiscrimination and equality. For instance, there is only one openly gay chief executive officer (CEO) of a Fortune 500 company, which is Apple's Tim Cook.[215] Todd Sears, a former financial advisor at Merrill Lynch who now runs Out on the Street, an organization that helps companies recruit and retain LGBT employees, argues that, "when people see that 90 percent of companies have nondiscrimination policies in place, that's great. But to me, a better indicator, is, how many senior leaders are there who are gay and who are out? If LGBT people look around and they don't see other LGBT people who are out, if they don't hear inclusive messages, they're not going to feel valued."[216]

[215] Benjamin Snyder, "Apple's CEO becomes the Fortune 500's only openly gay CEO. Here are 11 other workplace stats," *Fortune*, Oct. 30, 2014, http://fortune.com/2014/10/30/apples-ceo-becomes-the-fortune-500s-only-openly-gay-ceo-here-are-11-more-workplace-stats/.

[216] Hunter Stuart, "U.S. Companies Less LGBT-Friendly Than They'd Like You To Believe," *The Huffington Post*, Jun. 27, 2014, http://www.huffingtonpost.com/2014/06/27/lgbt-employees-equality-discrimination-protection-at-work_n_5526746.html.

[*This page intentionally left blank*]

CHAPTER 3: VIEWPOINTS IN FAVOR AND AGAINST FEDERAL LEGISLATION

Ensuring Equal Rights and the Normative Argument

Advocates who favor federal legislation protecting employees against discrimination based on sexual orientation and gender identity assert that passing comprehensive protections for LGBT Americans that include anti-discrimination employment provisions is essential to ensure equal rights for all citizens.[217] Selisse Berry from Out and Equal Workplace Advocates, a panelist at our briefing, noted that "we live in an interesting time. LGBT people can be married in 37 states and we can still be fired in 29 states simply because of who we love and who we are."[218] At the time of the briefing, in March 2015, same-sex marriage was a state-by-state determination. Since that time, the Supreme Court has determined that states must license marriage between two people of the same sex and recognize same-sex marriages performed in other states.[219] Kate Kendell, the Executive Director for the National Center for Lesbian Rights, stated that "[b]oth methodological and anecdotal information enforces that LGBT, particularly transgender employees, even in this moment of great acceleration of LGBT rights, [still] suffer in the employment realm."[220]

The debate concerning extending specific anti-discrimination protections to LGBT Americans often draws comparisons to enacting the Civil Rights Act and issues of racial discrimination in the United States. Opponents of enacting federal legislation argue that discrimination against LGBT communities is not analogous to discrimination based on race or sex. For instance, the Family Research Council argues that unlike race and sex which are considered "inborn, involuntary and immutable" sexual orientation and gender identity are not.[221] Further, these opponents argue, unlike historical discrimination against an individual's race or sex, the LGBT community cannot make similar discrimination claims. Peter Sprigg of the Family Research Council argues that

> [t]he bad name given to the word 'discrimination' relates primarily to our country's shameful history of racial discrimination, including over two centuries of slavery and

---

[217] For example, *see* Senate Hearing 112-915. "Equality at Work: The Employment Non-Discrimination Act," Hearing of the Committee on Health, Education, Labor, and Pensions, June 2012, *available at* https://www.gpo.gov/fdsys/pkg/CHRG-112shrg92383/html/CHRG-112shrg92383.html; Human Rights Campaign, "Federal Legislation," http://www.hrc.org/resources/federal-legislation; Neera Tanden and Ted Strickland, "We Need A Federal LGBT Non-Discrimination Act," *Newsweek*, Dec. 10, 2014, http://www.newsweek.com/we-need-federal-lgbt-non-discrimination-act-290907; Shalyn Caulley, *The Next Frontier to LGBT Equality: Securing Workplace-Discrimination Protections*, 2017 U. Ill. L. Rev. 909 (2017); Sarah Warbelow, Legal Director for Human Rights Campaign, testimony, Briefing Transcript at 75.

[218] Berry testimony, Briefing Transcript at 158.

[219] *Obergefell v. Hodges*, 576 U.S. __, 135 S. Ct. 2584 (2015).

[220] Kate Kendell, Executive Director of the National Center for Lesbian Rights, testimony, Briefing Transcript at 70.

[221] Family Research Council, *supra* note 16.

> another century of segregation. Homosexuals can claim no comparable disadvantage. Until less than a century ago, women were not even granted the most fundamental right of voting. Again, homosexuals have no comparable claim. Protecting against religious discrimination advances the cause of religious liberty which was enshrined in our nation's Constitution at the Founding. No comparable guarantee of sexual liberty is found in the Constitution.[222]

Thus, they argue that members of LGBT communities do not need federal legislation to prohibit workplace discrimination. During his testimony before the Commission, Ryan Anderson of the Heritage Foundation argued that "[t]he Civil Rights Act of 1964 barring discrimination on the basis of race was a proper response. America has no similar history of society-wide legal prohibition on employment based on sexual orientation or gender identity."[223]

Proponents argue discrimination against LGBT communities is similar to historical discrimination based on race and sex. Many studies support the claim of historic and continuing employment discrimination against employees on the basis of sexual orientation and gender identity. Historians, researchers, and the courts have all recognized that LGBT workers have faced a long, serious, and pervasive history of employment discrimination.[224] Scholars have argued that not only did LGBT individuals face societal stigma, but also faced various forms of institutional discrimination including being barred from federal or state government employment.[225] Gary Gates, the Research Director at UCLA Law School's Williams Institute, found that judicial opinions from appellate courts in seven states—California, Connecticut, Iowa, Maryland, Montana, Oregon, and Washington, including six of those states' highest courts—have all agreed that LGBT individuals have faced a long history of discrimination, regardless of how the court ultimately ruled on whether sexual orientation is a suspect classification.[226] For example, Maryland's highest court in 2007 recognized that "[h]omosexual persons have been the object of societal prejudice by private actors as well as by the judicial and legislative branches of federal and state governments."[227] Additionally the court found that "homosexual persons, at least in terms of contemporary history, have been a

---

[222] S. M., "Indiscriminate," *The Economist, Democracy in America blog*, Jul. 12, 2013, http://www.economist.com/blogs/democracyinamerica/2013/07/gay-rights-workplace (quoting Peter Sprigg, "Homosexuality is Not a Civil Right," Family Research Council, 2007).

[223] Anderson testimony, Briefing Transcript at 280-281.

[224] Sears, *supra* note 46; *Conaway v. Deane*, 932 A.2d 571, 609 (Md. 2007). Christine Michelle Duffy and Denise Visconti, eds., *Gender Identity and Sexual Orientation Discrimination in the Workplace: A Practical Guide*, Bloomberg BNA, October 2014; Pizer, *supra* note 51.

[225] Stephanie Rotondo, eds., "Employment Discrimination against LGBT Persons," 16 Geo. J. Gender & L. 103 (2015); Alison Lorenzo, "Constitutional Law—Equal Rights Amendment, Equal Protections, and Due Process—The Right of Same-Sex Marriage is Not Fundamental, Prohibiting Same-Sex Marriage Does Not Constitute Gender-Based Discrimination, and Restrictions on the Right of Marriage are Rationally Related to the State's Interest in Regulation of Marriage," 39 Rutgers L.J. 1003, nn. 122–124 (2008).

[226] Sears, *supra* note 46, at Chapter 6, https://williamsinstitute.law.ucla.edu/wp-content/uploads/6_FindingsCourtsScholars.pdf.

[227] *Conaway*, 932 A.2d at 609.

disfavored group in both public and private spheres of our society."[228] In 2004, a concurring opinion filed by a justice of the Supreme Court of Montana described how LGBT people have been marginalized by their "government and institutions," and cited a number of cases documenting discrimination by state and local governments to demonstrate how "gays and lesbians historically have been the focus of discriminatory treatment in the workplace."[229]

The Supreme Court and federal courts have also recognized that LGBT employees have historically faced issues of workplace discrimination. For instance, the Ninth Circuit held that "[d]iscrimination against homosexuals has been pervasive in both the public and private sectors. Legislative bodies have excluded homosexuals from certain jobs and schools, housing, churches, and have prevented homosexual marriage."[230] The court concluded that "the discrimination faced by homosexuals in our society is plainly no less pernicious or intense than the discrimination faced by other groups already treated as suspect classes, such as aliens or people of a particular national origin."[231]

The Sixth Circuit in 1995 concluded "[h]omosexuals have suffered a history of pervasive irrational and invidious discrimination in government and private employment, in political organization and in all facets of society in general, based on their sexual orientation."[232] Additionally, that same year, a District of Columbia Court of Appeals judge cited examples of such discrimination in a dissent, including that: "[b]eing identified with homosexuality has been the basis of refusals to hire, the ruin of careers, undesirable military discharges, denials of occupational licenses, denials of the right to adopt, to the custody of children and visitation rights, denials of national security clearances and denials of the right to enter the country."[233]

Further, according to Congressional testimony by M.V. Lee Badgett, economist and research director of the Williams Institute and director of the Center for Public Policy and Administration, following over a decade of research and twelve studies, gay male workers were paid significantly less on average than their heterosexual male counterparts.[234] Data on the earnings for lesbians tend to be more inconsistent. Several studies show that lesbian or bisexual women do not earn less than

---

[228] *Id.* at 610.
[229] *Snetsinger v. Mont. Univ. Sys.*, 104 P.3d 445, 455 (Mont. 2004) (Nelson, J., specially concurring).
[230] *Watkins v. U.S. Army*, 875 F.2d 699, 724 (9th Cir. 1989), *cert. denied*, 498 U.S. 957 (1990).
[231] *Id.*
[232] *Equal. Found. of Greater Cincinnati v. City of Cincinnati*, 54 F.3d 261, 264 n.1 (6th Cir. 1995) (quoting trial court findings), *cert. granted, judgment vacated*, 518 U.S. 1001 (1996).
[233] *Dean v. D.C.*, 653 A.2d 307, 334 (D.C. 1995) (quoting Elvia Arriola, Sexual Identity and the Constitution: Homosexual Persons as a Discrete and Insular Minority, 10 Women's Rts. L. Rep. 143, 157 (1988)).
[234] Testimony on H.R. 2015, The Employment Non-Discrimination Act of 2007: Hearing on H.R. 2015 Before the House Committee on Education & Labor and the House Subcommittee on Health, Employment, Labor & Pensions, 110th Cong. 4 (2007) (statement of M.V. Lee Badgett), *available at*: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Badgett-HR2015-testimony-Sept-2007.pdf.

heterosexual women.[235] Badgett et al., argue that this does not imply the absence of employment discrimination. They argue that these findings suggest that since lesbians may not be constrained by the same gender expectations that result from being in relationships with men, they may make different decisions than heterosexual women (*e.g.*, choosing to delay or not have children, invest more into training, go into male-dominated professions) which may hide effects of discrimination.[236] Regardless, lesbian, bisexual, and heterosexual women all earn less than either gay or heterosexual men.[237] Moreover, when transgender individuals are surveyed separately the disparities are even more apparent. In six surveys conducted between 1996 and 2006, 20 percent to 57 percent of transgender respondents reported having experienced employment discrimination during some point in their life. At the time of the report, no detailed wage and income studies have been conducted regarding the transgender community, but convenience samples of the transgender population find that six percent to 60 percent of respondents report being unemployed, and 22 percent to 64 percent earn less than $25,000 per year.[238]

Another argument for extending LGBT protections is grounded in the principle of equal access to public markets and equal dignity of persons. Some researchers argue that as a society we have implemented legal safeguards intended to ensure equal access to necessities (*e.g.*, food, shelter, work) through federal and state statutes and common law principles.[239] This demonstrates that, as a society, we acknowledge the necessity for all citizens to have access to public accommodations, housing, and employment regardless of arbitrary characteristics like race, religion, nationality, disability, sex, and—with increasing consistency—sexual orientation and gender identity. Thus, the argument is that discrimination against LGBT persons is a clear violation of the normative principle of equal access and ultimately is dangerous and dehumanizing.

Conversely, Richard Epstein, Professor of Law at New York University School of Law and Senior Fellow at The Hoover Institution, argues that workplace antidiscrimination legislation would interfere with business owners' freedom of contract.[240] Epstein argues that in a free market society,

---

[235] Arabshebani, G. Reza, Alan Marin and Jonathan Wadsworth. 2007. "Variations in Gay Pay in the USA and the UK," in M. V. Lee Badgett and Jefferson Frank, eds. "Sexual Orientation Discrimination: An International Perspective." London: Routledge; Badgett, M. V. Lee. 1995. "The Wage Effects of Sexual Orientation Discrimination." Industrial and Labor Relations Review 48(4): 726-739; Black, Dan A., Hoda R. Makar, Seth G. Sanders, and Lowell J. Taylor. 2003. "The Effects of Sexual Orientation on Earnings." Industrial and Labor Relations Review 56(3): 449-469.

[236] Lee Badgett, *supra* note 53.

[237] M.V. Lee Badgett and Alyssa Schneebaum, "The Impact of Wage Equality on Sexual Orientation Poverty Gaps," Williams Institute, June 2015, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Impact-of-Wage-Equality-on-Sexual-Orientation-Poverty-Gaps-June-2015.pdf.

[238] *Ibid.*

[239] Isaac Saidel-Goley, "The Right Side of History: Prohibiting Sexual Orientation Discrimination in Public Accommodations, Housing, and Employment," 31 Wisc. J. of L., Gender & Soc'y 2 (2017).

[240] Richard Epstein, "Freedom of Association and Antidiscrimination Law: An Imperfect Reconciliation," *Liberty Law Forum*, Jan. 2, 2016, http://www.libertylawsite.org/liberty-forum/freedom-of-association-and-antidiscrimination-law-an-imperfect-reconciliation/.

the markets will correct the injustices of discrimination and discriminatory practices by punishing those who discriminate (*e.g.*, loss of profits, loss of qualified workforce), and thus result in economic equality for all.[241] In addition, he argues that antidiscrimination legislation is too costly, burdensome, and inefficient for the federal government to legislate over business practices.[242] In a somewhat similar vein, Andrew Koppelman, Professor of Law and Political Science at Northwestern University, argues that "[t]he general principle governing transactions between private parties should be freedom of association, for reasons of both liberty and efficiency. Any departure from that rule, such as a prohibition of discrimination, has the burden of proof."[243] However, Koppelman argues that Epstein does not consider the pervasive nature of discrimination and prejudice in our culture.[244] While some groups may be subject to historic and current pervasive discrimination, Epstein argues that economic equality cannot be achieved because those who choose not to prohibit discrimination still comprise the majority share of the market as a whole. Koppelman argues that when discriminators dominate the market, which at the present time it is for LGBT employees, then legal intervention is arguably justified.[245] He posits that not only can antidiscrimination laws help mitigate a society's pattern of stigma and marginalization that marks some members in society as inferior to others; but also, since "[h]abits of discrimination are hard to break, and legal intervention can help to break them."[246]

Further, the principle of the equal dignity of persons incorporates the "fundamental assumption that human beings are to be treated with dignity and respect"[247] and the equally fundamental assumption that all humans are to be treated with "equal dignity in the eyes of the law."[248] This principle is perhaps one of the most basic and foundational tenets of a free and democratic society, and a cornerstone of American society.[249] One viewpoint holds that "we can all accept that invidious sex discrimination violates equal dignity, and it is logically impossible to accept that notion without also accepting that sexual orientation [and gender identity] discrimination violates equal dignity."[250] Likewise, as stated by panelist Kylar Broadus, "[t]he bottom line is that it boils

---

[241] *Ibid.* at 207.
[242] *Ibid.*
[243] Andrew Koppelman, "Richard Epstein's Imperfect Understanding of Antidiscrimination Law," *Liberty Law Forum*, Jan. 12, 2016, *available at* http://www.libertylawsite.org/liberty-forum/richard-epsteins-imperfect-understanding-of-antidiscrimination-law/.
[244] *Ibid.* at 208.
[245] *Ibid.*
[246] *Ibid.*
[247] Joseph William Singer, *Normative Methods for Lawyers*, 56 UCLA L. Rev. 899, 959 (2009).
[248] *Obergefell*, 135 S. Ct. at 2608.
[249] *Id.*
[250] Saidel-Goley, *supra* note 239, at 126.

down to we're all human beings on this planet and that in the United States you have to have a job to survive and that protections are needed."[251]

Employment discrimination can have long-lasting material effects, especially if it hinders individuals from securing steady employment. Those who suffer from chronic and cyclical under- and unemployment are more likely to be impoverished and often have secondary effects (*e.g.*, long-term earnings losses, declines in psychological and physical well-being, social withdrawal, family disruption) that can create additional difficulties for individuals and their families.[252] According to a 2015 study, Badgett and Schneebaum found that non-married gay and bisexual men earn less than non-married heterosexual men.[253] Looking at the poverty rates among same-sex and opposite-sex couples, same-sex white male couples tend to fare better (3.3 percent),[254] but the researchers found that lesbian couples have higher rates of poverty (7.9 percent) than heterosexual couples (5.8 percent). Critically, breaking these numbers down by race exposes even deeper inequities. Researchers found that African American lesbian couples have a poverty rate of 24.7 percent and gay African American couples have a rate of 14.5 percent, making them 3.1 and 1.8 times more likely to be in poverty compared to heterosexual African American couples (eight percent), respectively.[255]

Researchers have shown that state-employment protections for LGBT workers correlate with reduced poverty rates for those workers. In 2013, researchers found that in states where employment protections exist for LGBT workers, the poverty rate for both married opposite-sex couples and same-sex (both female and male) couples decreased.[256] In contrast, in states without protections, male same-sex couples tend to have slightly lower rates than opposite-sex couples, however, female same-sex couples are nine percent more likely to be in poverty than married opposite-sex couples.[257] Throughout the report, researchers found that employment discrimination protections seem to have a positive effect on all workers, but especially LGBT workers. For instance, poverty rates for both heterosexual and LGBT workers were shown to be lower in states with employment discrimination protections as opposed to states without protections, where

---

[251] Broadus testimony, Briefing Transcript at 224-25.
[252] Jennie Brand, "The Far-Reaching Impact of Job Loss and Unemployment," *Annual Review of Sociology*, Vol 41, 359-375; Lindsey Hanson and Timothy Essenburg, eds., "The New Faces of American Poverty: A Reference Guide to the Great Recession," ABC-CLIO, 2014.
[253] Lee Badgett, *supra* note 237.
[254] This is largely due to their demographic makeup because white men are still on average the highest earners in the U.S.
[255] Lee Badgett, *supra* note 237.
[256] Lee Badgett, *supra* note 7.
[257] *Ibid.*

LGBT poverty is significantly higher than the poverty rate of heterosexual citizens.[258] Kate Kendell, Executive Director of the National Center for Lesbian Rights, noted

> many of the calls that we get are from individuals in these 29 States where there are no protections. If they live in a State where there are protections, it's an easy answer for them. We encourage them to file a complaint. We refer them to attorneys that do LGBT employment discrimination cases. There is recourse they can take. And then our resource is really just to hook them up with the knowledge base and with someone who can be their advocate. Most of what we—the calls that we get are in States where there is no protection. And it's only been recently in light of the EEOC's Macy ruling that we've seen an expansion of Title VII perhaps being available as a vehicle. Many, many times the most difficult answer that we give to people when they call saying that they've suffered some adverse employment action is, I'm sorry, there is nothing we can do. There is no protection in your State.[259]

Some opponents argue that discrimination against LGBT Americans has declined to the point that federal legislation has become unnecessary.[260] However, Coffman et al., argue that the magnitude of antigay sentiment is substantially underestimated.[261] They found that many individuals when asked sensitive questions are less likely to answer honestly, especially if the opinion is considered socially undesirable. When Coffman et al., utilized a "veiled" methodology[262] they found that antigay sentiments were reported at much higher rates. Specifically regarding the workplace, they found that respondents were 67 percent more likely to disapprove of an openly gay manager and 71 percent more likely to say it should be legal to discriminate in hiring on the basis of sexual orientation. In FY 2015, the EEOC received 1,412 claims alleging sex discrimination based on sexual orientation and/or gender identity/transgender status.[263] This represented an overall increase of approximately 28 percent of the total LGBT charges filed in 2014 (1,100).

Gina Duncan, the Transgender Inclusion Director of Equality Florida, the state's largest LGBT advocacy organization, touted the work of her organization in increasing legislative employment

---

[258] *Ibid.*

[259] Kendell testimony, Briefing Transcript at 95–96.

[260] For example, *see* Anderson testimony, Briefing Transcript at 281 (arguing that "American businesses seldom discriminat[e] based on sexual orientation") (quoting Hans Bader of the Competitive Enterprise Institute).

[261] Katherine Coffman, Lucas Coffman, Keith Marzilla Ericson, "The Size of the LGBT Population and the Magnitude of Anti-gay sentiment are Substantially Underestimated," *National Bureau of Economic Research*, (2013), *available at* http://www.nber.org/papers/w19508.pdf.

[262] The researchers refer to their methodology as "veiled" to mean that they utilized a method to reduce social desirability bias by being able to obscure a participant's identity from being matched to their answers. They utilized the item count technique that has been proven effective by Miller, JD, "A new survey technique for studying deviant behavior," PhD Diss. G Wash U, 1984.

[263] U.S. Equal Employment Opportunity Commission, "What You Should Know About EEOC and the Enforcement Protections for LGBT Workers," *available at* https://www.eeoc.gov/eeoc/newsroom/wysk/enforcement_protections_lgbt_workers.cfm.

protections,[264] but at the Commission's briefing, she expressed concerns regarding the continued opposition she faced:

> The gender identity and expression piece of most legislation passed and pending has come under the most scrutiny and opposition and, frankly, the understanding of the transgender community is minimal among our elected officials, locally and at the statewide level. In lobbying in Tallahassee for legislation, I am often told I'm the first transgender person a lawmaker has ever met and I say, that you know of. The issue of public accommodations, *i.e.*, public bathrooms, as they relate to transgender citizens is always the baseless point of opposition that we must overcome to pass fully inclusive laws in Florida and in states across the country.[265]

Members of Congress have also made equal rights arguments in favor of passing a non-discrimination federal statute to extend workplace protections to all members of LGBT communities. For example, Rep. Alan Lowenthal sees the Equality Act as providing the same protections that all persons have under the 1964 Civil Rights Act, related to race. He stated that passing the Act would give

> the lesbian, gay, and trans community the same civil rights status as those other groups that had been denied equal access and equal opportunity under the law. I think it's the most comprehensive and sweeping way to ensure equal opportunities and equal protection under the law for all people. I think it's the right thing to do, because if you don't do it under the Equality Act, you're going to have to do [it] piece by piece, through piecemeal legislation. That's what's happened up until now.[266]

What Does Existing Federal Law (Title VII) Mean for Additional Federal Legislation?

Some proponents of workplace protection legislation argue that the primary need for federal legislation stems from the need to halt inconsistent and irreconcilable decisions which exist under the growing patchwork of employment discrimination decisions across the nation. As discussed in detail above, "courts have not taken a uniform position by any means with respect to the interpretations of Title VII discrimination."[267] The court decisions, in particular, are often

---

[264] Ms. Duncan stated that Equality Florida has worked to pass fully inclusive human rights ordinances across the state and that as of the time of the briefing, over 55% of the population of Florida is now protected against discrimination in employment, housing, and public accommodations. Duncan testimony, Briefing Transcript at 209.
[265] *Ibid.* at 209-210.
[266] John Riley, "Exclusive: Rep. Alan Lowenthal on why Congress must pass the Equality Act," *Metro Weekly*, Mar. 23, 2017. http://www.metroweekly.com/2017/03/congressman-alan-lowenthal-on-why-congress-must-pass-the-equality-act/. *See also* U.S. Congress, *supra* note 86 (stating that "Workplace discrimination on the basis of sexual orientation and gender identity remains a problem in the American workplace and carries significant economic consequences.").
[267] Goldberg testimony, Briefing Transcript at 32.

confusing and contradictory regarding whether discrimination based on sexual orientation or gender identity can be alleged under Title VII, as reported to the Commission:

1. Jeanne Goldberg, Senior Attorney Advisor in the Office of the Legal Counsel of the EEOC, stated that court decisions are "not consistent," especially "on the sexual orientation issue." She went on to state that what federal legislation "would add as a general proposition is explicit protections and would therefore provide clarity and consistency across the country for our stakeholders, both employees and employers." She concluded that "at this point in time," such clarity does not exist.[268]
2. Kate Kendell, Director of the National Center for Lesbian Rights, put it more starkly: "Most of . . . the calls that we get are in States where there is no protection . . . Many, many times the most difficult answer that we give to people when they call saying that they've suffered some adverse employment action is, I'm sorry, there is nothing we can do. There is no protection in your State."[269]

Debates have also arisen as to what extent federal legislation protecting against discrimination based on sexual orientation and gender identity should replicate existing federal legislation terms—specifically whether the *bona fide* occupational qualification exception or the religious exemption found in Title VII should be included. Discussion in this area also concerns whether such federal legislation is constitutional, with proponents relying on the court decisions holding that the Civil Rights Act was constitutional, and opponents arguing that the histories and policies surrounding protections of race are different than for protections based on a person being LGBT. These points of view are discussed further herein.

BONA FIDE OCCUPATIONAL QUALIFICATION EXCEPTION

Title VII of the Civil Rights Act allows for employment decisions to be made on the basis of sex, religion, or national origin (but not race or color) if sex, religion, or national origin is a *bona fide* occupational qualification reasonably necessary for the operation of the business.[270] This is a "narrow" exception that allows an employer to "discriminate on the basis of 'religion, sex, or national origin in those certain instances where religion, sex, or national origin is . . . reasonably necessary to the normal operation of that particular business or enterprise.'"[271] The employer bears

---

[268] *Ibid.* at 33-34.

[269] Kendell testimony, Briefing Transcript at 96.

[270] 42 U.S.C. § 2000e-2(e)(1).

[271] *Automobile Workers v. Johnson Controls, Inc.*, 499 U.S. 187, 200–01, 111 S. Ct. 1196 (1991) (*"Johnson Controls"*) (quoting 42 U.S.C. § 2000e–2(e)(1)). In *Johnson Controls,* a female plant worker in a battery manufacturing plant sued her employer because of a company policy that prohibited all women from working near lead—which entailed a health risk of harm to any fetus carried by a female employee—unless the employee documented her infertility. The Supreme Court held that even "the professed moral and ethical concerns about the welfare of the next generation do not suffice to establish a BFOQ of female sterility. Decisions about the welfare of

the burden of establishing the affirmative defense that a particular qualification falls within the exception.[272] The 2017 version of the Equality Act (and ENDA) did not include such an exception to discriminate on the basis of sexual orientation, and modifies the BFOQ exception as to sex to state that "individuals are recognized as qualified in accordance with their gender identity."[273] While some have argued that any federal legislation should include this exception,[274] a representative of the EEOC indicated that employers have not raised the issue in the cases she is aware of.[275] In Goldberg's testimony to the Commission, she stated that employers generally do not raise BFOQ exceptions as an excuse.[276] Thus, with the infrequency of this qualification, it makes it unlikely to be relevant regarding this specific issue. Others have argued that sexual orientation and gender identity more closely align with race, and thus, there are no *bona fide* reasons to discriminate.[277] Some would support only an extremely narrow exception similar to the BFOQ exception for discrimination based on gender.[278] Of note, courts have held that a customer preference invokes the exception only when it is based on the company's inability to perform the primary function or service it offers.[279]

RELIGIOUS LIBERTY AND FREE EXERCISE CONCERNS

Title VII of the Civil Rights Act allows a religious employer to discriminate on the basis of religion when it hires an employee.[280] For example, a Christian organization may require its employees to

---

future children must be left to the parents who conceive, bear, support, and raise them rather than to the employers who hire those parents." *Id.* at 206. It further stated "our cases have stressed that discrimination on the basis of sex because of safety concerns is allowed only in narrow circumstances." *Id.* at 202.

[272] *See Dothard v. Rawlinson*, 433 U.S. 321 (1977), in which a prison rejected the application of female correctional counselor (prison guard) because she failed to meet the minimum 120-pound weight requirement of an Alabama statute. In deciding for the employee, the Court determined that the employer failed to rebut the *prima facie* case of discrimination on the basis that the height and weight requirements are job-related in that they have a relationship to the strength essential to efficient job performance as a correctional counselor, produced no evidence correlating such requirements with the requisite amount of strength thought essential to good job performance and, in fact, had not offered evidence of any kind in specific justification of the statutory standards.

[273] https://www.congress.gov/bill/115th-congress/house-bill/2282/text.

[274] Clegg testimony, Briefing Transcript at 148.

[275] Goldberg testimony, Briefing Transcript at 50.

[276] *Ibid.*

[277] Kylie Byron, "Natural Law and *Bona Fide* Discrimination: The Evolving Understanding of Sex, Gender, and Transgender Identity in Employment," 6 Wash. U. Jur. Rev. 343 (2014), *available at*: http://openscholarship.wustl.edu/law_jurisprudence/vol6/iss2/4; Laura Underkuffler, "Odious Discrimination and the Religious Exemption Question," 32 Cardozo L. Rev. 2069 (2011), *available at*: http://cardozolawreview.com/content/32-5/Underkuffler.32-5.pdf.

[278] Sarah Warbelow, Briefing Transcript at 154.

[279] *See Diaz v. Pan-Am*, 442 F.2d 385 (5th Cir. 1971) ("Similarly, we do not feel that the fact that Pan Am's passengers prefer female stewardesses should alter our judgment [that the *bona fide* occupational exception applies]. On this subject, EEOC guidelines state that a BFOQ ought not be based on 'the refusal to hire an individual because of the preferences of co-workers, the employer, clients or customers.'").

[280] Title VII of the Civil Rights Act of 1964 (Pub. L. 88-352).

be Christians.[281] The previously introduced version of ENDA (2013) included a religious exemption based upon the Title VII religious exemption.[282] The inclusion of this provision was criticized by some as not sufficiently protective of religious liberty. According to Ryan Anderson of the Heritage Foundation, "[w]hile ENDA provides some religious liberty protections, they are inadequate and vaguely defined . . . The religious liberty language in ENDA has been subject to repeated litigation with conflicting rulings by different courts as to which religious institutions are considered religious enough . . . the bill would not protect those who wish to run their businesses and other organizations in keeping with their moral or religious values."[283]

There are also multiple, conflicting viewpoints within the LGBT community on whether any religious exemption should be included. Many, but not all, LGBT advocacy groups withdrew their support for the religious exemption in ENDA after the Supreme Court's decision in *Hobby Lobby*.[284] The heart of these advocacy groups' concerns is that:

> ENDA's discriminatory provision, unprecedented in federal laws prohibiting employment discrimination, could provide religiously affiliated organizations—including hospitals, nursing homes and universities—a blank check to engage in workplace discrimination against LGBT people. The provision essentially says that anti-LGBT discrimination is different—more acceptable and legitimate—than discrimination against individuals based on their race or sex. If ENDA were to pass and be signed into law with this provision, the most important federal law for the LGBT community in American history would leave too many jobs, and too many LGBT workers, without protection. Moreover, it actually might lessen non-discrimination protections now provided for LGBT people by Title VII of CRA and very likely would generate confusion rather than clarity in federal law. Finally, such a discrimination provision in federal law likely would invite states and municipalities to follow the unequal federal lead. All of this is unacceptable.

---

[281] 42 U.S.C. § 2000e-1. *See also Amos*, 483 U.S. at 327 (holding that a gym operated by the Mormon Church could legally require their staff to be Mormons in good standing).

[282] 42 U.S.C. § 2000e -1; Employment Non-Discrimination Act of 2013, S. 815, 113th Cong. (2013) (as passed by Senate November 7, 2013).

[283] Anderson testimony, Briefing Transcript at 281-82.

[284] *See, e.g.*, David Badash, "After Hobby Lobby, Seven Top LGBT and Civil Rights Orgs Drop Support for ENDA," New Civil Rights Movement, July 8, 2014, *available at* http://www.thenewcivilrightsmovement.com/breaking_after_hobby_lobby_six_top_lgbt_and_civil_rights_orgs_drop_support_for_enda; "ACLU Withdraws Support for ENDA," American Civil Liberties Union, July 8, 2014, *available at* https://www.aclu.org/lgbt-rights/aclu-withdraws-support-enda; and Chris Johnson, "Nadler 'Concerned,' Wants to Narrow ENDA's Religious Exemption," Washington Blade, July 8, 2014, *available at* http://www.washingtonblade.com/2014/07/08/rep-nadler-says-enda-religious-exemption-overbroad/. David Badash, "HRC Charts Lone Course, Reiterates Support for ENDA Despite Religious Exemptions," New Civil Rights Movement, July 8, 2014, *available at* http://www.thenewcivilrightsmovement.com/hrc_standing_alone_reiterates_support_for_enda_despite_religious_exemptions.

> The Supreme Court's decision in Hobby Lobby has made it all the more important that we not accept this inappropriate provision. Because opponents of LGBT equality are already misreading that decision as having broadly endorsed rights to discriminate against others, we cannot accept a bill that sanctions discrimination and declares that discrimination against LGBT people is more acceptable than other kinds of discrimination.[285]

Finally, some would use the exact same language as found in Title VII and have argued that the existing Title VII case law properly defines the line for which religious organizations should be able to use such an exception. As Alan Brownstein, law professor at University of California, Davis, testified before the Commission:

> I've written that there's a parallel between religion and sexual orientation both because there's a conduct dimension to both religion and sexual orientation, because both are relational and involve obligations based on relationships, because the protection of both religious liberty and the rights of the LGBT community are usually challenged by the same kind of slippery slope arguments that have been used to defeat both. So, I think there's some basis for saying not that discrimination against LGBT people is somehow sui generis and unique, and we need a separate regime of exemptions for the LGBT community. But I think one could argue that there's an analogy and a parallel between religion and sexual orientation so that the same religious exemptions that would apply with regard to discrimination on the basis of religion in hiring ought also to apply with regard to discrimination on the basis of sexual orientation.[286]

Constitutionality of Federal Legislation

Although not a focus of the Commission's investigation, opponents of legislation affording workplace nondiscrimination protections to LGBT Americans question the constitutionality of such a law.[287] In particular, they object to use of the Commerce Clause and Section 5 of the Fourteenth Amendment as the constitutional basis.[288] Article 1, Section 8, clause 3 of the U.S.

---

[285] "Joint Statement on Withdrawal of Support for ENDA and Call for Equal Workplace Protections for LGBT People," American Civil Liberties Union, Gay & Lesbian Advocates and Defenders, Lambda Legal, National Center for Lesbian Rights, and Transgender Law Center, July 8, 2014, *available at* https://www.aclu.org/sites/default/files/assets/joint_statement_on_enda.pdf.

[286] Alan Brownstein, Law Professor at University of California, Davis, Briefing Transcript, pp. 284-85.

[287] Clegg testimony, Briefing Transcript at 101-104.

[288] Section 5 of the 14th Amendment provides Congress "power to enforce, by appropriate legislation, the provisions of this [amendment]" which, in Section 1, provides that, "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." Section 5 of the 14th Amendment provides Congress the power to enforce, by appropriate legislation, the substantive provisions of the Amendment. U.S. CONST., amend. XIV, sec. 5.

Constitution describes the enumerated power of Congress "[t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[289] In *U.S. v. Lopez*,[290] the U.S. Supreme Court articulated that one test for determining whether an activity is within Congress' power to regulate under the Commerce Clause is "whether it substantially affects interstate commerce." Organizations and individuals who oppose this legislation believe that "Congress is going to have a hard time meeting those standards."[291] The Supreme Court also opined that "the power of Congress to promote interstate commerce also includes the power to regulate the local incidents thereof, including local activities in both the States of origin or destination, which might have a substantial and harmful effect upon that commerce."[292]

Proponents of anti-discrimination workplace protections for LGBT Americans counter that the interconnectedness of our national economy strengthens the argument that LGBT workplace protections affect interstate commerce:

> More so than ever, our economy is interconnected. We no longer live in a world in which goods and services are produced in one particular area; they stay in that area. Mom and pop shops are virtually a thing of the past when you're talking about production that is solely within a given area.[293]

Similarly, as discussed throughout this report, LGBT employees work throughout the United States and are employed by corporations that conduct business across state lines. For example, Northrop Grumman employs LGBT workers and "is located in all 50 states."[294] Such factual evidence seems to support the use of the Commerce Clause as the basis for federal anti-discrimination legislation.

In sum, as stated by briefing panelist Brownstein, "we fought that battle [about interstate commerce and nondiscrimination laws] and we've concluded as a society that the rights of employees, and the rights of people who seek public accommodations outweigh the rights of employers."[295]

---

[289] U.S. CONST., art. I § 8, cl. 3.
[290] 514 U.S. 549 (1995).
[291] Clegg testimony, Briefing Transcript at 101 ("Now, it was certainly arguable in 1964 that the widespread and systemic discrimination against blacks in large parts of the country had a substantial effect on interstate commerce. But can it be credibly argued that, in 2015, discrimination against homosexuals has a "substantial" effect on interstate commerce? I don't think so.").
[292] *Heart of Atlanta Motel, Inc. v. U.S.*, 379 U.S. 241, 258 (1964).
[293] Warbelow testimony, Briefing Transcript at 99.
[294] Sylvester Mendoza, Global Director of Global Inclusion and Strategic Alliance at Northrop Grumman, testimony, Briefing Transcript, p. 172.
[295] Brownstein testimony, Briefing Transcript at 295.

Are Existing Public Sector Protections Enough?

While there have been formal restrictions and barriers in the private sector against LGBT employees, there also has been a long history of LGBT workers being barred from employment in the federal government.[296] The Merit Systems Protections Board cited a 2012 OPM survey that "found that lesbian, gay, bisexual, and transgender federal employee perceptions of the workplace were generally less positive than other employees."[297] When surveying federal LGBT employees, scholars Lewis and Pitts found that many LGBT workers do not believe they are given the same treatment as their heterosexual colleagues. They gave more negative responses to every question about their jobs, organizations, leaders, and co-workers.

> LGBT employees are 1 to 3 percentage points less likely than heterosexuals to think their performance appraisals are fair and to be satisfied with their pay; 3 to 6 points less likely to be satisfied with their advancement opportunities or to feel that merit drives rewards in their agencies; 4 to 6 points less likely to think highly of their immediate supervisors, agency leadership, or organizations; and 4 to 8 points less likely to be satisfied with their agencies' treatment of diversity, [prohibited personnel practices] and employee empowerment. They are also 3 to 8 percentage points more likely to say that they are planning to look for a new job outside their agency. Given the low percentages reporting dissatisfaction, LGBTs are one quarter more likely than heterosexuals to express dissatisfaction on most measures.[298]

Additionally, outside of reporting EEOC claims, the federal government does not appear to collect data regarding whether the efforts to ensure federal anti-discrimination policies are fully implemented. Advocates argue that it would be helpful if "every federal agency [were] charged with collecting information on sexual orientation and gender identity in all of their surveys."[299] According to the National LGBTQ Task Force, collecting additional data on sexual orientation and gender among LGBT federal employees, federal contractors, and federally assisted contractors could be "spearheaded by a presidential Executive Order calling for agencies to determine best methods for integrating these demographic questions into their data collection instruments" and to examine the "levels of filing" of complaints and what is happening in federal enforcement and oversight.[300] It is worth noting that adding demographic measures may not be a wanted change for all LGBT people in fear of privacy concerns. Due to the societal stigma of embodying an LGBT

---

[296] Sears, *supra* note 224.
[297] Merit Systems Protection Board, *Sexual Orientation in the Federal Workplace, Policy and Perspective*, (May 2014) (discussing and citing the Office of Personal Management's 2012 Employee Viewpoint Survey at iii).
[298] Gregory B. Lewis and David W. Pitts, "LGBT–Heterosexual Differences in Perceptions of Fair Treatment in the Federal Service," *American Review of Public Administration*, 1-19 (2015), p. 15.
[299] Simmons testimony, Briefing Transcript at 82-83.
[300] *Ibid.* at 93.

identity and the fear of prejudice, some LGBT individuals may not want to disclose their sexual orientation or gender identity in surveys.

Outside of federal employment, an estimated one million LGBT employees work in the public sector for state and local governments.[301] Of these employees, only 45 percent of American workers live in a jurisdiction prohibiting sexual orientation discrimination in employment, and only 34 percent of workers live in a jurisdiction prohibiting gender identity discrimination.[302] These workers may face a patchwork of employment protections, depending on what state or local jurisdiction they work for. For instance, Lisa Howe, Executive Director of the Nashville LGBT Chamber of Commerce, explained at the briefing how state-by-state protections do not offer adequate protections for all LGBT workers. She reported that in Tennessee there are "very few protections . . . for contractors or anything like that. So in Nashville the metro government did pass a policy to extend sexual orientation, gender identity onto the employment—the discrimination policies for their contractors and the state overturned it and said that local governments do not have that authority."[303]

Even though some states have policies for state and local LGBT employees, researchers have found that discrimination is still pervasive and occurs nearly as frequently as discrimination in the private sector.[304] Looking at public sector complaints in 123 jurisdictions, Mallory and Sears found that the rate of discrimination complaints filed by LGB state and local employees was slightly lower than, but similar to, that of filings by LGB employees in the private sector.[305] They found that the frequency is similar with state and local government employment, but state filings are slightly lower (2.8 complaints for state government and 3.2 complaints for local government for every 10,000 LGB employees). Mallory and Sears found the rate of sexual orientation and gender identity complaints occurred at a similar rate as discrimination claims based on race and sex.[306] They further discussed that the actual rate of discrimination against LGBT employees may be drastically underreported for several reasons. First, some state and local agencies lack the resources and staff necessary to effectively enforce nondiscrimination laws. Panelist Roger Clegg brought up this point in his testimony, stating that having to resort to litigation and regulation is "very

---

[301] Chris Mallory and Brad Sears. "Discrimination Against State and Local Government LGBT Employees." *LGBTQ Policy Journal*, Volume 4, (2012).
[302] Lee Badgett et al., "Executive Order to Prevent Discrimination Against LGBT Workers," Center for American Progress and Williams Inst., 4 (Feb. 2013), https://www.americanprogress.org/issues/lgbt/reports/2013/02/19/53931/an-executive-order-to-prevent-discrimination-against-lgbt-workers/.
[303] Howe testimony, Briefing Transcript at 173.
[304] Lee Badgett, *supra* note 53.
[305] Mallory and Sears, *supra* note 301. Three per every 10,000 LGB public sector employee compared to 4.1 per every 10,000 LGB private sector employee.
[306] *Ibid.* at 46-47 (four per every 10,000 LGB employee, 3.9 per every 10,000 racial minority employee, 5.2 per every 10,000 female employee).

expensive and distortive media."[307] This argument may be likely to have bipartisan support for those in favor and those who oppose federal legislation. Second, LGBT people may be hesitant to file complaints because of a perception of judicial unresponsiveness. Third, LGBT people may choose not to file complaints in order to avoid further "outing" themselves and thus risk suffering further negative consequences in the workplace.

Are Private Sector Policies Enough?

Opponents of federal legislation assert that "while racial integration might not have been forthcoming apart from the Civil Rights Act, in the case of sexual orientation, voluntary actions and market forces have emerged that undermine the clamor for federal action."[308] Proponents of federal legislation disagree, arguing that although the federal government, corporations, and businesses are increasingly creating and enforcing LGBT-inclusive policies, LGBT workers still lack an array of national legal protections, leaving many to hide who they are for fear of discrimination in the workplace. These proponents note that private sector policies are necessary, but not sufficient to create a national climate of inclusion. Proponents for federal legislation argue that voluntary measures implemented by some major corporations are not enough, since the effects of workplace discrimination against members of the LGBT community remain very serious. For individuals, workplace discrimination can drastically increase psychological stress and other mental health problems. A fifth of LGBT respondents to the Human Rights Campaign Foundation's 2014 survey reported feeling exhausted from expending time and energy hiding their identities and a third felt distracted from their duties at work due to negative workplace environments.[309] As the Director of Human Rights Campaign's Workplace Equality Program has stated "[t]he inclusive policies coming from the boardroom have not fully made it into the everyday culture of the American workplace."[310]

Further, business policies are not enforceable in courts, and businesses may decide not to follow their own policies. The Director of the Public Policy at the National LGBTQ Task Force shared the story of an insurance company receptionist, who was terminated the same day an agency executive saw him kiss his partner in the work parking lot.[311] The employer had a general company policy of non-discrimination; yet according to testimony before the Commission, the employee perceived that he had no recourse to challenge the termination decision. This case occurred in 2002, therefore it was before the EEOC's decision to extend workplace protections based on sexual

---

[307] Clegg testimony, Briefing Transcript at 108.
[308] Anderson testimony, Briefing Transcript at 281.
[309] Fidas, *supra* note 39, at 3.
[310] "HRC Study Shows Majority of LGBT Workers Closeted on the Job," News release, HRC, May 7, 2014.
[311] Simmons Statement at 7.

orientation. Panelist Long-Simmons used this example to highlight the importance of enacting federal legislation to protect LGBT workers since businesses merely having a stated policy may not offer these employees full protections.

Lastly, even though the EEOC has held that claims of discrimination based on sexual orientation and gender identity can be brought under Title VII, for employees to "truly benefit from these legal protections, explicit statutes must be enacted to make sure that the law is clear to everyone, including employers, workers, and courts."[312] "Courts are not strictly bound to follow the [EEOC's] interpretation of the law."[313] Given the current inconsistent Circuit court decisions, should a private employer in some jurisdictions not agree with the EEOC's decision, it could refuse to abide by it, which may result in a court overturning the EEOC's decision.[314]

How Would Federal Legislation Impact the Economy?

ECONOMIC SUPPORT OF FEDERAL LEGISLATION

There is substantial support for federal legislation in the business community. As Mary Beth Maxwell, the former Principal Deputy Assistant Secretary for Policy at the Department of Labor put it, "Equality in the workplace is not only the right thing to do; it turns out to be good business."[315] Sylvester Mendoza, Director of Global Inclusion and Strategic Alliances at Northrop Grumman, stated that discrimination "has no place in the workplace, and we believe in doing everything possible to eliminate discrimination against any employee, including members of the LGBT community."[316] Northrop Grumman's zero tolerance policy offers protections to their employees from "discrimination based on sex, gender, gender identity, expression, and sexual orientation."[317] They feel that diversity and inclusion are strengths necessary to a global corporation. By providing an inclusive working environment, Northrop Grumman believes that employees "bring their whole authentic selves to work every day, contributing diverse ideas, perspectives, and talents to solve our customers' toughest challenges."[318] While this policy is an example of a positive and inclusive step towards workplace equality for LGBT employees, this policy only protects Northrop's workers from discrimination. Thus, this example illustrates how

---

[312] Mendoza testimony, Briefing Transcript at 193; Ilona Turner, Legal Director at the Transgender Law Center, testimony, Briefing Transcript, p. 204.
[313] Turner testimony, Briefing Transcript at 207. As discussed in more detail above, only one circuit court has followed EEOC's lead and held that Title VII permits sexual orientation lawsuits.
[314] *See ibid.* at 207-08.
[315] Maxwell testimony, Briefing Transcript at 21.
[316] Mendoza testimony, Briefing Transcript at 166.
[317] *Ibid.* at 167.
[318] *Ibid.*

the need to eliminate patchwork protections for LGBT employees is imperative so all employees can have the reassurance of being protected from discrimination.

There are many companies like Northrop Grumman who believe that discrimination against LGBT employees and applicants leads to less qualified staff.[319] Discrimination lowers motivation to invest in future education. Not only does this affect individuals, it also lowers a company's overall skilled staff and the entire U.S. labor force. Furthermore, this leads to a decrease in productivity and, therefore, a decrease in profit and economic growth. LGBT and heterosexual employees alike who work for businesses that discriminate show high rates of absenteeism and are generally less committed to their respective businesses.[320] Accordingly, many businesses support federal legislation:

1. 63 percent of small businesses support legislation to legally protect LGBT employees regardless of employer's religious beliefs.[321]
2. Almost six in ten small-business owners also believe that employment nondiscrimination laws improve or would improve their businesses' bottom lines by allowing access to the most talented individuals, regardless of sexual orientation or gender identity.[322]

Employment protection policies often cost companies little to nothing to implement or maintain antidiscrimination policies. Eighty-six percent of small businesses that do not already have such an antidiscrimination policy state that these policies cost them "nothing or next to nothing," while only two percent of small businesses with such policies say there is a "small but significant" cost associated with antidiscrimination policies. None of the businesses surveyed reported a substantial cost. [323]

Furthermore, findings suggest there are economic benefits in extending LGBT employees' equal benefits and adding protective inclusion and diversity policies. As discussed previously, employees perceive these policies as positive, thus contribute positively to business profits. Moreover, with the increasing numbers of same-sex households, the buying power of LGBT consumers is also growing. Studies suggest there has been a 20 percent increase in LGBT market growth from 2006 to 2012, which equates to approximately $790 billion.[324] Further, surveys suggest that consumers (both LGBT and allies) see acceptance and tolerance positively, thereby

---

[319] Mendoza testimony, Briefing Transcript at 166-67. Human Rights Campaign Foundation, *supra* note 105.
[320] Out & Equal, Harris Interactive, and Witeck Combs Communications, "Out & Equal Workplace Culture Report," 2008.
[321] Small Business Majority, *supra* note 87.
[322] *Ibid.*; Movement Advancement Project, *supra* note 52.
[323] Small Business Majority, *supra* note 87.
[324] Witeck-Combs Communications, "America's LGBT 2012 Buying Power Projected at $790 Billion," 2012.

increasing customer flow and money earned for the economy.[325] A majority of heterosexual and LGBT consumers state that friendliness and support of equal rights for the LGBT community influence the decision to purchase products or services from a business. In a national survey in 2011, 87 percent of LGBT individuals and 75 percent of heterosexuals say they consider choosing a brand known to provide equal benefits to employees regardless of sexual orientation or gender identity.[326] In the same survey, researchers found that brand loyalty is important to LGBT consumers. They found that 71 percent LGBT adults said that they are likely to remain loyal if the business is believed to be "very friendly" and "supportive" of the LGBT community, regardless if the less-friendly company is cheaper and/or more conveniently located.[327]

Conversely, the potential for boycotts of a company's products or services has impacted many businesses' view of supporting LGBT rights. For decades, most companies rarely targeted or advertised to the LGBT community, choosing instead to stay away from partisan issues to avoid taking a position that might isolate a segment of their customer base.[328] Today though, customers increasingly see their dollars as an extension of their power in the voting booth.[329] Social media campaigns have bolstered boycotts, which have allowed people around the country to organize protests and boycott products.[330] As the Chief Executive of the Center for Talent Innovation has noted "[t]here's enormous value in figuring out how to be seen and to act as a LGBT-friendly company."[331] However, even with the positive voluntary measures that companies have implemented to end discrimination against LGBT employees, as stated previously, many people are not covered and discrimination remains a significant problem for these communities.

---

[325] Ogilvy, "LGBT-Inclusive Advertising Is Driving Business Yet Consumers Demand Authenticity According to Ogilvy Survey," June 28, 2017, https://www.prnewswire.com/news-releases/lgbt-inclusive-advertising-is-driving-business-yet-consumers-demand-authenticity-according-to-ogilvy-survey-300481056.html, Harris Interactive, "LGBT Adults Strongly Prefer Brands That Support Causes Important to Them and That Also Offer Equal Workplace Benefits," *PR Newswire*, Jul. 18, 2011, http://www.prnewswire.com/news-releases/lgbt-adults-strongly-prefer-brands-that-support-causes-important-to-them-and-that-also-offer-equal-workplace-benefits-125742178.html.

[326] Harris Interactive, *supra* note 325.

[327] *Ibid.*

[328] Katherine Sender, *Business, Not Politics: The Making of the Gay Market*, Columbia University Press, February 2005; Samantha Felix, "15 Ads That Changed the Way We Think About Gays and Lesbians," *Business Insider*, Oct. 13, 2012, http://www.businessinsider.com/15-ads-that-changed-the-way-we-think-about-gays-and-lesbians-2012-10?op=1.

[329] Amanda Hoover, "Major Companies Back Transgender Teen in Supreme Court Case: A New Trend?", *Christian Science Monitor*, Mar. 2, 2017, https://www.csmonitor.com/USA/2017/0302/Major-companies-back-transgender-teen-in-Supreme-Court-case-a-new-trend.

[330] Americus Reed and Judith Samuelson, "When Do Consumer Boycotts Work?", *New York Times, Opinion Pages, Room for Debate*, Feb. 7, 2017, https://www.nytimes.com/roomfordebate/2017/02/07/when-do-consumer-boycotts-work.

[331] Hoover, *supra* note 329.

ECONOMIC OPPOSITION TO FEDERAL LEGISLATION

Opponents of the Employment Non-Discrimination Act and the Equality Act argue that anti-discrimination laws against LGBT people will prove economically disadvantageous to businesses and the economy.[332] Some believe that anti-discrimination laws will be counterproductive and result in less frequent hiring of LGBT employees because of the risk of costly lawsuits. Their concern is that employers will hire a non-LGBT person over an LGBT person because the former does not present the risk of later lawsuits claiming discrimination.[333] Additionally, opponents argue that employers may not want to lay off employees who are protected by the Employment Non-Discrimination Act, even if the layoff is for legitimate reasons, because the employee could sue for wrongful termination. Because of this, opponents argue businesses will be stuck with "unproductive or superfluous workers," which will cause further economic stress.[334] Opponents believe this reluctance to fire people would also result in hiring fewer LGBT individuals because employers feel such employees cannot be fired. The end result of federal legislation on hiring and firing employees, according to those opposed to federal legislation, will be less job creation in the market as a whole.[335]

Opponents of federal legislation are concerned that there may be additional litigation due to what they perceive as the subjective nature of sexual orientation and gender identity, which is more difficult for an employer to identify than sex or race. According to some opponents, this means that an LGBT employee who is fired could, theoretically, bring more lawsuits against a former employer, which could harm all businesses, including those that already have antidiscrimination policies in place.[336] One author asserts that, even if the employer were to win a wrongful termination suit, the business would still have to pay at least $250,000 in attorney fees. Additional costs, though minimal, could also come from training seminars on a new federal law and the cost of following strict guidelines.[337]

---

[332] For example, *see* Ryan Anderson, "ENDA Threatens Fundamental Civil Liberties," Heritage Foundation, November 2013, http://www.heritage.org/civil-society/report/enda-threatens-fundamental-civil-liberties; Heritage Action For America, "'No' On the Employment Non-Discrimination Act (ENDA), November 2013, *available at* http://heritageaction.com/key-votes/employment-non-discrimination-act-enda/. The U.S. Chamber of Commerce did not take a position either for or against the Employment Non-Discrimination Act when it was debated in 2013. Chris Johnson, "U.S. Chamber of Commerce stays neutral on ENDA," *Washington Blade*, Sept. 18, 2013, http://www.washingtonblade.com/2013/09/18/chamber-stays-neutral-enda/.

[333] Courtney Michaluk and Daniel Burnett, "Gayconomics 101: Why the Latest LGBT Rights Legislation Could Be the 'ENDA' the Road for Some Job Seekers," *Huffington Post*, Nov. 25, 2013, http://www.huffingtonpost.com/courtney-michaluk/enda_b_4326767.html.

[334] Anderson, *supra* note 332.

[335] *Ibid.*

[336] For example, *see* Hans Bader, "Employment Non-Discrimination Act Makes as Little Sense as Chemotherapy for a Cold," Competitive Enterprise Institute, June 13, 2012, https://cei.org/blog/employment-non-discrimination-act-makes-little-sense-chemotherapy-cold.

[337] Michaluk, *supra* note 333; Small Business Majority, *supra* note 87.

At the Commission's briefing, panelists noted that in states that have enacted LGBT anti-discrimination protections, there has not been a flood of litigation in response. Kate Kendell stated:

> We have a number of states that have passed laws that prohibit discrimination based on gender identity . . . And there hasn't been some—there hasn't been a huge flood of litigation, nor has there been inane interpretations. What these laws do, is they set a tone for how we think people should be treated on the job. And by existing, they stop the very discrimination that they're meant to redress. And then in extreme cases, people then are free and have the ability to bring cases. The ability to answer the question, what kind of country do we want to live in? With the statute that says, we want to live in a country where people, all sorts of people, including people based on sexual orientation or gender live free, honored for who they are and able to do their jobs to the highest of their ability. And their ability is what matters, not who they are. That seems to me to be a good thing for this country to do.[338]

Of note, the number of EEOC claims alleging sexual orientation and/or gender identity discrimination counters against the narrative of additional lawsuits. The EEOC reports that it "receives close to 95,000 charges a year on all of the statutes we enforce . . . in those three quarters of fiscal year 2013 and looking at a snapshot of 2014, we are talking about a fraction, really small fraction—talking about 800 charges altogether raising these issues, and, obviously, a number of them may not be meritorious."[339] After the EEOC held that sexual orientation and gender identity fall within Title VII, the number of charges filed alleging discrimination on these bases did rise to 1,768 for FY 2016, which is approximately 1.8 percent of all charges filed with the EEOC.

Another concern about the effect of federal legislation and additional federal regulation on business hiring and firing could negatively impact the free market system.[340] The "at-will" employment concept in which businesses fire and rehire at any time follows this economy philosophy. They argue that businesses hire the most qualified regardless of sexual orientation or gender identity because it is in their best interest to do so.[341] This belief holds that "the free market is already correcting what bureaucratic red tape cannot fix."[342]

---

[338] Kendell testimony, Briefing Transcript at 115.
[339] *Ibid.* at 55-56.
[340] Statement of Roger Clegg, President and General Counsel at Center for Equal Opportunity, U.S. Commission on Civil Rights, *Briefing: Examining Workplace Discrimination Against LGBT Americans,* (Washington, DC, March 16, 2015) at 4; *see also* Clegg testimony, Briefing Transcript at 277 (raising concerns about "government interference in the marketplace.").
[341] Clegg testimony, Briefing Transcript at 67. ("If discrimination on the basis of sexual orientation is always irrational, then employers that engage in such discrimination will be at economic disadvantage, and the market will punish them.").
[342] Michaluk, *supra* note 333.

New Developments in Federal Legislation

In May 2017, the Equality Act was reintroduced in Congress.[343] This newest version extends protections for LGBT individuals not only in the workplace, but also in public accommodations, housing, federally funded programs, jury service, and credit. This is significant and worth noting in this report since the right of transgender persons to access the bathroom that correctly aligns with their gender identity has gained national attention. Kylar Broadus, Senior Public Policy Counsel of the Transgender Civil Rights Project, at the briefing explained the frustrating dilemma in simply trying to access a bathroom. He told the Commission: "I didn't go to the bathroom for years [in public facilities] because I would be accosted by police at every place and thrown out of the women's room."[344] While a full discussion of these issues is beyond the scope of this report, we acknowledge them for contextual reasons.

Specifically regarding the workplace, transgender rights advocates argue that employers should allow transgender workers to use the restroom that conforms to their gender identity and/or allow them access to private, single user facilities.[345] And the American public seems to also agree. A 2016 survey found broad, bi-partisan support for LGBT nondiscrimination laws, with 72 percent of Americans saying they favor laws that would protect LGBT individuals from discrimination in jobs, public accommodations, and housing.[346] Further, a majority (53 percent) of Americans oppose laws that require transgender persons to use the bathroom that corresponds to their assigned sex at birth rather than their gender identity.[347] A lack of a clear policy surrounding the use of restrooms for transgender employees (and citizens more broadly) creates an uncomfortable and sometimes hostile atmosphere for transgender people. Mara Keisling from the National Center for Transgender Equality, stated the explicit connection between bathroom rights and workplace protections. In her testimony she stated: "If you're allowed to have a job and you can't be fired but they don't have to let you use a bathroom at work, you can't work."[348]

Access to restrooms for transgender people is also a health issue relevant to both employees and businesses. The Department of Labor's (DOL) Occupational Safety and Health Administration (OSHA) released guidelines in 2015 for employers to ensure all employees have access to facilities they need. The report states: "all employees, including transgender employees, should have access to restrooms that correspond to their gender identity." The department argues that lack of access

---

[343] https://www.congress.gov/bill/115th-congress/house-bill/2282/text.
[344] Broadus testimony, Briefing Transcript at 224.
[345] Chang, *supra* note 103.
[346] Robert P. Jones, Betsy Cooper, Daniel Cox, and Rachel Lienesch, "Majority of Americans Oppose Laws Requiring Transgender Individuals to Use Bathrooms Corresponding to Sex at Birth Rather than Gender Identity." *PRRI*. 2016, *available at* http://www.prri.org/research/poll-lgbt-transgender-bathroom-bill-presidential-election/.
[347] *Ibid.*
[348] Keisling testimony, Briefing Transcript at 219.

to proper and hygienic restrooms can cause health problems or risks to physical safety for affected individuals.[349] For instance, the National Center for Transgender Equality found that in the past year, 8 percent of respondents reported having a urinary tract infection, kidney infection, or another kidney-related problem as a result of avoiding restrooms.[350] Further, the DOL's Office of Federal Contract Compliance Program (OFCCP) released a fact sheet stating that gender identity is protected under their policy prohibiting sex discrimination. Its new rule requires "contractors to allow workers to use bathrooms, changing rooms, showers, and similar facilities consistent with the gender with which the workers identify."[351] These policies by the Department of Labor reflect some of the ongoing policy struggles in this realm—for both state and local laws—that inhibit an individual's access to a bathroom that corresponds with the individual's gender identity (e.g., Texas and North Carolina).[352] However, some private companies have instituted their own policies regarding their public and employee bathrooms (*e.g.*, Target and Starbucks)[353] to compensate for the lack of federal protections.

Over the past several years, the business community has become more vocal about social issues, both for and against LGBT rights. Corporations have taken positions on state religious freedom restoration laws, which allow businesses to discriminate against customers on the basis of religion that many see as anti-gay. For example, corporations like Hobby Lobby and Chick-Fil-A have both come under fire by advocates for touting anti-LGBT rhetoric and adopting non-inclusive policies.[354] Conversely, many corporations have publicly declared support for extending employment protections for LGBT workers and customers. Todd Sears, founder and principal of Out Leadership, argues that these actions from the business community are "the new normal . . . [and] it's not just that companies are speaking out, there's actually a price to not speaking out."[355] For instance, after then-North Carolina Governor Pat McCory passed the HB 2 bill that blocked local governments from passing anti-discrimination laws protecting LGBT people, repealed existing municipal housing and employment protections for LGBT people, and forced transgender

---

[349] U.S. Department of Labor, Occupational Safety and Health Administration, *A Guide to Restroom Access for Transgender Workers*, 2015, *available at* http://www.dol.gov/asp/policy-development/TransgenderBathroomAccessBestPractices.pdf.

[350] James, *supra* note 55.

[351] U.S. Department of Labor, Office of Federal Contract Compliance Programs, *OFCCP's Sex Discrimination Final Rule*, 2016, *available at* https://www.dol.gov/ofccp/SexDiscrimination/SexDiscrimFinalRuleFactSheet_JRFQA508c.pdf.

[352] http://www.legis.state.tx.us/tlodocs/85R/billtext/pdf/SB00006I.pdf; M.S.R., "Texas Republicans revive their 'bathroom bill,'" *The Economist*, Jul. 27, 2017, https://www.economist.com/blogs/democracyinamerica/2017/07/toilet-talk. See below for an in-depth discussion of the North Carolina legislation.

[353] Hadley Malcolm, "How other stores are handling transgender bathroom policies," *USA TODAY*, Apr. 27, 2016, https://www.usatoday.com/story/money/2016/04/27/retailers-transgender-bathroom-policy-lgbt/83560714/.

[354] The Advocate, "Chick-Fil-A," http://www.advocate.com/chick-fil (last visited Nov. 12, 2017); Emma Margolin, "How Hobby Lobby will reverberate throughout the LGBT community," *MSNBC*, Jul. 10, 2014, http://www.msnbc.com/msnbc/hobby-lobby-reverberate-throughout-lgbt-community.

[355] Hoover, *supra* note 329.

people to utilize public bathrooms based on the sex on their birth certificates rather than their gender identities, many companies refused to continue doing business in the state. When businesses and corporate investors oppose legislation, such as when the National Basketball Association pulled its 2017 All-Star Game out of North Carolina in opposition to HB 2, they are likely to influence local and state policy going forward. For example, when the Georgia state legislature attempted to pass their own religious freedom bill, Governor Nathan Deal vetoed it, stating that it would hurt Georgia business growth.[356] According to the *Associated Press*, the "bathroom bill" has cost North Carolina an estimated $3.76 billion in lost business revenue.[357] Due to the political, economic, and social backlash from HB2, now-Governor Roy Cooper promised during his 2017 gubernatorial campaign that he was going to repeal the bill. However, he did not issue a full repeal. Rather in March 2017 he offered a "compromise" in the form of House Bill 142.[358] This new bill forbids "state agencies, boards, offices, departments, institutions," and "branches of government," including public universities, from regulating "access to multiple occupancy restrooms, showers, or changing facilities."[359] HB 142 further restricts local governments, school boards, and public universities from passing their own LGBT-inclusive policies and bans any city in North Carolina from "regulating private employment practices or regulating public accommodations" until December 1, 2020.[360] This new bill has assuaged some of the concerns from HB 2, for instance the NCAA has decided to return to North Carolina despite the continued discriminatory impacts of this new bill. The NCAA governors argue that HB142 brings North Carolina laws in step with the majority of the other states.[361] However, LGBT advocates argue that the bill "literally does not do one thing to protect the LGBT community and locks in HB2's most basic and offensive provision."[362]

On May 30, 2017 the Seventh Circuit Court of Appeals ruled in favor of a transgender plaintiff regarding bathroom access.[363] The court ruled that restricting the transgender student from using

---

[356] Sandhya Somashekhar, "Georgia governor to veto religious freedom bill criticized as anti-gay," *Washington Post*, Mar. 28, 2016, https://www.washingtonpost.com/news/post-nation/wp/2016/03/28/georgia-governor-to-veto-religious-freedom-bill-criticized-as-anti-gay/?utm_term=.a7a46bc15b99.

[357] Emery Dalesio and Jonathan Drew, "Price tag of North Carolina's LGBT law: $3.76B" *Associated Press*, Mar. 27, 2017, https://www.apnews.com/fa4528580f3e4a01bb68bcb272f1f0f8.

[358] Eliot McLaughlin, "North Carolina's HB142: Repeal? Compromise? What does it all mean?", *CNN*, Mar. 30, 2017, http://www.cnn.com/2017/03/30/us/north-carolina-hb2-repeal-hb142-explainer/; Mark Joseph Stern, "The HB2 "Repeal" Bill Is an Unmitigated Disaster for LGBTQ Rights and North Carolina" *Slate*, Mar. 30, 2017, http://www.slate.com/blogs/outward/2017/03/30/hb2_repeal_bill_is_a_disaster_for_north_carolina_and_lgbtq_rights.html.

[359] General Assembly of North Carolina, Session Law 2017-4, House Bill 142.

[360] *Id.*

[361] Camila Domonoske, "NCAA Returning to North Carolina After Partial Repeal of 'Bathroom Bill'", *National Public Radio*, Apr. 4, 2017, http://www.npr.org/sections/thetwo-way/2017/04/04/522579434/ncaa-returning-to-north-carolina-after-partial-repeal-of-bathroom-bill.

[362] The Observer Editorial Board, "HB2 repeal: Cooper turns back on LGBT community" *The Charlotte Observer*, Mar. 30, 2017, http://www.charlotteobserver.com/opinion/editorials/article141667999.html.

[363] *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d. 1034 (7th Cir. 2017).

the bathroom that corresponded to his gender identity was a form of sex discrimination, which is protected under Title IX.[364] While this case was specifically regarding a Wisconsin high school student, the court's decision has sweeping implications for how Title IX will be interpreted in the future, and potentially for the 14th Amendment.[365] Where courts interpret bans against sex discrimination to prohibit discrimination against transgender individuals, their reasoning offers analogies in other contexts in which bans against sex discrimination apply (*e.g.*, workplace, housing, public accommodations).

[364] Education Amendments of 1972, Pub. L. 92-318, codified at 20 U.S.C. § 1681 et seq.

[365] In February 2017, the Departments of Education and Justice rescinded earlier guidance, dated May 13, 2016, from the Departments of Education and Justice stating that Title IX's prohibition of discrimination on the basis of sex required access to sex-segregated facilities based on an individual's gender identity. Civil Rights Division of the U.S. Department of Justice and Office for Civil Rights of the U.S. Department of Education, Dear Colleague letter, Feb. 22, 2017, *available at* https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201702-title-ix.docx.

[*This page intentionally left blank*]

CHAPTER 4: FINDINGS AND RECOMMENDATIONS

The Commission makes the following findings and recommendations:

Findings and Recommendations

FINDINGS

1. **Overview**

   a) Historians, researchers, and courts have extensively documented that lesbian, gay, bisexual, and transgender (LGBT) workers have faced a long, serious, and pervasive history of official and unofficial employment discrimination by both federal, state, and local governments and private employers.
   b) Anti-LGBT employment discrimination persists and has wide-ranging, damaging implications for the quality of life for many LGBT Americans, their children and families, and communities.
   c) In the absence of explicit federal statutory nondiscrimination protections, LGBT workers face serious barriers to both gaining and keeping jobs and promotions. Workplace discrimination against LGBT communities can cause job instability and high turnover, resulting in greater unemployment and poverty rates as well as substantial wage gaps between LGBT workers and workers outside the LGBT community. Studies have shown that state anti-discrimination laws appear to help reduce these wage gaps.
   d) Federal data sources do not effectively capture rates of LGBT employment or rates of LGBT employment discrimination.

2. **Anti-Discrimination Laws**

   a) An inconsistent and irreconcilable patchwork of state laws against anti-LGBT workplace discrimination and federal court decisions interpreting existing federal law render LGBT employees insufficiently protected from workplace discrimination.
   b) Currently, only 20 states and the District of Columbia prohibit employment discrimination on the basis of sexual orientation and gender identity.
   c) Seventeen states offer no employment protections on the basis of sexual orientation or gender identity, but cities and local municipalities may offer their own protections.
   d) Twenty states and the District of Columbia currently have laws that explicitly prohibit employment discrimination based upon gender identity or expression, and two other states have laws prohibiting sexual orientation discrimination, but exclude transgender protections.

e) Some federal courts have concluded that the existing federal statutory protection against discrimination based on sex, under Title VII of the Civil Rights Act of 1964, includes within its protection discrimination based on sexual orientation and gender identity. Other federal courts have disagreed. These inconsistent interpretations result in different protections available to individuals based on their jurisdiction, and it is not clear when the Supreme Court will resolve the dispute.

f) Public opinion supports Congress enacting a non-discrimination bill to protect against workplace discrimination against LGBT people.

g) In the past Administration, federal agencies including the EEOC and Departments of Justice and Labor interpreted existing federal law to protect LGBT persons against employment discrimination. Under the current administration the Department of Justice has changed its position, while other agencies, including the EEOC, have not yet taken different positions on the issue.

h) In July 2017, the Department of Justice filed an amicus brief arguing that the prohibition against discrimination based on sex found in Title VII of the Civil Rights Act does not include claims based on sexual orientation. In October 2017, Attorney General Jeff Sessions withdrew guidance issued by Attorney General Eric Holder in 2014 and stated that going forward the Department of Justice would take the position that Title VII's prohibition on sex discrimination does not include discrimination based on gender identity. In addition, the current Administration has interpreted related federal civil rights laws, such as Title IX, in ways that depart from an interpretation that nondiscrimination protection on the basis of sex necessarily includes protection on the basis of sexual orientation and/or gender identity.

i) As evidenced by the Department of Justice's change in position with respect to the interpretation of "sex" in Title VII, federal agency policies and positions can be changed depending on the Administration and do not provide the same weight of protection as federal legislation.

j) The lack of binding and enumerated federal employment protections for LGBT workers remains a central vulnerability for LGBT people.

k) It has not been difficult for some private companies to adopt and implement workplace policies or practices that prohibit discrimination on the basis of sexual orientation and/or gender identity. As of 2016, 92 percent of Fortune 500 companies included sexual orientation and 82 percent included gender identity in their equal employment opportunity policies. Businesses that support these policies note such practices are beneficial to their businesses by attracting the most qualified workforce and increasing productivity.

l) There has not been a flood of litigation in response to the passage of LGBT workplace anti-discrimination laws in the states that have adopted them. To the extent litigation does occur, evidentiary requirements limit baseless claims.

RECOMMENDATIONS

a) In order to effectively and consistently protect LGBT employees from workplace discrimination, Congress should immediately enact a federal law explicitly banning discrimination in the workplace based on sexual orientation and gender identity.
b) In addition to Congressional action, federal agencies including the Departments of Justice and Labor, the Equal Employment Opportunity Commission, and the Office of Personnel Management should issue and—where relevant—reaffirm specific guidance for federal and private employers outlining protections for LGBT individuals in the workforce, including specifically enumerating protections for transgender persons.
c) Congress should authorize the necessary appropriations to ensure that all current and future non-discrimination protections are fully enforced by agencies including, but not limited to, the Departments of Justice and Labor and the Equal Employment Opportunity Commission.
d) The Commission strongly supports religious freedom and nondiscrimination on the basis of religion. Title VII offers a workable model for protecting religious freedom in the context of federal statutory nondiscrimination protections in the workplace. In *Hosanna-Tabor Evangelical Lutheran Church and School v. Equal Employment Opportunity Commission the Supreme Court* also unanimously endorsed the common law ministerial exemption, which recognizes the right of religious groups to select their own ministers and clergy. No further expansion of exceptions to nondiscrimination protections in the workplace are necessary or warranted to balance the rights to freedom of religion and to nondiscrimination on the bases either of religion or LGBT status.
e) Workplace discrimination data should be collected through the inclusion of sexual orientation and gender identity questions in population-based surveys of the workforce such as the Census, American Community Survey, and surveys fielded by the Bureau of Labor Statistics and other agencies.

[*This page intentionally left blank*]

COMMISSIONERS' STATEMENTS, REBUTTALS, AND SURREBUTTALS

Statement of Chair Catherine E. Lhamon, in which Vice-Chair Patricia Timmons-Goodson concurs

Firing a person because of who the person is, rather than for nonperformance of job requirements, offends the concept of equity and ought to be unequivocally unlawful. For lesbian, gay, bisexual, and transgender (LGBT) Americans in too many parts of this country right now, it is not.

Our report notes that public opinion, untethered to political affiliation, supports fair workplace treatment for LGBT individuals.[1] While I appreciate the popular support for equity, in fact our national ideals have always sounded in equity and our federal civil rights laws have, for the past six decades, otherwise strongly protected equity. Failure to include formal federal civil rights protection for LGBT persons, regarding employment among other aspects of life, marks a distinct and unjustifiable outlying gap in the fabric of our laws.

In fact, its absence has led to tortured discussions in federal cases,[2] analyzing whether and how much sex discrimination protection applies to sexual orientation and gender identity. Together with diametrically opposing views on these questions expressed and enforced in the Trump and Obama Administrations, they underscore the need for Congress to act unequivocally to protect all workers from employment discrimination based on who they are.[3]

Congress does not fail to act on a blank slate: it has and has had concrete information about the harms LGBT Americans experience in workplace harassment and discrimination as well as about the degree of uncertainty about federal civil rights coverage applicable to LGBT employees. Over

---

[1] U.S. Commission on Civil Rights, Working for Inclusion: Time for Congress to Enact Federal Legislation to Address Workplace Discrimination Against Lesbian, Gay, Bisexual, and Transgender Americans, 2017 [*hereinafter* Report] at p. 1.

[2] *See, e.g., Evans v. Georgia Reg'l Hosp.*, 850 F.3d 1248, 1266–67 (11th Cir. 2017) (Rosenbaum, J., concurring and dissenting) (arguing that the decision attempted to create "an artificial line between discrimination because an employee has not behaved in a way that the employer thinks a person of that gender should, on the one hand, and discrimination because an employee is not the way that the employer thinks a person of that gender should be, on the other. . . [which] makes no sense from a practical, textual, or doctrinal point of view."); *Videckis v. Pepperdine Univ.*, 150 *F. Supp.* 3d 1151, 1159 (C.D. Cal. 2015) (collecting cases and concluding that "the line between sex discrimination and sexual orientation discrimination is 'difficult to draw' because that line does not exist, save as a lingering and faulty judicial construct").

[3] At the time of this writing, the United States Supreme Court has pending a petition seeking its review of the question whether Title VII sex discrimination protection covers sexual orientation. *Evans v. Georgia Reg'l Hosp.*, No. 17-370, Petition for Writ of Certiorari (U.S. Sept. 7, 2017). A Supreme Court answer to that question could—or could not—render federal legislation partially duplicative, depending both on whether the Court takes the case and on what it rules if it does. The petitioners have not asked the Court to take up the question of whether Title VII sex discrimination protection covers gender identity, and so there will be a gap of protection regardless of how the Supreme Court acts in this particular case. Because we cannot know in advance whether the Court will review the question or how it will rule, Congress should act now to ensure workplace protection for LGBT Americans.

the four decades during which Congress has considered but not enacted specific workplace protective laws covering LGBT Americans, it has considered workplace vulnerability of LGBT employees as well as the reality that states and cities have specifically enacted laws excluding LGBT persons from coverage. In 1996, when the Supreme Court ruled one such law from Colorado unconstitutional, it concluded that the law, "in making a general announcement that gays and lesbians shall not have any particular protections from the law, inflicts on them immediate, continuing, and real injuries that outrun and belie any legitimate justifications that may be claimed for it."[4] Whereas Congress has not announced that LGBT Americans may not be protected in law, its inaction—in the face of evidence that some courts view existing federal law as inapplicable to these employees—nonetheless leaves these persons notably vulnerable.[5]

Before that Colorado case reached the U.S. Supreme Court, Burke Marshall—who wrote the 1964 Civil Rights Act that included Title VII, was Assistant Attorney General for Civil Rights in the Kennedy Administration, and taught me constitutional law the year of this testimony—testified as an expert in the case in trial court.[6] Marshall testified that "civil rights protections bring those discriminated against 'safely into the mainstream of American society' and enable them 'to participate fully in the life of the United States, including its economic life.'"[7] He further testified that "the purpose of anti-discrimination laws is to upset a social norm of discrimination and 'to create a society that respects and complies by the value of equality . . . which is made a constitutional norm by the . . . 14th amendment and is part of the American tradition of fairness.'"[8] I know, because when I was a third-year law student writing a paper about Title VII coverage of transgender employees, we discussed the questions, that Burke Marshall believed without question that the law he wrote—Title VII—protected transgender persons and lesbian, gay, and bisexual persons, from discrimination. And I know still, all these years later, that LGBT Americans, like all Americans, deserve the legal protection that, in Burke Marshall's expert terms, "respects and complies by the value of equality" in the "American tradition of fairness."[9]

---

[4] *Romer v. Evans*, 517 U.S. 620, 635 (1996).

[5] Cementing this point, in 2003, the Court ruled that criminalization of intimate acts between same-sex couples was tantamount to "an invitation to subject homosexual persons to discrimination both in the public and in the private spheres." *Lawrence v. Texas*, 539 U.S. 558, 575 (2003). In 2013, it declared the Defense of Marriage Act unconstitutional as it "impose[d] a disadvantage, a separate status, and so a stigma upon all who enter into same-sex marriages." *United States v. Windsor*, 570 U.S. __, __, 133 S. Ct. 2675, 2693 (2013). In 2015, the Court recognized that "the right to marry is a fundamental right inherent in the liberty of the person, and under the Due Process and Equal Protection Clauses of the Fourteenth Amendment couples of the same-sex may not be deprived of that right and that liberty." *Obergefell v. Hodges*, 576 U.S. __, __, 135 S. Ct. 2584, 2604 (2015).

[6] *Evans v. Romer*, No. CIV. A. 92 CV 7223, 1993 WL 518586, at *11 (Colo. Dist. Ct. Dec. 14, 1993), aff'd, 882 P.2d 1335 (Colo. 1994), aff'd, 517 U.S. 620 (1996) (*hereinafter Evans II*).

[7] Suzanne B. Goldberg, *Gay Rights Through the Looking Glass: Politics, Morality, and the Trial of Colorado's Amendment 2*, 21 Fordham Urb. L. J. 1057, 1069 (1994) (quoting deposition transcript of Professor Burke Marshall, *Evans II*, at 13), *available at* http://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=2581&context=ulj.

[8] *Id.* at 1069-70 (*quoting* deposition transcript of Professor Burke Marshall, *Evans III*, at 24-26).

[9] *Id.*

I urge Congress to act to put an end to decades of questions about whether some among us may—finally, today—be equal to all among us.

Resistance to formal federal protection from discrimination for LGBT employees often purports to rely on a putative conflict between religious freedom and nondiscrimination. My own experience of faith, in addition to my love of our Constitution, animates my every action—and I am offended by the notion that our existing constitutional and federal statutory protections for religious freedom prevent like protection for nondiscrimination for lesbian, gay, bisexual, and transgender Americans. I saw the fallacy of that putative conflict play out painfully some thirteen years ago, when I represented students in a south Los Angeles high school whose teachers and administrators discriminated against them because they were gay and lesbian students. Their school staff defended standing by while, among other actions, a student physically attacked another student in class, because the teacher believed the attacked student needed to be taught to be more "manly"; telling a deeply religious Catholic student she would go to hell because she dated another girl; and outing two boys to their parents in the course of disciplining the boys because the boys had been caught kissing in a school building where opposite sex couples were also kissing at the same time but were not disciplined for their behavior. These school staff reported that their religious faith dictated their actions to harm these students, because the students were gay or lesbian. A teacher's decision to tell a devout Catholic girl she would go to hell for dating another girl lowlights the error in the assumption that LGBT persons are not simultaneously persons of faith—and underscores the distinct (and in our system of laws profoundly unconstitutional) harm that privileging one understanding of faith over another can visit on people. The teachers and administrators at that school were and are free to disapprove of same sex relationships, and even of the status of being LGBT, on religious or other bases; they were and are not, however, free to act on that disapproval in ways that harmed the students as people or as learners. Likewise in an employment context, our laws should protect LGBT employees from discrimination while also protecting all of our religious freedom.

Congress and our courts have, many times in our history, reconciled religious objections to civil rights protections without denigrating the rights of Americans to be who they are. In one stark example, the United States Supreme Court quoted the federal trial court judge who sanctioned criminalization of interracial marriage justifying his decision because "'Almighty God created the races white, black, yellow, malay and red, and he placed them on separate continents. . . The fact that he separated the races shows that he did not intend for the races to mix.'"[10] Despite the invocation of a religious basis for upholding a racially discriminatory law, the Court ruled Virginia's laws against interracial marriage unconstitutional because "classifications so directly

[10] *Loving v. Virginia*, 388 U.S. 1, 3 (1967) (quoting *Loving v. Virginia* (Circuit Court of Caroline County, Virginia, 1959)).

subversive of the principle of equality at the heart of the Fourteenth Amendment . . . deprive all the State's citizens of liberty without due process of law."[11] Just as religious objection to interracial marriage or interracial association has not and as a matter of course should not have prevented federal nondiscrimination protection on the basis of race, so religious objection, where it exists, is no impediment to federal nondiscrimination protection for LGBT Americans.

The possibility that questions could arise regarding how to reconcile sincerely held religious views with nondiscrimination protections for LGBT persons does not lead logically to a conclusion that LGBT persons should lack legal protection. We already have strong religious freedom protections both in the Constitution and in federal law. The First Amendment protects against discrimination on the basis of religion, and particular additional protections are included in the Religious Freedom Restoration Act[12] as well as exemptions detailed in our longstanding federal civil rights laws.[13] What we do not have now in federal law is explicit protection for LGBT persons; that gap should be filled while simultaneously ensuring respect for faith in all its forms as well as sexual orientation and gender identity in all of theirs.

It is the Commission's core function to advise Congress, the President, and the American public about federal civil rights policy. I wholeheartedly support the Commission's recommendations including that Congress enact federal legislation as soon as possible to correct the harms we have already borne witness to, guard against future such harms, and fulfill the "American tradition of fairness."[14]

---

[11] *Id.* at 12; *see also Bob Jones Univ. v. United States*, 461 U.S. 574, 603 (1983) (holding that religious objection does not justify race discrimination with respect to interracial marriage or association).
[12] Religious Freedom Restoration Act of 1993, PL 103–141, November 16, 1993, 107 Stat 1488, codified at 42 U.S.C. § 2000bb et seq.
[13] *See e.g.*, 42 U.S.C. § 2000e-2(2) (regarding Title VII's religious exemption) and 20 U.S.C. § 1681(a)(3) (regarding Title IX's religious exemption).
[14] Goldberg, *supra* note 7, at 1070.

Statement of Commissioner David Kladney

This report raises an inevitable question: why would an employer seek to fire, harass, or otherwise reduce the productivity of a successful employee merely because of that person's sexual orientation or gender identity? It makes no sense. Business leaders in many industries continually band together to say LGBT employment discrimination is bad for business. It is better to accept that every person has their own idea of how to express gender and form (or not form) a family.

Business plans for inclusion are encouraging. A representative of Northup Grumman described the way they not only accept LGBT people, but embrace them in office culture.[1] This is exactly what companies should be doing, for their own competitive advantage and because it is right. As business representatives testified they value every employee and cannot afford to turn away well-qualified people who can help them succeed.[2] Many companies make clear they welcome and value LGBT employees.

As business is growing more accepting by the day, why are employment discrimination protections necessary? As this report explains, with all the progress made in this area, employment discrimination still occurs for no valid reason. It is prevalent. As I see it, even if discrimination were rare, we should still have a federal law prohibiting it because it is wrong each and every time it happens.

Business initiative is not enough. The speed at which LGBT rights have advanced belies the progress still needed. Hundreds of companies have come out in support of a law requiring them to do what they have done voluntarily: create a work environment where people can succeed without discrimination.[3] Equal protection requires that LGBT citizens are not left to the whim of their employers. Most of these employers are corporations, large and small, who take advantage of the legal protections and shields the government affords them. As such, they should be required to not discriminate against any qualified United States citizen in employment. To do so is not consistent with the American values.

Relying on companies to do the right thing voluntarily also presumes the progress only moves one direction. It assumes that there can be no backlash to the advancements LGBT people have

---

[1] Testimony of Sylvester Mendoza, Briefing Transcript, p. 166-170, *available at* http://www.usccr.gov/calendar/trnscrpt/Discrimination_LGBT_03-16-2015.pdf (stating, "Our LGBT community is mission critical to our advancement, innovation and to being a responsible global corporate citizen and global security company.")

[2] *See* Briefing Transcript, p. 166-202 (testimony on economic impacts of non-discrimination protections).

[3] *See, e.g.*, Charles E. Ramirez, *More than 100 companies join Equality Act coalition*, The Detroit News, September 25, 2017, http://www.detroitnews.com/story/news/local/detroit-city/2017/09/25/more-than-100-companies-join-equality-act-coalition/699224001/; Human Rights Campaign, *Business Coalition for Workplace Fairness, Members*, https://www.hrc.org/resources/business-coalition-for-workplace-fairness-members.

achieved. This is not the case. As we see with President Trump's unilateral ban of transgender people from serving in the military, decision makers can act in a willy-nilly fashion without any regard to the best interests of the objective—success of the mission.[4] The varying interpretations of Title VII depending on which presidential administration is interpreting it demonstrate the shifting sands beneath what should be bedrock principles of non-discrimination.[5]

The bottom line is this: people should have the right to work to support themselves and succeed for their families and our country. When people have requisite skills, they should not have to fear that their right to work is contingent on their ability to successfully hide a fundamental aspect of themselves. The purges of people from the federal government because of sexual orientation are not so far in the past.[6] Transgender people in particular still lack basic acknowledgment by the federal government that they deserve protections from discrimination.[7] People in the LGBT community are our friends and members of our families. They are in every community in the world. In this country, where we value equality and fairness, they should be able to live and work freely.

---

[4] Reporting indicated the Joint Chiefs of Staff were not consulted prior to the policy change, and as of this writing the Department of Defense has delayed implementation of the ban for troops currently serving, citing the need for more study. *See* Barbara Starr, Zachary Cohen and Jim Sciutto, US Joint Chiefs blindsided by Trump's transgender ban, CNN, July 27, 2017, http://www.cnn.com/2017/07/27/politics/trump-military-transgender-ban-joint-chiefs/index.html; Dan Lamothe, Transgender ban frozen as Mattis moves forward with new review of options, Washington Post, August 29, 2017, https://www.washingtonpost.com/news/checkpoint/wp/2017/08/29/pentagon-chief-mattis-freezes-trumps-ban-on-transgender-troops-calls-for-more-study.
Numerous retired generals have stated they believe the ban, if implemented, would degrade military readiness. The Palm Center, Fifty-Six Retired Generals and Admirals Warn That President Trump's Anti-Transgender Tweets, If Implemented, Would Degrade Military Readiness, August 1, 2017, http://www.palmcenter.org/fifty-six-retired-generals-admirals-warn-president-trumps-anti-transgender-tweets-implemented-degrade-military-readiness.

[5] *See* Attorney General Jeff Sessions, Memorandum re Revised Treatment of Transgender Employment Discrimination Claims Under Title VII of the Civil Rights Act of 1964, Oct. 4, 2017, *available at* https://www.documentcloud.org/documents/4067437-Sessions-memo-reversing-gender-identity-civil.html

[6] *See, e.g.*, Judith Adkins, Congressional Investigations and the Lavender Scare, National Archives, Prologue Magazine, Summer 2016, https://www.archives.gov/publications/prologue/2016/summer/lavender.html.

[7] *See* Revised Treatment of Transgender Employment Discrimination Claims, *supra* note 5.

Statement of Commissioner Karen K. Narasaki, in which Vice-Chair Patricia Timmons-Goodson concurs

Fundamental to the founding of our nation is the principle that every person has a universal and inalienable right to "life, liberty, and the pursuit of happiness."[1] In *Obergefell v Hodges*, Justice Kennedy explained that liberty includes the right of individuals "to define and express their identity."[2] Sexual orientation and gender identity are characteristics that are fundamental and essential to one's identity.[3] To deny a person equal protection under the law due to these characteristics—whether in the workplace or elsewhere—violates not only one of our country's most sacred tenets, but the basic dignity and humanity that all people inherently deserve.

Freedom from discrimination based on sexual orientation or gender identity also naturally incorporates many other rights recognized under the Constitution, including the right to privacy[4] and freedom of expression and association. Moreover, international human rights laws complement and reinforce our nation's laws by recognizing that "all human beings are born free and equal in dignity and rights" and therefore LGBT people are entitled to the numerous protections afforded by human rights laws, including the right to be free from discrimination.[5]

Some opponents to legislation protecting LGBT workers and their families from discrimination mistakenly contend sexual orientation and gender identity are unlike other protected categories such as race and sex, which in their view are protected because they are considered immutable.[6]

---

[1] The Declaration of Independence para.2 (U.S. 1776); U.S. Const. amend XIV (no State shall "deprive any person of life, liberty, or property, without due process of law").

[2] *Obergefell v. Hodges*, 135 *S. Ct.* 2584, 2593 (2015); *Lawrence v. Texas*, 539 U.S. 558, 562 (2003) (private sexual conduct included in right to liberty under Due Process Clause) ("Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.").

[3] *See* Brief for American Psychological Ass'n *et al.* as Amici Curiae in Support of Petitioners 10, *Obergefell*, 135 *S. Ct.* 2584 (No. 14-556), 2015 WL 1004713 ("[S]exual orientation is integrally linked to the intimate personal relationships that human beings form with others to meet their deeply felt needs for love, attachment, and intimacy. It defines the universe of persons with whom one is likely to find the satisfying and fulfilling relationships that, for many individuals, comprise an essential component of personal identity.").

[4] *Lawrence*, 539 U.S. 558.

[5] *See* UN Office for the High Commissioner for Human Rights, Discriminatory Laws and Practices and Acts of Violence Against Individuals Based on Their Sexual Orientation and Gender Identity 4 (2011), http://www2.ohchr.org/english/bodies/hrcouncil/docs/19session/A.HRC.19.41_English.pdf ("The application of international human rights law is guided by the principles of universality and non-discrimination enshrined in Article 1 of the Universal Declaration of Human Rights, which states that "all human beings are born free and equal in dignity and rights." All people, including lesbian, gay, bisexual and transgender (LGBT) persons, are entitled to enjoy the protections provided for by international human rights law, including in respect of rights to life, security of person and privacy, the right to be free from torture, arbitrary arrest and detention, the right to be free from discrimination and the right to freedom of expression, association and peaceful assembly.").

[6] *See* Report at 45 (citing Family Research Council, "The Employment Non-Discrimination Act (ENDA): A Threat to Free Markets and Freedom of Conscience and Religion," Issue Brief, October 2013, *available at* http://downloads.frc.org/EF/EF13J68.pdf ("[The Civil Rights Act of 1964 bars discrimination based on "race, color, national origin, sex, and religion." The first four of these are included largely because they are inborn, involuntary

Whether a person's sexual orientation or gender identity is changeable is not the appropriate inquiry. Rather, as Ninth Circuit Court Judge Norris describes it, it is whether such "traits [] are so central to a person's identity that it would be abhorrent for government to penalize a person for refusing to change them, regardless of how easy that change might be physically."[7] Religion, for example, is not immutable in the classic sense but is central to the identity of many people,[8] which is why the First Amendment protects the right to practice religion[9] and why we have laws prohibiting employment discrimination based on religion.

Our understanding of sexual orientation and gender identity continues to evolve. Because of that, significant progress for LGBT equality has been made in recent decades, but as our report reveals much work remains.[10] As Senior Judge Davis concluded when he sided with transgender youth Gavin Grimm's efforts to use the bathroom that corresponds with his gender identity, it is now up to the resolve of our leaders and our nation to stand for equality and human dignity:

> [S]ome entities will not protect the rights of others unless compelled to do so. Today, hatred, intolerance, and discrimination persist—and are sometimes even

---

and immutable. (Religion, while voluntary, is explicitly protected by the First Amendment to the U.S. Constitution.)."). However, Columbia University sociologist Shamus Khan argues sexual identity, like race, is a social construction. Shamus Khan, Not Born This Way, Aeon (July 23, 2015), https://aeon.co/essays/why-should-gay-rights-depend-on-being-born-this-way ("True, many gay and lesbian people will note that they 'always felt different' or that they knew about their homosexuality for as long as they've been aware of themselves as sexual beings. Is this not evidence of a powerful biological drive? Not necessarily, because it is also consistent with the idea of sexuality as co-determined by biology and environment. Race is a social construct, and its experience is felt from the moment we begin our lives."); *see also G.G. v. Gloucester County Sch. Bd.*, 853 F.3d 729, 730 (4th Cir. 2017) (Davis, J., concurring) ("[Gavin Grimm's] plight has shown us the inequities that arise when the government organizes society by outdated constructs like biological sex and gender.")

[7] *Watkins v. U.S. Army*, 875 *F.2d* 699, 726 (9th Cir. 1988) (Norris, J., concurring). Or as the district court in *Obergefell* stated, "To the extent that "immutability" is relevant to the inquiry of whether to apply heightened scrutiny, the question is not whether a characteristic is strictly unchangeable, but whether the characteristic is a core trait or condition that one cannot or should not be required to abandon." *Obergefell v. Wymyslo*, 962 *F. Supp.* 2d 968, 990 (S.D. Ohio 2013), *rev'd sub nom. DeBoer v. Snyder*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom. Obergefell*, 135 *S. Ct.* 2584; Report at 49 (discussing dignity); *see also* Jessica A. Clarke, *Against Immutability*, 125 Yale L.J. 2, 6 n.7 (2015) (citing numerous comments in support of "new" immutability based on human dignity and moving away from traditional equal protection jurisprudence).

[8] Steward Harrison Oppong, *Religion and Identity*, Am. Int'l J. Contemporary Research, July 2013, at 10, http://www.aijcrnet.com/journals/Vol_3_No_6_June_2013/2.pdf (exploring link between religion and identity).

[9] Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 Harv. L. Rev. 1409, 1491-92 ("Religion is understood to be a product of individual choice, and protected as such."). In fact, the first "free exercise" clause on the continent was passed by Maryland in 1649 and guaranteed that "no[] person . . . professing to believe in Jesus Christ, shall . . . be compelled to the belief[] or exercise of any other Religion against his or her consent." *Id.* at 1425. Scholars have also argued religion should be treated as immutable because of "fundamental interests in not changing them." *See* Clarke, *supra* note 7, at 24 n. 111 (citing Douglas Laycock, *Taking Constitutions Seriously: A Theory of Judicial Review*, 59 Tex. L. Rev. 343, 383 (1981)); Testimony of Mara Kiesling at 251-52 ("[W]e believe that people should be able to select their religion. In fact, that's the beauty of religion. You have to really come to it. You really have to make the decision. It is not born to you. You may be born into a religion. But we still want to protect people's religions. We still want to respect people. We still want them to be able to have jobs, and it does not matter that . . . you're not born with your religion. But you know what? You just are born with your gender identity and you are born with your sexual orientation and saying not doesn't make it not.").

[10] *See e.g.* Testimony of Mara Kiesling at 108-09.

promoted—but by challenging unjust policies rooted in invidious discrimination, . . . one day, equality will prevail, and [ ] the core dignity of every one of our brothers and sisters is respected by lawmakers and others who wield power over their lives.[11]

[11] *Gloucester County Sch. Bd.*, 853 F.3d 729, 731 (4th Cir. 2017).

[*This page intentionally left blank*]

Statement of Commissioner Michael Yaki

The concept of what constitutes "rights" has been fluid throughout time. At the time of the Founders, the notion of liberty was viewed through a lens of a land-owning white male. Freedom of speech, of religion, the freedom to assemble and speak were all, to be true, radical notions in the day. There was, in fact much debate whether these "rights" should be enshrined at all—these rights being the first ten amendments to the Constitution. Some argued government had no right to put these into the Constitution. Others, perhaps more presciently, were concerned that listing enumerated rights meant *expressio unius est exclusio alterius*—the mention of one thing amounts to the exclusion of others, and thus, nothing else could be considered now or in the future.

As we know now, a Constitution that once counted black Americans as three-fifths the worth a white American for the purposes of apportionment has been changed, through the adoption of the Thirteenth and Fourteenth Amendments, to mean something entirely different. While the Equal Protection Clause of the Fourteenth Amendment does not enumerate to whom those protections extend, jurisprudence over a century has sought to define it to mean the "suspect classes" of race, religion, and national origin. Thus, even now, *expressio unius est exclusio alterius* continues to vex constitutional scholars, Supreme Court justices, and policymakers in terms of who is entitled to equal protection.

For members of the lesbian, gay, bisexual and transgender community, the struggle to receive recognition, to be given the same rights and treatment as other Americans, has been difficult. As an elected official, I voted for the first domestic partnership registry in America, and was proud to officiate at the first ceremonies in San Francisco City Hall. From those first domestic partnerships to the U.S. Supreme Court's recognition of the right to marry[1] less than twenty years later, the strides made by the LGBT community have been significant. The fundamental right to marry, however, has not been met by equal strides in other areas of civil rights—to the point of this report, in the area of employment discrimination. Yet even today, they fight to not be excluded from the broad protections afforded other oppressed groups under the Constitution and our laws.

I. A Seminal Report at a Critical Time

As a prefatory comment, the Commission has been in existence for sixty years. This year, its' sixtieth, marks the first instance in which the Commission has undertaken and published an investigation focused solely upon the civil rights burdens suffered by lesbian, gay, bisexual, and transgender ("LGBT") people.[2] I thank my esteemed colleague, the Honorable Roberta

[1] *Obergefell v. Hodges*, 576 US ___ (2015).
[2] In its 2011 statutory enforcement report, the Commission addressed problems faced by LGBT youth alongside an examination of youth targeted due to sex, race and national origin, disability, and religion. *See* U.S. Commission on

Achtenberg, for bringing this inquiry before the Commission. The Commission's briefing was powerful.[3] Our report[4] is very thoroughly researched and written. It is comprehensive and explains the often-painful, real-life implications of federal, state, and private sector employment discrimination against LGBT people in great detail. The findings and recommendations are clear, succinct, well-grounded, and powerful. This project deservedly takes its place among our finest work.[5]

Our nation's LGBT population has a vulnerability unique among all those whom the Commission is mandated to protect: it is the only class under our jurisdiction which lacks the shelter of at least one powerful, civilian, federal statutory protection. The right to marry does not have transitive properties, at least in terms of the qualities that, to date, the Courts have looked at for protection under the Civil Rights Act of 1964. Yet, it is undisputed that LGBT Americans have faced and still face invidious discrimination at the hands of the government and private sectors. Therefore, the Commission has a special duty to be mindful of civil rights deprivations faced by LGBT Americans, to investigate and publicize those abridgements, and to recommend loudly and clearly to the Congress and the President actions which the federal government must take to remediate and prevent such abuses. With regard to our LGBT community, the Commission has a special obligation to fulfill its role as the conscience of the nation, and sound alarms as current and future developments may dictate.

The Commission's far-reaching report comes at a critical juncture of the incremental march toward full legal equality and social inclusion for LGBT people in this country. The obstacles have been many, as homophobia and transphobia have long permeated the American worldview. Until 1973, the American Psychiatric Association classified a homosexual orientation as a mental disorder[6]—and it considered a transgender identity in the same category until 2012.[7] States had the ability to—and did—criminalize intimate same-sex conduct between consenting adults and imprison "offenders" until the U.S. Supreme Court put an end to so-called "sodomy laws" a mere fourteen

---

Civil Rights, "Peer to Peer Violence + Bullying: Examining the Federal Response," September 2011, *available at* http://usccr.gov/pubs/2011statutory.pdf.

[3] In particular, thanks are due to panelists Mara Keisling, Kylar Broadus, Gina Duncan, and Ilona Turner for their briefing statements regarding transgender issues.

[4] U.S. Commission on Civil Rights, "Working for Inclusion: Time for Congress To Enact Federal Legislation to Address Workplace Discrimination Against Lesbian, Gay, Bisexual, and Transgender Americans," September 2017, *available at* http://www.usccr.gov/pubs/LGBT_Employment_Discrimination2017.pdf ("USCCR Report").

[5] Thanks are due to all staff members, past and present, who worked diligently on this investigation and report.

[6] *See, e.g.,* Jack Drescher, "Out of DSM: Depathologizing Homosexuality," *Behavioral Sciences*, December 4, 2015, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4695779/pdf/behavsci-05-00565.pdf; *and* Carla Moleiro and Nuno Pinto, "Sexual Orientation and Gender Identity: Review of Concepts, Controversies and Their Relation to Psychopathology Classification Systems," Frontiers in Psychology, U.S. National Library of Medicine, National Institutes of Health, October 2015, *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4589638/.

[7] Moleiro and Pinto, n. 6 *supra.*

years ago in 2003.[8] The challenges remain intense, as many powerful fundamentalist Christian and other conservative groups vociferously oppose legal and social equality for LGBT people.

It is in this context, therefore, that sexual orientation was hardly mentioned, let alone even considered for inclusion, when courts began naming those characteristics that required greater scrutiny as they began to interpret the breadth of the Equal Protection Clause. And by omission—by *exclusion alterius*—the issue of sexual orientation remained in the closet of jurisprudence for much of the 20th century.

Since the final quarter of the 20th century, many sectors of American society have been moving, inch by inch, toward the end of marginalization and demonization of LGBT people in society.[9] We can only hope that these changes in social attitudes will erode the pervasive discrimination which LGBT people face in the employment sector. And where changes in social attitude move deliberately, the swifter enactment of laws to protect LGBT people, as this report recommends, becomes more important.

II. The Federal Government's (Forgotten?) History of Perpetuating Employment Discrimination Against LGBT People: 1940s through the 1970s

From the 1940s into the 1970s, the federal government was no mere bystander in the societal discrimination against the LGBT community. To the contrary, it was an overt proponent of employment discrimination against LGBT people. Many "homosexuals and other sex perverts" lost their federal jobs during the "Lavender Scare" that began in the Truman Administration.[10] This purge was fueled when:

---

[8] *Lawrence v. Texas*, 539 U.S. 558 (2003). *See also* William N. Eskridge, Jr., Dishonorable Passions: Sodomy Laws in America 1861-2003, Viking, 2008.

[9] *See, e.g.*, GALLUP News, "Gay and Lesbian Rights," 2017, *available at* http://news.gallup.com/poll/1651/gay-lesbian-rights.aspx; Pew Research Center, Religion and Public Life, "Changing Attitudes on Gay Marriage," June 26, 2017, *available at* http://www.pewforum.org/fact-sheet/changing-attitudes-on-gay-marriage/; and Andrew R. Flores, "National Trends in Public Opinion on LGBT Rights in the United States," The Williams Institute, November 2014, *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/POP-natl-trends-nov-2014.pdf.

For information on "acceptance" of homosexuality across the globe, with better statistics coming in general from more affluent and less religious nations, *see, e.g.*, Pew Research Center, Global Attitudes and Trends, "The Global Divide on Homosexuality," June 4, 2013, *available at* http://www.pewglobal.org/2013/06/04/the-global-divide-on-homosexuality/. Of note is this Commissioner's objection to the notion of the terminology and concept of "acceptance" of homosexuality or any status on the LGBTQ (lesbian, gay, bisexual, transgender, and queer) spectrum, while recognizing its widespread use in social discourse and academic parlance. These human conditions simply exist. "Accepting" them is not the core issue, as people do not have the right to "accept" people—or not—based upon race, color, sex, national origin, age, disability status, gender identity, sexual orientation, or any other inherent characteristic. People simply are who they are. Merely recognizing their existence and valuing the equality of all individuals, regardless of sexual orientation or gender identity, is at the center of a compassionate value system.

[10] *See, e.g.*, David K. Johnson, The Lavender Scare: The Cold War Persecution of Gays and Lesbians in the Federal Government, The University of Chicago Press, 2004; U.S. Merit Systems Protection Board, "Sexual Orientation and the Federal Workplace: Policy and Perception: A Report to the President and Congress of the United States," May

> the U.S. Senate created a subcommittee, chaired by North Carolina Senator Clyde Hoey, to evaluate the threat homosexuals presented to public civil service and national security. [fn. 10: *See generally* JOHNSON, *supra* note 1, at 101-18 (providing a thorough account of the subcommittee's investigation, the evidence it ignored, and its report).] In December 1950, the Hoey Subcommittee issued its report, entitled *Employment of Homosexuals and Other Sex Perverts in Government*, unanimously concluding that those who engage in acts of homosexuality and other perverted sex activities are unsuitable for employment in the Federal Government. In the committee's view, homosexuals and other sex perverts should be barred from civil service positions, those who were already employed should be fired, and the government should expend resources to aggressively ferret them out. [fn. 11: S. COMM. ON EXPENDITURES IN THE EXEC. DEP'T, SUBCOMM. ON INVESTIGATIONS, 81ST CONG. 2ND SESS., EMPLOYMENT OF HOMOSEXUALS AND OTHER SEX PERVERTS IN GOVERNMENT 4527-4528 (Cong. Rec. Vol. 96 1950). The report stated "It is the opinion of this subcommittee that those who engage in acts of homosexuality and other perverted sex activities are unsuitable for employment in the Federal Government. This conclusion is based upon the fact that persons who indulge in such degraded activity are committing not only illegal and immoral acts, but they also constitute security risks in positions of public trust."][11]

In 1953, President Eisenhower issued Executive Order 10450, "Security Requirements for Government Employment," which effectively prohibited the United States government from retaining or employing in the first instance anyone who engaged in "sexual perversion."[12] Thousands of LGBT federal employees were fired simply due to their sexual orientation, and thousands of applicants were denied jobs.[13] "Although we will never know the exact number of individuals who were denied employment or who had their employment terminated based on their

---

2014, *available at* https://www.mspb.gov/mspbsearch/viewdocs.aspx?docnumber=1026379&version=1030388&application=ACROBAT; and Brad Sears, Nan D. Hunter, Christy Mallory, "Documenting Discrimination on the Basis of Sexual Orientation and Gender Identity in State Employment," The Williams Institute, September 2009, *available at* https://williamsinstitute.law.ucla.edu/research/discrimination/documenting-discrimination-on-the-basis-of-sexual-orientation-and-gender-identity-in-state-employment/.

[11] Sears, Hunter, and Mallory, "Documenting Discrimination on the Basis of Sexual Orientation and Gender Identity in State Employment," p. 5–4, n. 7 *supra*, *available at* https://williamsinstitute.law.ucla.edu/wp-content/uploads/5_History.pdf.

[12] Executive Order 10450, "Security Requirements for Government Employment," Sec. 8(a)(1)(iii), 3 CFR, 1949-1953 Comp., p. 396, April 27, 1953, *available at* https://www.archives.gov/federal-register/codification/executive-order/10450.html.

Ironically, President Eisenhower advocated for the creation of this United States Commission on Civil Rights as part of the Civil Rights Act of 1957 (Pub.L. 85-315, 71 Stat. 634). The juxtaposition of these two actions of his demonstrates just how far removed from the civil rights domain any consideration of LGBT rights remained.

[13] *See, e.g.*, Capehart, Jonathan, "Frank Kameny: American Hero," The Washington Post, October 21, 2011, *available at* https://www.washingtonpost.com/blogs/post-partisan/post/frank-kameny-american-hero/2011/03/04/gIQAH2DRfL_blog.html; and Sears, Hunter, and Mallory, n. 8 *supra*.

actual or assumed sexual orientation, one estimate places this number between 7,000 and 10,000 in the 1950s alone."[14] State and local employment purges were common as well.[15]

The ban remained in full effect for twenty years. In 1973, the U.S. District Court for the District of Columbia ruled, upon motion from two gay men denied continued federal employment, that "the [Civil Service] Commission *is* prohibited from excluding plaintiffs from federal employment unless *particular* circumstances are enumerated which may justify dismissal on charges relating to homosexual conduct."[16]

However,

> [i]t was not until July 1975 that the CSC announced a new approach to determining the suitability of homosexual applicants for Federal employment. The CSC stated that the new guidelines were a significant change from past policies and were a result of court decisions requiring that persons not be disqualified from Federal employment based solely on homosexual conduct. The new guidelines applied the same standards to evaluating sexual conduct, whether heterosexual or homosexual. Although applicants could no longer "be found unsuitable based on unsubstantiated conclusions concerning possible embarrassment for the Federal service, a person may be dismissed or found unsuitable where the evidence exists that sexual conduct affects job fitness." [orig. fn. 86: "Homosexual Hiring is Revised by U.S.," The New York Times, July 4, 1975, p. 45.]
>
> This change in policy was not absolute, however—the CIA and FBI were exempted from its requirements.[17]

LGBT people's access to security clearances may have been negatively impacted by vague, hold-ever rules until as late as 1991[18] or even 1995.[19] No President put forth any openly LGBT candidate for a position requiring Senate confirmation until President Bill Clinton nominated our recent Commissioner Roberta Achtenberg for Assistant Secretary of Fair Housing and Equal Opportunity at Housing and Urban Development in 1993, who prevailed after a deeply homophobic effort to deny her confirmation.[20] We did not have an openly LGBT U.S. Ambassador until James Hormel

---

[14] U.S. Merit Systems Protection Board, p. i, n. 10 *supra*.
[15] Sears, Hunter, and Mallory, pp. 5—18, n. 11 *supra*.
[16] *Baker v. Hampton*, U.S. District Court for the District of Columbia, No. 2525-71, decided December 21, 1973, 1973 WL 274 (not reported in F.Supp.).
[17] U.S. Merit Systems Protection Board, p. 18, n. 10 *supra*.
[18] *See, e.g.*, U.S. General Accounting Office, "GAO Report: Security Clearances: Consideration of Sexual Orientation in the Clearance Process," March 1995, p. 2, *available at* http://www.gao.gov/assets/230/220962.pdf.
[19] Executive Order 12968, "Access to Classified Information," Sec. 3.1, August 2, 1995, 60 CFR 40245, August 7, 1995, *available at* https://fas.org/sgp/clinton/eo12968.html. *See also* Todd S. Purdum, "Clinton Ends Ban on Security Clearance for Gay Workers," The New York Times, August 5, 1995, *available at* http://www.nytimes.com/1995/08/05/us/clinton-ends-ban-on-security-clearance-for-gay-workers.html.
[20] "Nomination: Roberta Achtenberg, of California, to be an Assistant Secretary of Housing and Urban Development, . . . 05/24/1993: Confirmed by the Senate," Action PN154—103rd Congress (1993-1994), *available*

was put in place by virtue of President Clinton's recess appointment in 1999,[21] an appointment held up by a vicious and bigoted smear campaign launched by extremist groups. Until the 2011 implementation of the Don't Ask, Don't Tell Repeal Act of 2010, lesbians, gay men, and bisexuals could not serve openly in our military.[22] The U.S. Supreme Court finally capped decades of social and political debate, legislation, and litigation by recognizing that the fundamental right to marriage extends to same-sex couples as recently as 2015.[23]

III. Selected Historical Efforts by LGBT Americans to Foster Inclusivity

The recent progress, of course, has been no accident. It is fueled by the decades of momentum created by brave LGBT Americans who risked prosecution, careers, and families to come together, to stand up publicly against condemnation and criminalization, and to demand their rights to full equality.

Activist Harry Hay and others co-founded the Mattachine Society in 1951 for purposes of furthering societal equality and also personal growth. The Mattachine Society . . . began sponsoring discussion groups in 1951, providing lesbians and gay men an opportunity to share openly, often for the first time, their feelings and experiences. The meetings were frequently emotional and cathartic.[24]

---

at https://www.congress.gov/nomination/103rd-congress/154. An elected member of the San Francisco Board of Supervisors from 1990 to 1993, Assistant Secretary Achtenberg was the highest-ranking openly LGBT official in the Clinton administration. *See also* Michael Ross, "Gay Activist OKd for Fair Housing Post: Government: Roberta Achtenberg of San Francisco is the First Openly Declared Lesbian to Serve in High Federal Office, Senate Approval on 58-31 Vote Follows Impassioned Debate on Gay Rights," The Los Angeles Times, *available at* http://articles.latimes.com/1993-05-25/news/mn-39579_1_gay-rights. President Barack Obama appointed Assistant Secretary Achtenberg to the U.S. Commission on Civil Rights in January 2011, a seat she held until her term expired in December 2016. *See, e.g.,* Nick Wing, "Obama Announces Three High-Profile LGBT Appointments," The Huffington Post, January 28, 2011, *available at* https://www.huffingtonpost.com/2011/01/28/obama-announces-lgbt-appointments_n_814852.html.

[21] *See, e.g.*, Claude Summers, "Obama's 6 Gay U.S. Ambassadors are Leading the Global Fight for LGBT Rights," The New Civil Rights Movement, August 21, 2016, *available at* http://www.thenewcivilrightsmovement.com/claude_summers/america_s_openly_gay_ambassadors. *See also* Colby Itkowitz, "The Six Openly Gay U.S. Ambassadors Were in One Room Together," The Washington Post, March 25, 2015, *available at* https://www.washingtonpost.com/blogs/in-the-loop/wp/2015/03/25/the-six-openly-gay-u-s-ambassadors-were-together-in-one-room/.

[22] H.R. 2965, S. 4023 (2011); *see also* Elisabeth Bumiller, "Obama Ends 'Don't Ask, Don't Tell' Policy," The New York Times, July 22, 2011, *available at* http://www.nytimes.com/2011/07/23/us/23military.html.

It was 2016 before we had our first openly LGBT Service Secretary, Eric Fanning, Secretary of the Army. *See. e.g.*, Aaron Mehta and Joe Gould, "Senate Confirms Eric Fanning, First Openly Gay Service Secretary," Defense News, May 17, 2016, *available at* https://www.defensenews.com/interviews/2016/05/17/senate-confirms-eric-fanning-first-openly-gay-service-secretary/.

[23] *Obergefell v. Hodges*, n. 1 *supra.*

[24] Craig Kacaorowski, "Mattachine Society," glbtq, Inc., 2004, *available at* http://www.glbtqarchive.com/ssh/mattachine_society_S.pdf. A friend and fellow activist of Mr. Hay's, Phyllis Lyon, said, "He was marvelous. "He was one of the first to remind us we need to stop, to consolidate our efforts," said Lyon, who with her partner Del Martin, founded the nation's first lesbian rights organization, the Daughters of Bilitis in 1955. "He was really the originator of the concept of gays, lesbians, bisexuals and transgender people as a minority to be reckoned with."

The Mattachine Society's visionary Statement of Purpose, which set forth the road map on which the movement for full LGBT inclusion and equality yet travels, states

> It is the purpose of this organization to act by any lawful means:
>
> (a) To secure for homosexuals the right to life, liberty, and the pursuit of happiness, as proclaimed for all men by the Declaration of Independence; and to secure for homosexuals the basic rights and liberties established by the word and the spirit of the Constitution of the United States;
>
> (b) To equalize the status and position of the homosexual with those of the heterosexual by achieving equality under law, equality of opportunity, equality in the society of his fellow men, and be eliminating adverse prejudice, both private and official;
>
> (c) To secure for the homosexual the right, as a human being, to develop and achieve his full potential and dignity, and the right, as a citizen, to make his maximum contribution to the society in which he lives.[25]

This succinct credo has shaped, both by design and by virtue of common sense, the LGBT civil rights movement.

Life-long couple Phyllis Lyon and Del Martin co-founded the Daughters of Bilitis in 1955 for women. They offered private and public meetings regarding homosexuality.[26] Their iconic newsletter, "The Ladder," reached isolated women and offered hope and empowerment for many years.[27] Del Martin and Phyllis Lyon were the first couple married when San Francisco, CA offered same-sex marriage certificates in 2004, and again in 2008 when the state of California recognized marriage equality. Unfortunately, Del Martin did not live to see marriage equality become the law of the land.[28]

Christopher Heredia, "Henry 'Harry" Hay—Gay Rights Pioneer / He Started Mattachine Society," (obituary), San Francisco Chronicle Gate, October 25, 2002, *available at* http://www.sfgate.com/bayarea/article/Henry-Harry-Hay-gay-rights-pioneer-He-2779360.php.

[25] Mattachine Society of Washington, "Mattachine Society of Washington Statement of Purpose," undated, digitized archival copy, accessed September 15, 2017, *available at* https://rainbowhistory.omeka.net/items/show/4937957.

[26] Teresa Theophano, "Daughters of Bilitis," glbtq, Inc., 2004, *available at* http://www.glbtqarchive.com/ssh/daughters_bilitis_S.pdf.

William Grimes, "Del Martin, Lesbian Activist, Dies at 87," The New York Times, August 27, 2008, *available at* http://www.nytimes.com/2008/08/28/us/28martin.html.

[27] Stuart Hinds, "The Ladder: the Voice of A Lesbian Generation," The Phoenix Newsletter, Winter 2014, *available at* https://library2.umkc.edu/spec-col/glama/pdfs/history/phoenix-2014-01-winter.pdf. *See also* Diana Lee Johnson, "A Narrative Life Story of Activist Phyllis Lyon and Her Reflections on a Life with Del Martin," Masters Thesis, Grand Valley State University, (2012), *available at* http://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1021&context=theses.

[28] William Grimes, "Del Martin, Lesbian Activist, Dies at 87," The New York Times, August 27, 2008, *available at* http://www.nytimes.com/2008/08/28/us/28martin.html.

The Daughters of Bilitis also rallied the community against abusive police raids on neighborhood LGBT bars.[29] Transgender people, including Marsha P. Johnson and Sylvia Rivera, took their place alongside lesbians and gay men in the public fight for equality at the Stonewall Riots in New York City which ushered in a new era in the march for LGBT equality.[30]

When the Stonewall Riots began in Greenwich Village on June 28, 1969, neighborhood bars where LGBT people gathered across the country were no strangers to police raids. These raids were carried out to, often under the pretext of stopping illegal liquor and cigarette sales, to harass, intimidate and subjugate the LGBT community because they had to create their own public places in which to congregate.[31] When police conducted a raid at the Stonewall Inn on that fateful night,

> [a] crowd had gathered outside the tavern by the time the police were ready to load up their wagons with contraband alcohol, Stonewall employees, and unhappy bar goers. When the cops started to manhandle their unruly prisoners, the onlookers became enraged, throwing coins, stones, and bottles at the officers. The police, a few prisoners, and a writer from the Village Voice who had noticed the fracas from his nearby office, were forced to retreat into the bar, which the mob then tried to set on fire. The cops were eventually rescued with the intervention of the fire department and the riot squad, which dispersed the crowd. But low-level protests lasted for four more days, flaring up for a final time on Wednesday, when the Voice published an inflammatory account of the uprising. Why did the gays of Christopher Street suddenly fight back after decades of persecution? Witness Morty Manford likened the melee to "a slight lancing of the festering wound of anger at this kind of unfair harassment and prejudice." He said, "We had just been kicked and punched around symbolically by the police. They weren't doing this at heterosexual bars. And it's not my fault that the local bar is run by organized crime and is taking payoffs and doesn't have a liquor license."[32]

---

[29] *See, e.g.,* Zoe Sonnenberg, "Daughters of Bilitis: Historical Essay," FoundSF, 2015, *available at* http://www.foundsf.org/index.php?title=Daughters_of_Bilitis.

[30] *See, e.g.,* Jamilah King, "Meet the Trans Women of Color Who Helped Put Stonewall on the Map," Mic, June 25, 2015, *available at* https://mic.com/articles/121256/meet-marsha-p-johnson-and-sylvia-rivera-transgender-stonewall-veterans#.3RBDc3H9O.

[31] *See, e.g.*, June Thomas, "The Gay Bar: Why the Gay Rights Movement Was Born in One," Slate, June 2011, *available at http://www.slate.com/articles/life/the_gay_bar/2011/06/the_gay_bar_4.html.*

[32] *Id.*

There were at least two known instances prior to the Stonewall Riots when gay patrons of gathering places resisted arrest.

In May 1959, a skirmish broke out around Cooper's Doughnuts, a shabby all-night Los Angeles coffee shop frequented by hustlers and their customers, when gays threw coffee cups and paper plates at police officers rather than submit to arbitrary arrests. This "was perhaps the first homosexual uprising in the world," according to Gay L.A. . . . Similarly, in the summer of 1966, transvestite patrons of Compton's Cafeteria in San Francisco's Tenderloin district fought with cops who were trying to detain them. Again, the incident failed to generate attention.

Id.

Perhaps buoyed by the energy of post-Stonewall community activism—and understanding that changing the laws that oppressed them could only be done through the political process—LGBT people began to openly enter the world of elected public service in the mid-1970s. In 1974, 21-year old Kathy Kozachenko become the nation's first openly LGBT elected official when she won a seat on the Ann Arbor, MI City Council.[33]

Harvey Milk, a child of Lithuanian Jewish immigrants,[34] a Navy veteran,[35] and the "Mayor of Castro Street,"[36] became California's first openly LGBT public official upon his election to the San Francisco Board of Supervisors in 1977.[37] He was quickly able to garner more than enough votes needed to pass a landmark gay rights ordinance, with ten out of the eleven Supervisors voting in support.[38] His brief eleven months in office came to a tragic end as former Supervisor Dan White—the only Supervisor who voted against the gay rights ordinance—gunned him down, along with Mayor George Moscone, in San Francisco City Hall on November 27, 1978.[39]

---

[33] Steve Friess, "The First Openly Gay Person to Win an Election in America Was Not Harvey Milk," Bloomberg Politics, December 11, 2015, *available at* https://www.bloomberg.com/news/features/2015-12-11/the-first-openly-gay-person-to-win-an-election-in-america-was-not-harvey-milk.

[33] Rebecca Spence, "Harvey Milk, in Life and on Film, Typified the Proud Jew as Outsider," Forward, December 2008, *available at* http://forward.com/news/14715/harvey-milk-in-life-and-on-film-typified-the-pro-02973/.

[34] Sam LeGrone, "Navy to Name Ship After Gay Rights Activist Harvey Milk," U.S. Naval Institute News, July 28, 2016, *available at* https://news.usni.org/2016/07/28/navy-name-ship-gay-rights-activist-harvey-milk.

The United States Navy announced plans to name a ship after Harvey Milk on July 14, 2016.

Id.

[36] *See, e.g.,* Randy Shilts, The Mayor of Castro Street: The Life and Times of Harvey Milk, Stonewall Editions, 1988.

[37] *See, e.g.,* Darby West, "Harvey Milk, the First Openly Gay Elected Official in California: Not Your Typical Candidate," FoundSF, accessed September 15, 2017, *available at* http://www.foundsf.org/index.php?title=Harvey_Milk,_the_First_Openly_Gay_Elected_Official_in_California:_Not_Your_Typical_Candidate.

[38] *See, e.g.,* Natalie Jones, "The Life of Harvey Milk," American Civil Liberties Union, accessed September 15, 2017, available at https://www.aclu.org/files/pdfs/lgbt/schoolsandyouth/ramona_milk_presentation.pdf.

[39] Tim O'Rourke, "Chronicle Covers: The Assassinations of Moscone and Milk," November 2016, *available at* http://www.sfchronicle.com/news/article/Chronicle-Covers-The-assassinations-of-Moscone-10629367.php.

Sen. Dianne Feinstein, then the president of the Board of Supervisors who would become mayor upon Moscone's death, was in City Hall when the killings occurred and found Milk's body. "I put my finger to see if there was any pulse, and it went in a bullet hole in his chest," Feinstein told The Chronicle's Carl Nolte in 2003. "I think of it as if it were yesterday. I remember Harvey's body, his blood on me. I see it all." Both Moscone and Milk died instantly.

Id.

Before his brutal end at age forty-eight, Supervisor Milk was aware of death threats. He hoped, unfortunately prophetically, that "[i]f a bullet should enter my brain, let that bullet shatter every closet door."

Jamie McGonnigal, "In Memoriam: 'If a bullet should enter my brain, let that bullet shatter every closet door,'" LGBTQ Nation, November 2011, *available at* https://www.lgbtqnation.com/2011/11/if-a-bullet-should-enter-my-brain-let-that-bullet-shatter-every-closet-door/.

Given the seminal nature of his San Francisco gay rights ordinance banning discrimination in public accommodations, housing, and employment, and the impact of the "White Night Riots"—which erupted in San Francisco on Mary 21, 1979, the night that his killer was given a light sentence for manslaughter—it is safe to say that Dan White's bullets helped to shatter closet doors for generations yet to come.

See, e.g., Martin Stezano, "What Were the White Night Riots?," History, June 2017, *available at* http://www.history.com/news/ask-history/what-were-the-white-night-riots.

Milk's assassination galvanized a generation of LGBT leadership that continue to this day. In 1987, Barney Frank (D-MA) became the first sitting Member of Congress to publicly identify as LGBT.[40] Rep. Frank served in Congress from 1981 to 2013, and "was the primary sponsor of 31 bills that were enacted," including the 2010 Dodd-Frank Act which precipitated an overhaul of the American finance industry.[41] A powerful and outspoken leader, Rep. Frank was Chair of the House Financial Services Committee.[42] In 2012, Rep. Frank became the first sitting Member of Congress to marry a same-sex spouse.[43]

Today, a record six openly LGBT members serve in the U.S. House of Representatives: Reps. David Cicilline (D-RI), Sean Patrick Maloney (D-NY), Mark Pocan (D-WI), Jared Polis (D-CO), Kyrsten Sinema (D-AZ), and Mark Takano (D-CA).[44] November 2012 saw the election of the country's first openly LGBT Senator, the former Representative Tammy Baldwin (D-WI).[45] At the state level, Oregon elected our country's first openly LGBT Governor, Kate Brown, in 2016.[46] That these public officials display integrity and commitment to serving all constituents during this difficult era in progressive politics is more than laudable.

IV. The White House Fuels A Rising Tide of Inequality

Despite this Report's recommendations, and despite the progress made by the LGBT community, it is clear that in today's climate, no gains are safe. No one who values LGBT equality can rest easily, despite decades' worth of advancements. In stark contrast to the time of the Commission's 2015 briefing on these issues, the American political landscape is at an inflection point that can

---

[40] Barney Frank, "My Life as a Gay Congressman," Politico Magazine, March 2015, *available at* http://www.politico.com/magazine/story/2015/03/barney-frank-life-as-gay-congressman-116027?o=0. *See also* Stuart Weisberg, Barney Frank: The Story of America's Only Left-Handed, Gay, Jewish Congressman, Sheridan Books, 2009.

[41] "Rep. Barney Frank," govtrack, accessed September 15, 2017, *available at* https://www.govtrack.us/congress/members/barney_frank/400140.

[42] *See, e.g.*, CNBC News Releases, "House Financial-Services Committee Chairman, Rep. Barney Frank (D) Massachusetts on 'Kudlow & Company' with Larry Kudlow (Transcript Included)," September 10, 2010, *available at* https://www.cnbc.com/id/20720084.

[43] Justin Sink, "Barney Frank to Marry Longtime Partner," The Hill, January 2012, *available at* http://thehill.com/blogs/blog-briefing-room/news/206799-report-barney-frank-to-marry; *and* Amanda Cedrone, "Barney Frank Marries Longtime Partner Jim Ready," The Boston Globe, July 8, 2012, *available at* https://www.bostonglobe.com/metro/2012/07/08/frank/J1ebJWjTAq2MgRUt2opQSM/story.html.

[44] Congressional Equality Caucus, "About the Caucus," accessed September 15, 2017, *available at* https://lgbt-polis.house.gov/about. (Note: This leadership list refers to members of the 114th Congress, but all members remain in office during the 115th Congress. In addition to its six openly LGBT Co-Chairs, the Caucus benefits from the membership of many other Representatives as well.)

[45] Emanuella Grinberg, "Wisconsin's Tammy Baldwin is First Openly Gay Person Elected to Senate," CNN, November 7, 2012, *available at* http://www.cnn.com/2012/11/07/politics/wisconsin-tammy-baldwin-senate/index.html.

[46] Camila Domonoske, "For First Time, Openly LGBT Governor Elected: Oregon's Kate Brown," National Public Radio, November 9, 2016, *available at* http://www.npr.org/sections/thetwo-way/2016/11/09/501338927/for-first-time-openly-lgbt-governor-elected-oregons-kate-brown.

move our nation forward, or send it backwards in a reactionary reflex to a time prior to the creation of the Commission. Recent progress is being actively and speedily undone.

Actions taken by President Trump and his administration, some of which are highlighted below, underscore the importance and timeliness of the Commission's report, including its Findings and Recommendations. Executive Branch documents on which the proverbial—or literal—ink is barely dry increase the urgency of the Commission's recommendations and decrease the likelihood that they will be honored in the near term. It is vitally important that Congress enact the Commission's recommendation to explicitly ban discrimination in the workplace based on sexual orientation and gender identity."[47] As this Administration revels in the cultural wars that it has created, Congress must act to even out an incomplete and contradictory patchwork of state and local laws, and to acknowledge that nothing akin to the federal government's reprehensible "Lavender Scare"[48] could be repeated.

During the 2016 Presidential campaign, then-candidate Trump worked hard to project the image of a devoted supporter of LGBT people.[49] However, the early record of his administration is replete with actions demonstrating that he is anything but interested in protecting LGBT Americans. This President is quickly building a legacy of transphobic and homophobic public policies.[50] Whether

---

[47] USCCR Report, p. 73, n. 4 *supra*.

[48] *See, e.g.*, Johnson, The Lavender Scare: The Cold War Persecution of Gays and Lesbians in the Federal Government; U.S. Merit Systems Protection Board May 2014 report; and Sears, Hunter, and Mallory, Williams Institute report, n. 10 *supra*.

[49] During the campaign, then-candidate Trump made the following statements:

"'People are people to me, and everyone should be protected,' he told The Washington Post in a May 2016 interview." Anne Gearan, "White House Spokeswoman Says Trump and Alabama's Roy Moore 'Don't Agree' on Gay Rights," The Washington Post, September 28, 2017, *available at* https://www.washingtonpost.com/news/post-politics/wp/2017/09/28/white-house-spokeswoman-says-trump-and-alabamas-roy-moore-dont-agree-on-gay-rights/

"Ask yourself who is really the friend of women and the L.G.B.T. community, Donald Trump with actions or Hillary Clinton with her words?", he said. "I will tell you who the better friend is, and someday I believe that will be proven out, big-league." Haberman, Maggie, "Furious Gay Rights Advocates See Trump's 'True Colors,'" The New York Times, July 26, 2017, *available at* https://www.nytimes.com/2017/07/26/us/politics/furious-gay-rights-advocates-see-trumps-true-colors.html. "I will do everything in my power to protect our L.G.T.B.Q. citizens from the violence and oppression of a hateful foreign ideology." *Id.*

Commentators note that

Trump is only a few months into his presidency, and we've already seen a quiet but steady chipping away of protections for LGBT Americans. This president may have said he would be great for the LGBT community, but actions speak louder than words. And it's clear his veneer of inclusion can't hide the intent of his administration to make the lives of LGBT people, young and old, more difficult.

Lanae Erickson Hatalsky and Nathan Kasai, "Trump's Quiet War Against LGBT Americans," Newsweek, April 24, 2017, *available at* https://www.usnews.com/opinion/civil-wars/articles/2017-04-24/donald-trumps-guerrilla-war-against-against-lgbt-americans. *See also* Emanuella Grinberg, "The First 100 Days in LGBT Rights," CNN, April 28, 2017., *available at* http://www.cnn.com/2017/04/28/politics/first-100-days-lgbt-rights-trnd/index.html.

Depending upon the actions of the judicial nominees whom he may be successful in placing on the federal bench, including, of course, the U.S. Supreme Court, this legacy will likely live long past 2020 or 2024. *See, e.g.*, Mark Joseph Stern, "Obergefell is Already Under Attack," *Slate*, September 20, 2017, *available at* http://www.slate.com/articles/news_and_politics/jurisprudence/2017/09/trump_is_laying_the_groundwork_to_overturn_marriage_equality.html.

or not a specific action which negatively impacts upon LGBT people directly affects workplace discrimination is not germane to this overarching inquiry; all pieces of this puzzle are interconnected, and the removal of one threatens the stability of all.

If Trump meant any word of his pre-election pronouncements, then he should waste little time in using one of his many Executive Orders to implement our specific recommendation that "federal agencies including the Departments of Justice and Labor, the Equal Employment Opportunity Commission, and the Office of Personnel Management should issue and—where relevant—reaffirm specific guidance for federal and private employers outlining protections for LGBT individuals in the workforce, including specifically enumerating protections for transgender persons."[51] Yet it is evident that the difference between candidate Trump and President Trump on the issue of LGBT rights and protections is stark. Already, some federal agencies have already taken actions which contravene the Commission's specific call for protection, changing the terms of engagement and likely rendering the enforcement issues moot.

It is particularly sad and disturbing that the new Administration's first public anti-LGBT action was aimed at children and youth. In February 2017, Attorney General Jeff Sessions and Education Secretary Betsy DeVos, at the direction of the President, rolled back protections of Title IX of the Civil Rights Act of 1964 which the Obama Administration had interpreted as allowing transgender youth to use the school bathrooms that aligned with their gender identities.[52] For an Administration which has trumpeted, through its First Lady, an anti-bullying manifesto, this action seems particularly cruel and hypocritical.

Also sadly, but predictably, the President struck a blow against LGBT workplace protections in March 2017 (and as discussed in the report) when he made it easier for federal contractors to discriminate against LGBT employees or prospective workers. Executive Order 13673 required federal contractors to demonstrate compliance with the antidiscrimination requirements of Executive Order 13672 and other Executive Orders and federal laws.

---

[51] USCCR Report, p. 73, n. 4 *supra.*
Further, recognizing that a right without a remedy is not a right at all, the Commission recommends that "Congress should authorize the necessary appropriations to ensure that all current and future non-discrimination protections are fully enforced by agencies including, but not limited to, the Departments of Justice and Labor and the Equal Employment Opportunity Commission."
Id. at p. 73.

[52] "'As President Trump has clearly stated, he believes policy regarding transgender bathrooms should be decided at the state level," the White House said in a statement . . . .'" Erin Dooley, Geneva Sands, Justin Fishel, Katherine Faulders, and Veronica Stracqualursi, "Trump Reverses Transgender Bathroom Guidance," ABC News, February 22, 2017, *available at* http://abcnews.go.com/Politics/trump-administration-issue-guidance-transgender-bathrooms/story?id=45663275. *See also* Jeremy W. Peters, Jo Becker, and Julie Hischfeld Davis, "Trump Rescinds Rules on Bathrooms for Transgender Students," The New York Times, February 22, 2017, *available at* https://www.nytimes.com/2017/02/22/us/politics/devos-sessions-transgender-students-rights.html.

The U.S. military has historically been a battleground for recognition of LGBT rights. From the first tentative steps of "don't ask, don't tell" of the Clinton Administration to the full integration of LGBT servicepersons during the Obama administration, the rights of LGBT to serve our country has been, unfortunately, a continuing flashpoint of controversy. Yet, until recently, the issue had been swiftly and surely receding. However, the President broadcasted a series of morning tweets on July 26, 2017,[53] apparently issued to the surprise of military leadership—despite the fact that he claimed consultation with them[54]—announcing that transgender people would no longer be allowed to serve in the U.S. military. He cited the "tremendous medical costs" associated with their care and the "disruption" they create as justification.[55] The President's reasoning for reversing existing policy is specious at best and transphobic at worst.

The two leading studies on the question of the military's medical costs associated with transgender service members to be anything but "tremendous." A better word, in the context of the military's astronomical budget, might be "miniscule." The RAND Corporation estimates the annual costs to be in the range of $2.4 to $8 million dollars.[56] The New England Journal of Medicine estimates $5.6 million annually.[57]

These numbers are the size of a speck of dust in the military's annual budget of $496 billion. They still pale in comparison to the military's reported annual expenditure of $64.4 million for Viagra and Cialis.[58] "Tremendous?" No. Taking this to scale, the annual costs projected for transgender

---

[53] "After consultation with my Generals and military experts, please be advised that the United States Government will not accept or allow . . . ." Trump, Donald J. (@realDonaldTrump), Tweet, July 26, 2017, *available at* https://twitter.com/realDonaldTrump/status/890193981585444864.

" . . . Transgender individuals to serve in any capacity in the U.S. Military. Our military must be focused on decisive and overwhelming . . . ." Trump, Donald J. (@realDonaldTrump), Tweet, July 26, 2017, *available at* https://twitter.com/realDonaldTrump/status/890196164313833472.

" . . . victory and cannot be burdened with the tremendous medical costs and disruption that transgender [people] in the military would entail. Thank you[.]" Trump, Donald J. (@realDonaldTrump), Tweet, July 26, 2017, *available at* https://twitter.com/realDonaldTrump/status/890197095151546369.

[54] Scott Maucione, "Congress Wants Answers on Who Advised Trump on Transgender Military Ban," Federal News Radio, October 10, 2017, *available at* https://federalnewsradio.com/defense-main/2017/10/congress-wants-answers-on-who-advised-trump-on-transgender-military-ban/. *See also* Nick Visser, "Letter From 1114 House Democrats Challenges Trump's Decision to Ban Transgender Troops," The Huffington Post, October 11, 2017, *available at* https://www.huffingtonpost.com/entry/trump-transgender-troop-ban_us_59dd9756e4b04fc4e1e9cfa9.

[55] Trump, n. 53 *supra*. *See also* Julie Hirschfeld Davis and Helene Cooper, "Trump Says Transgender People Will Not be Allowed in the Military," The New York Times, July 26, 2017, *available at* https://www.nytimes.com/2017/07/26/us/politics/trump-transgender-military.html.

[56] Agnes Gereben Schaefer, Radha Iyengar, Srikanth Kadiyala, Jennifer Kavanagh, Charles C. Engel, Kayla M. Williams, and Amii M. Kress, "Assessing the Implications of Allowing Transgender Personnel to Serve Openly," RAND Corporation, 2016, p. 33, 37, *available at* https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1530/RAND_RR1530.pdf.

[57] Aaron Belkin, "Caring for Our Transgender Troops—the Negligible Cost of Transition-Related Care," The New England Journal of Medicine, September 17, 2015, p. 1089, 1090, *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1509230.

[58] Paul Szoldra and Skye Gould, "The Pentagon Spends 5 Times More on Viagra Than Transgender Services," Business Insider, July 26, 2017, *available at* http://www.businessinsider.com/pentagon-transgender-medical-comparison-2017-7.

service members is akin to a federal budget rounding error. Further, discharging transgender service members is estimated to cost $960 million—more than the equivalent of over a decade's worth of their medical care.[59] In other words, notwithstanding whether there can even be an economic justification for the transgression of civil rights, the lie behind the President's statements is laid bare by even the most cursory of analysis.

The President cited the "disruption" which, by their very presence in the military, he apparently believes that transgender people create. Again, evidence that transgender people create disruption in the military is lacking. To the contrary, based on analysis of other nations which permit military service by transgender people, the RAND Corporation found that disruption was not inherent and that straightforward policy changes could minimize any impact upon unit cohesion.[60] At least eighteen of our sister nations across the globe allow transgender service members to serve openly.[61]

On the same day on which the President tweeted that transgender service members would be removed, his Department of Justice inserted itself into federal litigation involving civilian workplace protections for LGBT people. The Department, as an uninvited participant, is using the private litigation between a fired gay worker and his former employee as a forum in which to argue that Title IX of the Civil Rights Act of 1964 does not protect LGBT people from employment discrimination. This is starkly and sadly in opposition to a 2015 decision by the Equal Employment Opportunity Commission.[62]

The Commission has recommended that "[w]orkplace discrimination data should be collected through the inclusion of sexual orientation and gender identity questions in population-based surveys of the workforce such as the Census, American Community Survey, and surveys fielded by the Bureau of Labor Statistics and other agencies."[63] This worthy recommendation is likely to be ignored as well. The Census Bureau has already removed planned questions involving gender

---

[59] The Palm Center reports that "[t]he upshot of our analysis is that implementing President Trump's transgender service ban would cost $75,000 per person in order to accrue an annual savings of $656 per person. For the military as a whole, fully implementing President Trump's ban would cost $960 million in pursuit of saving $8.4 million per year." Aaron Belkin, Frank J. Barrett, Mark J. Eitelberg, and Marc J. Ventresca, "Discharging Transgender Troops Would Cost $960 Million," Palm Center, August 2017, p. 1, *available* at http://www.palmcenter.org/wp-content/uploads/2017/08/cost-of-firing-trans-troops-3.pdf.

[60] Schaefer, et al., n. 56 *supra.*

[61] Paul LeBlanc, "The Countries That Allow Transgender Troops to Serve in Their Armed Forces," CNN, July 27, 2017, *available at* http://www.cnn.com/2017/07/27/us/world-transgender-ban-facts/index.html.

[62] Alan Feuer, "Justice Department Says Rights Law Doesn't Protect Gays," The New York Times, July 27, 2017, *available at* https://www.nytimes.com/2017/07/27/nyregion/justice-department-gays-workplace.html.

[63] USCCR Report, p. 73, n. 4 *supra.*

identity and sexual orientation from the 2020 Census.[64] Further, federal survey questions regarding use of services by homeless and elderly LGBT people are on the chopping block. Sadly,

> [c]ombined with the withdrawal of another planned survey evaluating the effectiveness of a homelessness project for lesbian, gay, bisexual and transgender youth, the moves have alarmed watchdogs who worry they may point to a manipulation of government data collection to serve the ideology of a government they view as hostile to their causes.[65]

Even as the approved text of the Commission's report was being prepared for release, the President and his administration took additional actions against LGBT people's right to employment protection.

First, on October 4, 2017, the Department of Justice dismantled a powerful tool for the protection of transgender people in the workplace. It rescinded the Obama-era interpretation of the Civil Rights Act of 1964 Title VII as providing protection for transgender workers.[66] This Administration believes that Title VII "only prohibits discrimination on the basis of a worker's biological sex, and not their gender identity."[67]

Second, on October 6, 2017, the Administration took aim at employment protections for all LGBT people under the guise of "religious liberty." The Commission addressed this critical and highly-charged issue:

> Title VII offers a workable model for protecting religious freedom in the context of federal statutory nondiscrimination protections in the workplace. In *Hosanna-Tabor Evangelical Lutheran Church and School v. Equal Employment Opportunity Commission* the Supreme Court also unanimously endorsed the common law ministerial exemption, which recognizes the right of religious groups to select their own ministers and clergy. No further expansion of exceptions to nondiscrimination protections in the workplace are necessary or warranted to balance the rights to

---

[64] Stephen Dinan, "President Trump Cancels Sexual Orientation Questions on 2020 Census," The Washington Times, March 28, 2017, *availalable at* http://www.washingtontimes.com/news/2017/mar/28/trump-cancels-census-sexual-orientation-questions-/.

[65] Matt Sedensky, "Federal Surveys Trim LGBT Questions, Alarming Advocates," US News, March 20, 2017, *available at* "https://www.usnews.com/news/us/articles/2017-03-20/federal-surveys-trim-lgbt-questions-alarming-advocates.

[66] Laura Jarrett, "Sessions Says Civil Rights Law Doesn't Protect Transgender Workers," CNN, October 5, 2017, *available at* http://www.cnn.com/2017/10/05/politics/jeff-sessions-transgender-title-vii/index.html. (Note: The Department of Justice memo is embedded in this article.)

[67] Daniel Wiessner and Sarah N. Lynch, "U.S. Anti-Bias Law Does Not Protect Transgender Workers: Justice Dept.," Reuters, October 5, 2017, *available at* http://www.reuters.com/article/us-usa-lgbt/u-s-anti-bias-law-does-not-protect-transgender-workers-justice-dept-idUSKBN1CA1Z9?il=0.

> freedom of religion and to nondiscrimination on the bases either of religion or LGBT status.[68]

To the contrary, however, the Department of Justice published guidance directing the "interpreting religious liberty protections in federal law" in accordance with the President's May 2016 Executive Order 13798.[69] After setting forth the precept that stating that "individuals and organizations do not give up their religious-liberty [sic] protections by . . . seeking to earn or earning a living; [or] by employing others to do the same"[70] this guidance implicitly allows religious businesses—which openly agitated for this interpretation—to decline to hire LGBT people if the religion holds anti-LGBT beliefs.

Even more alarmingly, the guidance implicitly seeks to expand dramatically the reach of the Religious Freedom Restoration Act ("RFRA"), which, on its face, protects only the First Amendment Free Exercise rights of a "person."[71] The U.S. Supreme Court expanded that reach, holding in *Burwell v. Hobby Lobby*[72] that the federal RFRA prevents the government from dictating the religiously-motivated behavior of "a closely held, for-profit corporation."[73] The guidance rides the *Hobby Lobby* toboggan as it boldly careens down a slippery slope, declaring—in the apparent absence of statutory or judicial authority—"RFRA protects the exercise of religion by individuals and by *corporations, companies, associations, firms, partnerships, societies, and joint stock companies*."[74] It is unclear whether the Attorney General's twisted interpretation has, in fact, any legal authority. But many will take the guidance at face value.

V. Conclusion

As this statement was being written, the President became the first sitting President to address [an] anti-LGBTQ event.[75] He boasted about his new "religious freedom" guidance (as discussed above)

---

[68] Commission Report, p. 73, n. 4 *supra*.

[69] Executive Order 13798, "Promoting Free Speech and Religious Liberty," May 4, 2017, 82 CFR 21675, *available at* https://www.federalregister.gov/documents/2017/05/09/2017-09574/promoting-free-speech-and-religious-liberty.

[70] U.S. Department of Justice, "Memorandum for All Executive Departments and Agencies: Federal Law Protections for Religious Liberty," Paragraph 4, p. 2, October 6, 2017, *available at* https://www.justice.gov/opa/press-release/file/1001891/download. *See also* David Crary and Ricardo Alonso-Zaldivar, "Trump's One-Two Punch Hits Birth Control, LGBT Rights," Chicago Tribune October 7, 2017, *available at* http://www.chicagotribune.com/business/sns-bc-us--trump-religious-rules-20171006-story.html#article.

[71] The Religious Freedom Restoration Act, 42 U.S.C. sec. 2000bb—2000bb4, Pub.L. No. 103-141, 107 Stat. 1488, Sec. 3(a) November 16, 1993.

[72] *Burwell v. Hobby Lobby*, 573 U.S. ____, 2014.

[73] U.S. Department of Justice Memorandum, Paragraph 11, p. 4, n. 70 *supra*.

[74] *Id.*, italics added. *See also* Julie Moreau, "Justice Department 'Religious Liberty' Guidance: A 'License to Discriminate'?," NBC News, October 9, 2017, *available at* https://www.nbcnews.com/feature/nbc-out/justice-dept-religious-liberty-guidance-license-discriminate-n808836.

[75] Paige Lavender, "Trump Becomes First Sitting President to Address Anti-LGBTQ Event," The Huffington Post, October 13, 2017, *available at* https://www.huffingtonpost.com/entry/donald-trump-values-voter-summit_us_59e0b596e4b03a7be57fe666?ncid=inblnkushpmg00000009.

to the annual "Values Voter Summit" [76]organized by Family Research Council.[77] He spoke in full view of an audience that had been given pamphlets containing excerpts from "The Health Hazards of Homosexuality" and advertising the website www.HealthHazardsOfHomosexuality.info.[78] The pamphlet included statements that claimed that same-sex marriage "made sodomy a right" and that homosexuality was a mental disorder.[79] In the context of an event hosted by an organization that considers anyone in the LGTB community to be "unnatural"[80] and that the Bible punishes homosexuality[81] is it any wonder that many LGTB Americans would be alarmed when he said that his Administration was "returning moral clarity to our view of the world" and "stopping cold the attacks on Judeo-Christian values."[82]

So this President, who campaigned as a self-professed "friend . . . of the L.G.B.T. community,"[83] who compared himself to Secretary Hillary Clinton by averring, "I will tell you who the better friend is, and someday I believe that will be proven out, big-league,"[84] spoke proudly to an organization labelled an anti-LGBT hate group by the Southern Poverty Law Center.[85] It is in this context that the actions of the Administration become clear.

---

[76] *Id.*

[77] The Southern Poverty Law center states that "[t]he FRC often makes false claims about the LGBT community based on discredited research and junk science. The intention is to denigrate LGBT people as the organization battles against same-sex marriage, hate crime laws, anti-bullying programs and the repeal of the military's "Don't Ask, Don't Tell" policy." Southern Poverty Law Center, *available at* https://www.splcenter.org/fighting-hate/extremist-files/group/family-research-council

[78] Aris Foley, "Anti_LGBT Pamphlets Handed Out at Values Voter Summit Trump Spoke At," AOL News, October 13, 2017, *available at* https://www.aol.com/article/news/2017/10/13/anti-lgbt-pamphlets-handed-out-at-values-voter-summit-trump-spoke-at-hate-groups/23242678/. "The Health Hazards of Homosexuality" is written by Mass Resistance, which the Southern Poverty Law Center recognizes as a hate group. *See, e.g.,* Southern Poverty Law Center, "Texas Chapter of Anti-LGBT Hate Group Mass Resistance Launches, Helmed by Robert Oscar Lopez," March 29, 2017, *available at* https://www.splcenter.org/hatewatch/2017/03/29/texas-chapter-anti-lgbt-hate-group-mass-resistance-launches-helmed-robert-oscar-lópez.

[79] https://www.nbcnews.com/feature/nbc-out/hazards-homosexuality-flier-distributed-values-voter-summit-n810471.

[80] From the Family Research Council website: "Family Research Council believes that homosexual conduct is harmful to the persons who engage in it and to society at large, and can never be affirmed. It is by definition unnatural, and as such is associated with negative physical and psychological health effects." *Available at* http://www.frc.org/homosexuality.

[81] The Family Research Council has a publication entitled "The Bible's Teachings on Marriage and Family" which states that "[i]n recent years, homosexual advocates have argued that the Bible, rightly interpreted, does not forbid homosexual relationships, only perverse expressions of such. For example, they have argued that God's judgment on Sodom on Gomorrah (Genesis 18:17-19:29) was merely for these cities' inhospitality, not for the sin of homosexuality. However, while Sodom and Gomorrah did in fact show a lack of hospitality, *it is hardly conceivable that God would punish these cities by utter annihilation for this comparatively minor offense*. Also, the Epistle of Jude clearly states that the people of Sodom and Gomorrah "indulged in sexual immorality and pursued unnatural desire" (*i.e.* homosexuality; Jude 7; cf. Romans 1:26-27), emphasis added, *available at* http://www.frc.org/brochure/the-bibles-teaching-on-marriage-and-family.

[82] Lavender, n. 54 *supra;* and Dan Merica, "Trump: We Are Stopping Cold the Attacks on Judeo-Christian Values," CNN, October 13, 2017, *available at* http://www.cnn.com/2017/10/13/politics/trump-values-voters-summit/index.html.

[83] Haberman, n. 49 *supra.*

[84] *Id.*

[85] Southern Poverty Law Center, "Hate Groups," accessed September 15, 2017, *available at* https://www.splcenter.org/hate-map.

This incident underscores the fact that the Commission's report, especially when read in the context of all anti-LGBT actions by the current President and his Administration, is a call to action. The progress has been halted, the roll-backs are in motion, the need for immediate action is real. LGBT people, their allies (long including this Commissioner), and all who care about social justice and true equality for all must exercise vigilance in tracking new developments and participate in all non-violent and legal forms of activism to oppose setbacks. Without the pre-existing benefit of deeply-embedded federal and judicial protections, LGBT people are a fair target for discrimination by the government and private actors alike. It is apparently open season.

Despite the assurances from the candidate in 2016, the President and his Administration have taken actions in 2017 in contravention to the Commission's recommendations before the Commission could even get its report out the door or before this Commissioner could hit save on the final version of this Statement. For many in the LGTB community, it is dismaying that the President and this Administration have taken actions that appear to be committed to targeting LGBT people for the denial of hard-won basic rights and protections as minority members of our society. This behavior is decidedly un-American. It is vicious, spiteful, exclusionary, and—at its most basic—needless. The LGBT civil rights quest has never been about the dreaded boogeyman of "special rights." It is a search for mere equality, not supremacy. It is the oft-repeated story of disqualifying the qualified because of fear, jealous, and hatred.

The breadth and pace of this Administration's actions underscore the need for all fair-minded Americans to practice vigilance and activism. Part of that activism must be work to try to prevent future dangers. Just how far will this President and his Administration go in trying to force LGBT people back into the proverbial closet and reduce their abilities to participate fully and openly in American life—to interfere with their pursuit of happiness? The federal actions since Inauguration Day, and the specter of what may yet be in the offing, especially in appointments to the judiciary, only emphasize the need for federal legislation barring employment discrimination which the Commission recommends. Most telling, a chilling harbinger of what is yet to come, is the President's open embrace of the possible election of a United States Senator[86] with a long history of virulently homophobic beliefs.[87]

---

[86] The President has articulated enthusiastic support for Roy Moore. "'Spoke to Roy Moore of Alabama last night for the first time. Sounds like a really great guy who ran a fantastic race. He will help to #MAGA!' the president tweeted, referring to his own "Make America Great Again" campaign slogan."
Julia Manchester, "Trump: Roy Moore 'Sounds Like a Really Great Guy,'" The Hill, September 27, 2017, *available at* http://thehill.com/homenews/administration/352616-trump-speaks-to-roy-moore-after-primary-victory-tweets-support.

[87] Roy Moore has likened homosexuality to bestiality. *See, e.g.*. Eugene Scott, "How Roy Moore's Rhetoric on Gays, Muslims Harks Back to Alabama's Past," The Washington Post, September 27, 2017, *available at* https://www.washingtonpost.com/news/the-fix/wp/2017/09/27/roy-moores-values-could-take-alabama-back-to-a-place-many-of-its-residents-have-tried-to-get-past/?utm_term=.3e245740a6f9.

It is more apparent than it has been in decades that LGBT people require even farther-reaching, more comprehensive, federal legal protections than just in the workplace. Such safeguards in the arenas of employment, public accommodation, housing, credit, and federally funded programs are feasible via amendments to the Civil Rights Act of 1964, the Fair Housing Act, and other federal laws. Such amendments would place sexual orientation and gender identity under the Acts' umbrellas as protected classes. The bipartisan Equality Act of 2017 seeks to do just that.[88] This is not fringe legislation; there are 197 co-sponsors in the House[89] and 45 co-sponsors in the Senate.[90] The Commission's next step in executing its duty to safeguard the civil rights of LGBT people should be to explore the broader issues which underlie the Equality Act and the remedies which it offers.

If there is any lesson from the recent events in Charlottesville, it is that the ugliness of racism, bigotry, homophobia, and transphobia still resides within a deep dark crevasse of the American soul. It is the duty of leaders in our government, especially the President, to denounce and deny these groups and individuals in the strongest possible terms. It is the duty of leaders in our government, especially the President, to take strong action to dismantle and disarm the leaders and the organizations that give bigotry, hatred, homophobia, and transphobia a voice. And it is the duty of our leaders in government, especially the President, to show that our government will enact laws to protect people from bigotry, hatred, homophobia, and transphobia.

This Commission has a duty to be the federal government's watchdog on civil rights, a mandate placed on it 60 years ago, a charge that requires us to give voice to the oppressed. It has been the Commission's voice that has spoken loudest when the civil rights laws of this country were required to be extended to other groups not named in the testimony surrounding the Civil Rights Act of 1964, as we did for women, as we did for the disabled, and as we do today for the LGBT community. It is a terrible day when the Oval Office chooses not just to ignore what we say on behalf of the American people, but to deliberately, and callously, act in opposition to the extension of these those hard-won civil rights to a group that is deserving and in need of their protection.

While Chief Justice of Alabama, Moore opined that "[h]omosexual conduct by its very nature is immoral, and its consequences are inherently destructive to the natural order of society." In *re D.H. v. H.H.*, Supreme Court of Alabama, Docket No. 1002045, decided February 15, 2002, *available at* http://caselaw.findlaw.com/al-supreme-court/1303306.html.

[88] H.R. 2282: Equality Act, 115th Congress, 1st Session, introduced May 2, 2017, *available at* https://www.gpo.gov/fdsys/pkg/BILLS-115hr2282ih/pdf/BILLS-115hr2282ih.pdf. *See also* S. 1006: Equality Act, 115th Congress (2015-2017), introduced May 2, 2017, *available at* https://www.congress.gov/115/bills/s1006/BILLS-115s1006is.pdf.

[89] "All Information (Except Text) for H.R.2282—Equality Act," Congress.gov, accessed September 15, 2017, *available at* https://www.congress.gov/bill/115th-congress/house-bill/2282/all-info.

[90] "S.106—Equality Act," Congress.gov, accessed September 15, 2017, *available at* https://www.congress.gov/bill/115th-congress/senate-bill/1006/cosponsors .

[This page intentionally left blank]

Dissenting Statement of Commissioner Gail Heriot

I have sympathy for some of the goals of the basic legislative proposal discussed in this Report. In a different world, I might have been able to support at least a more modest version of it. I continue to support Title VII of the Civil Rights Act of 1964's provisions prohibiting discrimination in employment on the basis of race, color, religion, sex and national origin. But, alas, given the ways in which that legislation has been misapplied over the years, I worry about the wisdom of expanding it further unless the expansion comes packaged with general Title VII reform.

For example, under current interpretations of Title VII, employers must endeavor to prevent their employees from engaging in the sexual harassment of their colleagues. That is a worthwhile goal. But the concept of sexual harassment has been given such a broad and vague construction that its effect has been to force employers to squelch not just sexual harassment, but free expression at the workplace.[1] By extending the reach of anti-discrimination laws to sexual orientation and gender identity, the proposed legislation would only compound this problem.

Quite apart from my concerns over the proposed legislation, I have concerns over this report's usefulness as a guide to Congress.[2] The data are not always presented fairly and in context. For example, by focusing on employee *perceptions* of discrimination, it almost certainly overstates the

---

[1] A good example of this is the recent firing of Google software engineer James Damore, which I discuss infra at Part IB(2).

[2] The report is unsatisfying in part because of an unbalanced record. Given that I had no fixed view on this particular issue—that is, I am not categorically against all anti-discrimination laws of this kind— I was looking forward to a balanced panel that could help me clarify my thinking. A balanced briefing on this topic should have had about the same number of witnesses who are generally for, as well as generally against, federal prohibitions on sexual orientation and gender identity discrimination in employment. Yet this briefing had 15 panelists generally in favor of such prohibitions and two generally against them. The Commission secured one of the two witnesses against—Ryan Anderson—at the very last minute, only after Commissioner Kirsanow and I complained vociferously about panel imbalance.

Although I was told that staff made a good-faith effort to secure a balanced panel and that the panel was imbalanced only because too many opponents declined to testify, that appears to be untrue. At a Commission business meeting on February 20, 2015, about three weeks before the briefing, the then-head of the Commission's Office for Civil Rights Research and Evaluation ("OCRE") happily said that she had already confirmed 13 witnesses and was looking to fill only two more slots.

See United States Commission on Civil Rights, Transcript of Business Meeting, February 20, 2015, 19-21, *available at* http://www.usccr.gov/calendar/trnscrpt/UNEDITEDCommissionMeetingTranscript_02-20-15.pdf.

After that meeting, OCRE agreed to provide us with a list of witnesses who had already been invited.

That list showed that only two critics of sexual orientation discrimination laws had been invited as of then. OCRE then tried to argue that the briefing was balanced because some potential panelists from the Human Rights Campaign and the Center for American Progress criticized the proposed federal Employment Non-Discrimination Act for not going far enough. These organizations are nonetheless strong supporters of ENDA's core prohibition on sexual orientation discrimination; the Human Rights Campaign at the time had a large banner on its website that said "Pass ENDA Now," and the proposed witness Gene Robinson of the Center for American Progress has gone so far as to assert that Christian opposition to ENDA would embarrass Jesus. *See* http://www.huffingtonpost.com/bishop-gene-robinson/enda-vote-jesus_b_4234440.html.

The notion that these panelists were interchangeable with conservatives and libertarians or made the panels more balanced was risible. I am forced to conclude that there never was a plan in place for a balanced briefing.

extent of discrimination based on sexual orientation. It states, for example, that "[s]tudies have found that anywhere from 21[3] to 47[4] percent of LGBT adults faced employment discrimination because they were gay or transgender." Rep. at 10. But the cited studies were all based on the *perceptions* of job applicants/employees (and the latter figure was for transgender/gender-nonconforming persons only). When one looks at the Equal Employment Opportunity Commission's statistics on the matter, one learns that "charges" of discrimination are not the same as actual discrimination. The vast majority of charges filed by job applicants/employees with the EEOC are found to be without merit. For Fiscal Year 2016, the EEOC found ***"No Reasonable Cause" for 67.6% of all LGBT-based charges.*** It found ***"Reasonable Cause" for only a tiny number—3.7% of LGBT-based charges.*** An additional 17.1% of charges were not pursued by the charging party.[5]

To be sure, this problem is not unique to LGBT-based charges of discrimination. EEOC data for Fiscal Year 2016 are similar for race-based charges (No Reasonable Cause 73.7%, Reasonable Cause 2.1%), religion-based charges (No Reasonable Cause 70.7%, Reasonable Cause 3.2%), and sex-based charges (No Reasonable Cause 64.2%, Reasonable Cause 3.2%).[6] Dealing with non-meritorious charges is part of the price we pay for our protections against employment discrimination, and it is a price we should be willing to pay in a well-functioning system that seeks to root out non-meritorious claims quickly and efficiently.[7] But in deciding whether to extend Title

---

[3] The 21 percent figure appears to be taken from a Pew Research Survey: http://www.pewresearch.org/fact-tank/2013/11/04/as-congress-considers-action-again-21-of-lgbt-adults-say-they-faced-workplace-discrimination/. The actual question was whether the respondent had been "treated unfairly by an employer because of their sexual orientation or gender identity (5% say this happened within the past year and 16% report that this happened but not within the past year)." Note that some of what respondents consider unfair treatment may not violate employment discrimination laws.

[4] *See* Jaime M. Grant, Lisa A. Mottet & Justin Tanis, Injustice at Every Turn: A Report of the National Transgender Discrimination Survey 51 (2011)("Forty-seven percent (47%) said they had experienced an adverse job outcome, such as being fired, not hired or denied a promotion because of being transgender/gender non-conforming"), *available at* http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf. For a criticism of the methodology in this survey, see *infra* at 107.

[5] The rest of the cases were as follows: In 7.2%, some sort of settlement was arrived at without a finding of reasonable cause on the part of the EEOC. An additional 4.5% were classified as "withdrawals with benefits" in the sense that, while no official findings were ever arrived at, the employer gave the employee at least something in return for the withdrawal. Rep. at 13.

[6] Race-Based Charges, https://www.eeoc.gov/eeoc/statistics/enforcement/race.cfm; Religion-Based Charges, https://www.eeoc.gov/eeoc/statistics/enforcement/religion.cfm; Sex-Based Charges, https://www.eeoc.gov/eeoc/statistics/enforcement/sex.cfm.

[7] Note that as discrimination becomes more rare, the ratio of non-meritorious cases to meritorious cases likely gets higher. Since our system of rooting out non-meritorious cases leaves something to be desired, the downside of having a law against discrimination becomes more prominent. Commissioner Kladney argues that "even if discrimination were rare, we should still have a federal law prohibiting it because it is wrong each and every time it happens." Kladney Statement at 79. I wonder if he really means that. There are all sorts of ways in which an employer can act arbitrarily. Suppose, for example, I refuse to hire Commissioner Kladney because his given name is "David" and my ex-husband's name is David. Or I refuse to hire him because he rooted for the Indians instead of my beloved Cubs in the 2016 World Series . . . or because his wristwatch keeps better time than mine. All are bad reasons to deny someone a job. But the obvious solution for each would be for him to go onto the next opportunity. Since my hypothetical reasons for declining to hire him are so idiosyncratic, he is unlikely to be worse off. Just as there are a lot of fish in the sea, there are a lot of employers out there. If discrimination on the basis of sexual

VII's coverage, it is important that we understand that perceptions of discriminations on the part of job applicants/employees are just that—perceptions. To get a real estimate of the size of the problem of discrimination, one must try to dig deeper.

The misidentified statistics concerning "perceptions" of discrimination are not the only example. Parts of the Report positively bristle with statistics about various aspects of life in the LGBT community. But rather than take those statistics at face value, I would urge the reader to drill down to the material in the footnotes and to approach that material with a critical eye. Gathering statistics on the LGBT community requires researchers to find a broad, representative sample. That isn't as easy as it sounds, particularly for the transgender subset of the population, given its extremely small size. Some of the surveys cited in the report try to get around the difficulty by using problematic methodologies.

One survey cited in this report—*The National Transgender Discrimination Survey*—"decided to pay stipends to workers in homeless shelters, legal aid clinics, mobile health clinics and other service settings to host 'survey parties' to encourage respondents whose economic vulnerability, housing insecurity, or literacy level might pose particular barriers to participation."[8] While I respect the researchers' efforts to try to find hard-to-reach persons, it should not have been surprising that looking in these places tended to uncover lots of respondents with low incomes, spotty employment histories, and other personal difficulties. Would a different approach have yielded a brighter picture of what it is like to be transgender? That question cannot be answered with certainty, though it seems likely. But the Report makes no effort to grapple with these

---

orientation were rare to the point of being idiosyncratic, it's hard to see how Kladney could support its being outlawed, unless he would favor laws that employers can't make stupid decisions.

Commissioner Kladney makes another point in his Statement that deserves comment: He writes that most employers "are corporations, large and small, who take advantage of the legal protections and shields the government affords them" and that "[a]s such, they should be required to not discriminate against any qualified United States citizen in employment. To do so is not consistent with . . . American values." *Id.* This is another one that I have a hard time believing an easy-going guy like Commissioner Kladney really means. I can't imagine anything more inconsistent with American values than to demand that every employer who uses the corporate form (*i.e.* practically all private employers) act consistently with American values. A tolerant, plural society does not impose the values of the majority on everyone. That's what liberalism is supposed to be about (and what I thought it was about back in the days when I was a liberal).

[8] Approximately 500 out of a total of about 7,500 responses came from such efforts. The rest came through an online survey, which was evidently brought to the attention of potential respondents "through direct contacts with more than 800 transgender-led or transgender-serving community based organizations in the U.S." and "through 150 active online community listserves." See Jaime M. Grant, Lisa A. Mottet, & Justin Tanis, Injustice at Every Turn: A Report of the National Transgender Discrimination Survey at 12 (2011), *available at* http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf. This methodology, of course, has its own problems.

The Report cites this survey for a variety of purposes. For example, it cites the survey in stating that "90 percent of transgender employees report experiencing some form of harassment or mistreatment on the job"—a figure it terms "staggering." Report at 11, n.54.

methodological issues, instead accepting at face value these surveys' assertions about the problems faced by transgender persons.[9]

A second example is the U.S. Transgender Survey, which is the largest survey of transgender persons taken to date, conducted in 2015.[10] The researchers responsible for it relied heavily on transgender advocacy organizations to disseminate the survey. That, of course, can lead to problems. We have no way of knowing whether transgender persons who have suffered from discrimination are more likely to respond to such surveys than those who have had no problems. But intuitively it certainly seems likely. The study's authors therefore cautioned readers:

> Although the intention was to recruit a sample that was as representative as possible of transgender people in the U.S., it is important to note that respondents in this study were not randomly sampled and the actual population characteristics of transgender people in the U.S. are not known. Therefore, it is not appropriate to generalize the findings in this study to all transgender people.[11]

This warning about the survey's limitations didn't make it into this Report. For this and other reasons, some of which I will have the opportunity to detail below, many of the factual assertions in this Report need to be taken with a grain of salt.

I. THE CASE FOR ANTI-DISCRIMINATION LEGISLATION FOR SEXUAL ORIENTATION IS SOMEWHAT WEAKER THAN THAT FOR RACE, COLOR, RELIGION, SEX AND NATIONAL ORIGIN IN 1964 AND HAS BEEN MADE WEAKER STILL BY SUBSEQUENT EVENTS. THE CASE FOR ANTI-DISCRIMINATION LEGISLATION FOR GENDER IDENTITY HAS BEEN RENDERED EVEN WEAKER ON ACCOUNT OF OVER-BROAD DRAFTING.

---

[9] The methodological problem with the use of the General Social Survey ("GSS") in this Report is less dramatic, but nonetheless serious. The GSS surveys a large random sample of the country, and its findings concerning the views of Americans in general can usually be considered methodologically sound. But the Williams Institute chose to rely on its data to look at the employment experiences of sexual minorities in particular. Unfortunately, the number of GSS respondents who qualify as members of sexual minorities is tiny—57 self-identified as lesbian, gay or bisexual. In addition, 23 did not identify as lesbian, gay or bisexual, but nonetheless disclosed that they had had same-sex sexual partners. This is out of a total of 3,559 respondents. Even if one can assume that 3,359 respondents can be broadly representative of the American population as a whole, it is not at all clear that 80 can represent lesbian, gay and bisexual Americans.

[10] Rep. at n. 96 and 98.

[11] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet & Ma'ayan Anafi, The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality at 26 (2016) *available at* https://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf. This Report cited the 2015 U.S. Transgender Survey for the proposition that "Transgender individuals are three times as likely to be unemployed and are more than twice as likely to live in poverty compared to the rate in the U.S." Rep. at 15, n.71.

A. A Presumption in Favor of Freedom of Association Should Always Be Applied When Anti-Discrimination Legislation Is Proposed; While that Presumption Can Be (and Has Been) Overcome in the Right Cases, It Takes A Convincing Argument to Do So.

The report quotes Professor Andrew Koppelman for this: "The general principle governing transactions between private parties should be freedom of association, for reasons of both liberty and efficiency. Any departure from that rule, such as a prohibition of discrimination, has the burden of proof."[12]

Koppelman is no conservative. But nearly all conservatives as well as most moderates and liberals would likely agree: If one is going to depart from the ordinary rule that in a free society private parties get to decide for themselves how to order their activities, including how to hire employees for their businesses,[13] one must have a good reason.[14]

---

[12] Report at 49, *quoting* Andrew Koppelman, "Richard Epstein's Imperfect Understanding of Antidiscrimination Law, Library of Law and Liberty," January 2016, *available at* http://www.libertylawsite.org/liberty-forum/richard-epsteins-imperfect-understanding-of-antidiscrimination-law/.

[13] Interestingly, despite widespread agreement that race and sex discrimination are wrong, no one argues that prospective employees (as opposed to employers) should be prohibited from considering the race or sex of a prospective employer in deciding whether to apply for or accept an offer of employment.

[14] One person who seems not to agree is Commissioner Narasaki. Her statement seems to be premised on the notion that the freedom at stake in this area of the law is "freedom *from* discrimination" rather than freedom *of* association. Narasaki Statement at 81. As much as I respect Commissioner Narasaki, our views on the meaning of the word "freedom" and hence on the principles she identifies as fundamental to the founding of our nation could not be more different. Sometimes it is appropriate for the federal or state governments to coerce cooperation from private individuals (*i.e.* limit their freedom of association). But it is important not to lose sight of the fact that we are engaging in coercion, and dressing up coercion as providing "freedom *from*" this or that for others promotes unclear thinking. A free society must be ever vigilant before it encroaches on the freedom of private individuals (including employers) to choose the persons with whom they are willing to associate. As Koppelman put it, the "burden of proof" must always be on the advocates of departures from the basic rule of freedom of association.

As an American, I enjoy the Constitutional right to the free exercise of my religion. But I have no Constitutional right to require particular churches to accept me as one of their own. I have a right of free speech, but that does not include the power to coerce private individuals into buying my book.

Commissioner Narasaki uses *Obergefell v. Hodges*, 576 U.S. ___ (1976), as the starting point for her argument in favor of the proposed Employment Non-Discrimination Act. Since discrimination against same-sex marriage was prohibited in that case, it should be prohibited in employment as well—or so her argument goes. But *Obergefell* was not about the coercion of private individuals. It establishes a right of same-sex couples to marry, but it does not establish a right for individuals to marry someone who doesn't wish to marry them for reasons deemed arbitrary by the state.

For a law coercing individuals to marry someone they don't wish to marry, even if the reason given is arbitrary and capricious, would (I hope) take one heck of a reason. Coercing private employers to hire someone they don't wish to hire, even if their reason is rock stupid, presumably requires a lesser showing of necessity, but the presumption is still against it. In 1964, in passing Title VII to the Civil Rights Act, Congress decided that the problem of race, sex, religion, and national origin discrimination was so serious that the usual presumption in favor of freedom of association was overcome. But note that Congress did not decide that all wrongheaded decisions not to hire should be outlawed. It is still perfectly legal for an employer to be stupid. An employer can choose not to hire a job applicant because the applicant's hairstyle is too old-fashioned, the applicant used to date the employer's weird Cousin Cedric, the applicant is a Republican, the applicant is active in the Sierra Club, or the applicant is a devoted Star Trek fan.

How strong the presumption in favor of freedom of association should be is a question upon which reasonable minds will disagree. I'm not always sure myself. Reasonable individuals are on both sides of the question of whether

The reason for departing from that rule cannot be just that private parties are making bad decisions not to associate (or not to hire). If individuals are free only to make "good" decisions (*i.e.* decisions approved by the government), then they are not free at all. Nor can the reason be that by declining to associate with someone, private individuals have somehow "harmed" that person. While no one is free to physically attack another or to take, destroy, or otherwise injure another's property, declining to confer a benefit on someone (including the benefit of one's association) cannot be equated with imposing a harm. If it could be, the concept of freedom of association would evaporate. Something more is needed to overcome the presumption of freedom.[15]

So under what circumstances is the presumption in favor of free association overcome? A traditional example might be the common law rule that common carriers and public utilities must provide service to all who could pay. These entities were considered special because they tended toward monopoly. If a natural gas utility refuses service to anyone for a reason other than failure to pay, that individual has no practical alternative. If he relies on the free market to provide him with natural gas, he will be waiting a long time, since the town where he resides will likely have only one natural gas provider.

Anti-discrimination laws are a more recent addition to the list of exceptions. Because Title VII applied broadly to the conduct of private employers, it was by far the most controversial part of the Civil Rights Act of 1964. But there was nevertheless a strong argument for Congressional action—especially in the case of discrimination against African Americans. In the view of members of Congress, irrational race discrimination had become so pervasive, it could only be corrected through national legislation: Sometimes extraordinary steps are necessary.

It wasn't just that *some* employers in the South were discriminating on the basis of race: Essentially, all employers of any size were. The complex web of Jim Crow laws made it difficult for Southern employers to employ African-American workers on an equal basis even if they wanted to. If employers had to provide separate bathrooms, shower facilities and even pay

---

sexual orientation should join race, color, religion, sex and national origin as prohibited classifications for Title VII purposes. My only point is that we ought to be able to agree that the presumption should always be in favor of freedom of association (and hence of employer choice) and not coercion. The proponents of legislation thus have the burden of persuading us why sexual orientation should be made part of Title VII, rather than opponents of the legislation having the burden to prove it why it should not. This is why I object to Commissioner Narasaki's quotation at the end of her Statement, which attempts to associate opposition to coercive laws—even well-intentioned coercive laws—with "hatred" and "intolerance." There is massively less hatred in the world than social justice warriors who toss the word "hatred" around carelessly think. As for "intolerance," it is a much more complicated phenomenon than they seem to understand. It is not always the ones the crowd is accusing of intolerance who are the most intolerant.

[15] As Koppelman recognizes, it is not just the value of freedom that drives the presumption in favor of freedom of association. What he calls "efficiency," too, is at stake. It is sometimes tempting for governments to believe that they can make better decisions on behalf of individuals. But it often doesn't turn out the way they thought it would. Sometimes the individuals know more about their particular situation than the government does. What may look to outsiders like invidious discrimination may turn out to be something else entirely.

windows for each race, it is not remarkable that many employers didn't hire African Americans at all or did so only on a limited basis. [16]

That was the intent of those laws—to ensure that whites were hired first into the best jobs. This is what happens when an entire segment of the population is effectively disfranchised. Those who can vote pass laws designed to benefit themselves; those who cannot will be on the losing end of the deal. Discrimination was so pervasive that help wanted ads in newspapers customarily were divided into "Help Wanted—White" and "Help Wanted—Colored." This wasn't subtle stuff.

And it wasn't just employers. Formally or informally, unions were frequently whites only, not just in the South, but also in the North. And employers were obliged to play by union rules. This angle of the discrimination problem was compounded by the Davis-Bacon Act, Pub. L. 71-798,40 Stat. 1494, 40 U.S.C. §§ 3141-48, which requires the federal contractors on public works projects to pay the "prevailing wage" in a given locality. Prevailing wage in practice meant (and continues to mean) union-scale wage. Since union members would ordinarily be more experienced than non-union members, if one had to pay union-scale wages, one might as well hire union members. When these unions were whites only, the system worked to the detriment of African-American workers. [17]

In the view of many members of Congress at the time, the case for protection against sex discrimination may have been somewhat weaker, but it was nevertheless strong. Like race discrimination, sex discrimination was so pervasive it was the norm for help wanted advertisements to separate "Help Wanted—Male" from "Help Wanted—Female."

---

[16] This point tracks an observation made by C. Vann Woodward in The Strange Career of Jim Crow (1955)—the book Martin Luther King called "the bible" of the civil rights movement. Many people argued at the time that Southern culture had always and would always favor racial separation. It didn't matter whether the law required segregation or not; it would have happened without the law.

Woodward disputed this. He showed there was lots of early opposition to Jim Crow laws and without the power of the State to *require* segregation, it would likely not have become as ingrained in Southern culture as it did. To use Woodward's vocabulary, folkways did not dictate stateways. Instead, stateways—that is state laws—profoundly shaped Southern folkways—that is Southern culture. And as long as those laws remained unaltered, southern culture would be frozen in place. The Civil Rights Act of 1964, including Title VII, was a way of uprooting them. While it would be difficult to say that it was the perfect solution to the country's complex race problems, it did manage to accomplish the task of displacing those laws.

[17] Note that to supporters of the Davis-Bacon Act, this was a feature, not a bug. Rep. Robert Bacon, who represented a Long Island House District and for whom the law was named, was motivated in large part by race. In 1927, a contractor from Alabama won a bid to build a Veteran's Bureau in Long Island and brought an African American construction crew with him up from Alabama. Bacon was appalled and began his push to outlaw such competition. *See* David Bernstein, Roots of the Underclass: The Decline of Laissez-Faire Jurisprudence and the Rise of Racist Labor Legislation, 43 Am. U. L. Rev. 85, 115 (1993).

He was not alone. In supporting the proposed legislation, Rep. John J. Cochran of Missouri stated in connection with the proposal that he had "received numerous complaints in recent months about southern contractors employing low-paid colored mechanics getting work and bringing the employees from the South." Hearings on H.R. 7995 and H.R. 9232 Before the House Committee on Labor, 71t Cong. 2d Sess. 17 (26-27). Rep. Clayton Allgood agreed, complaining of "cheap colored labor" that "is in competition with white labor throughout the country." 74 Cong. Rec. 6513 (1931).

Some of this tendency was frozen in place by the law. Progressive Era state legislation often purported to make distinctions between men and women in order to protect the health of the supposedly weaker sex, but at least some of the motivation behind such laws was the desire to exclude women from the most desirable jobs. And while the hey-day of such laws was the early part of the 20th century (at a time when many women could not vote), many remained in place at the time Title VII was passed.[18]

In *Muller v. Oregon*, 208 U.S. 412 (1908), the Supreme Court had unanimously upheld the constitutionality of an Oregon statute restricting women from working for more than 10 hours a day. Justice Josiah Brewer's opinion for the Court stated:

> That woman's physical structure and the performance of maternal functions place her at a disadvantage in the struggle for subsistence is obvious. This is especially true when the burdens of motherhood are upon her. Even when they are not, by abundant testimony of the medical fraternity continuance for a long time on her feet at work, repeating this from day to day, tends to injurious effects upon the body, and as healthy mothers are essential to vigorous offspring, the physical well-being of woman becomes an object of public interest and care in order to preserve the strength and vigor of the race.

208 U.S. at 412.

As such laws multiplied during the Progressive Era and beyond, some feminists, like Suzanne LaFollette, voiced their objections:

> [I]f discriminative laws and customs are to continue to restrict the opportunities of women and hamper them in their undertakings, it makes little difference for whose benefit those laws and customs are supposed to operate, whether for the benefit of men, of the home, of the race, or of women themselves; their effect on the mind of woman and her opportunities will be the same. While society discriminates against her sex, for whatever reason, she can not be free as an individual.
>
> . . . Laws which fix fewer hours of work for women than for men may result . . . in the substitution of men—or children—for women in factories where but few have been employed. Laws prohibiting night-work may reduce the chances of women to get much-needed employment, and may sometimes shut them out of work which would offer higher returns on their labor than anything they might get to do during the day . . .

---

[18] The EEOC took the position that Title VII overruled all discriminatory statutes of this kind unless sex is a *bona fide* occupational qualification. But it took some work to uproot them. In *Megelkoch v. Industrial Welfare Commission*, 442 *F.2d* 1119 (9th Cir. 1971), a woman employee had to challenge California's maximum hour statute for women when her employer refused to promote her on the ground that she couldn't work the same hours as her male colleagues. She won. In *Weeks v. Southern Bell*, 408 *F.2d* 228 (5th Cir. 1969), the court held that a Georgia law imposing weightlifting limits of 30 pounds on women was void under Title VII. *Rosenfeld v. Southern Pacific Co.*, 293 *F. Supp.* 1219, 1223 (C.D. Cal. 1968), aff'd 444 *F.2d* 1219 (9th Cir. 1971), was similar.

Suzanne LaFollette, Concerning Women 19-20 (1926).

Sexual orientation provides an interesting comparison to race and sex. There is no doubt that racial minorities, sexual-orientation minorities, and women (as well as others) have suffered significant discrimination in employment. But there are interesting differences too, and these differences sometimes cut in different directions. For example, members of sexual orientation minorities have traditionally mitigated the effects of discrimination by declining to disclose their membership in a minority to their employer. For most women and members of racial minorities, that was never an option. On the other hand, the stigma associated with membership in a sexual orientation minority has in some ways been greater than the stigma associated with being female or with being a member of a racial minority.

Another interesting contrast: Unlike women and racial minorities, sexual orientation minorities have never been disfranchised on the ground of their sexual orientation. On the other hand, sexual orientation minorities tend to be very small and except in a small number of localities their voting power has been small.

This may be the most significant contrast: Few actual state laws have discriminated on the basis of sexual orientation in employment. Those that have existed have disappeared. This is in contrast to the situation with regard to race and even sex in 1964 when Title VII was promulgated. This is not to say that no government policies ever existed that hampered LGBT individuals from getting desired employment. As the Report indicates, for a time, the federal government took the position that the social stigma suffered by LGBT individuals made them vulnerable to blackmail and hence security risks. Rep. at 61. LGBT individuals applying for some federal jobs therefore had to hide their sexual orientation. If they were hired, their troubles were not over. If their sexual orientation became known, they would be fired.[19] To be fair, however, one must point out that this policy was abandoned decades ago.[20]

---

[19] For a more detailed discussion of the federal policy, see Yaki Statement at 87-96. At this point in time it is unclear how many LGBT individuals were discouraged from applying for, were screened out from, or were fired from a federal job on account of their sexual orientation. But my own mother, who was working for the Department of Defense in the 1950s, remembers a colleague of hers being unceremoniously removed from his job when his sexual orientation was apparently discovered for the first time. She is 92 years old today and has not forgotten the unfairness of it.

[20] The relationship of military serviceman or servicewomen to the federal government is not one of employment. The various legislative proposals discussed in this Report therefore do not apply. But it should be pointed out that it was not until the 1990s that the policy of "Don't Ask, Don't Tell" was implemented, thus allowing closeted gays, lesbians and bisexuals to join the military. Department of Defense Directive 1304.26 (December 21, 1993). It was not until 2011 that openly gay, lesbian and bisexual individuals were permitted to join the military. See Pub. L. 111-321, 124 Stat. 3515, 10 U.S.C. § 654 (2010)(policy went into effect September 20, 2011).

Policies that gave better benefits to married rather than unmarried discriminate on the basis of marital status, not sexual orientation. Most of those who end up with the short end of the stick are not LGBT. But nevertheless at a time that same-sex marriage was unrecognized in most states, LGBT individuals were disproportionately affected. Since *Obergefell v. Hodges*, 576 U.S. ___ (2015), however, all states have recognized same-sex marriage.

The bottom line, as far as I can see, is that the case for an anti-discrimination law for sexual orientation is weaker than the case for race or sex.[21] But, given the history of stigma associated with LGBT status, it is not insubstantial. That makes it a tough decision. What makes it somewhat easier to decide is the fact that Title VII has been misapplied so much over the years, it may be unwise to expand it before reforms are put into place.[22] Will it be possible to draft legislation that will make some version of the proposed Employment Non-Discrimination Act a good idea? I think so. Indeed, it is clear that some members of Congress have been working on the problem. But, in my view, we are not there yet.

On the other hand, the case for "gender identity" coverage is weak—not on the ground that transgender persons have not been historically discriminated against (they have been), but on the ground that the treatment of gender identity in the legislative proposals in this area to date have been overbroad to the point of incoherence.

---

[21] Some have argued that only immutable characteristics should form the basis of anti-discrimination laws. In response those who support the proposed legislation have argued that sexual orientation *is* an immutable characteristic. I have no need to resolve that dispute, since I do not believe that only immutable characteristics should form the basis of anti-discrimination laws (although immutability might well be a factor to consider in determining whether the argument for banning discrimination on that basis is strong enough to overcome the presumption against coercing private parties to associate). From the beginning, Title VII contained a provision banning discrimination based on religion, and yet religion is not an immutable characteristic. Religion and sexual orientation also have something in common in the sense that some employers may have religious or moral objections to working with persons of religious persuasions or sexual orientations they consider to be sinful or otherwise problematic. That raises important and interesting questions that need careful consideration. Rather than attempt to address them here, I refer the reader to my Commission Statement in Peaceful Co-Existence: Reconciling Nondiscrimination Principles with Civil Liberties at (September 2016)(Statement of Gail Heriot), *available at* http://www.usccr.gov/pubs/Peaceful-Coexistence-09-07-16.PDF. The Statement is also *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2897849.

Commissioner Narasaki makes a different argument—that a characteristic's immutability should not drive whether anti-discrimination laws are appropriate for it (I agree with this part), but that whether the characteristic is "central to a person's identity" should. Narasaki Statement at 81-2. But that dog won't hunt. That notion that "characteristics that are fundamental and essential to one's identity," *id.* at 1, should be made the subject of anti-discrimination laws, without any further justification, runs into the problem of human complexity.

Some people consider their race fundamental to their identities; others regard their race as literally skin deep. Indeed, up until fairly recently, it was the fashion among right-thinking liberals to believe exactly that—that race was unimportant. A few days ago I overheard a young man say to an elderly woman that he had no idea about the origins of his surname and didn't know his ethnicity. On the other hand, I've known individuals who regard their astrological sign, their musical ability, their sense of humor, their extremist political ideology, their artistic ability, their entrepreneurial spirit, their Myers-Briggs personality type, and their facility with the written word to be central to their identities. One could always argue with them about what is fundamental to *their* identities. But usually, if persons say that something is fundamental to their identity, it's best to just accept that it is.

Do individuals regard sexual orientation as central to their identity? The answer is almost certainly that some do and some don't. In some surveys, some individuals acknowledge frequent consensual same-sex activity, but nonetheless do not identify themselves as lesbian, gay or bisexual.

[22] I have expressed no opinion on the extent to which Title VII, through the Supreme Court's decision in *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), already offers protection to those who have been discriminated against on the basis of sexual orientation or gender identity. This issue became more of a front-burner issue for the Commission after this Report was approved. At the point of this writing, the Commission is preparing to address the Department of Justice's conclusion that Title VII does not cover sexual orientation and gender identity. Since I have not yet had time to consider the Commission's proposed amendments, I have not addressed them in this Statement.

Prior to 2007, the various versions of the proposed Employment Non-Discrimination Act applied only to sexual orientation and not to gender identity. Since then, however, a number of versions have been introduced that do cover gender identity. Typical of these proposed Employment Non-Discrimination Act of 2013 (S. 815),[23] which defines "gender identity" thusly:

> (7) GENDER IDENTITY.—The term "gender identity" means the gender-related identity, appearance, or mannerisms or other gender-related characteristics of an individual, with or without regard to the individual's designated sex at birth.

The proposed Act goes on to declare it to be "an unlawful employment practice for an employer" "to fail or refuse to hire or to discharge any individual, or otherwise discriminate against any individual . . . because of such individual's actual or perceived . . . gender identity."

That won't work. Race, sex, and sexual orientation (at least where sexual orientation is defined narrowly)[24] are statuses that for the most part are unrelated to how one does a particular job. Gender identity, however, at least as it is defined here, is not a single thing, but a whole range of things. Any "gender-related" "mannerisms" or "characteristics" constitute "gender identity."

The problem is that huge numbers of mannerisms and characteristics are gender-related, and some of them are commonly job-related. In general, we regard aggressiveness to be more characteristic of males than females. That was the whole point of *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989). The plaintiff in that case alleged that she was not promoted because she was thought to have an aggressive and hence "unladylike" personality, but that she would have been promoted if she had been a male with the same kind of personality. The Court agreed that if she would have been promoted if she had been male, she was discriminated against on the basis of sex within the meaning of Title VII.

By making gender-related characteristics (rather than sex itself) the subject of anti-discrimination laws, the proposed law would radically change the law. Right now it is a violation to fail to promote a woman with an aggressive personality if a man with the same personality would have been promoted. Under the proposed law, it would be a violation to fail to promote someone with a passive personality, if someone with an aggressive personality would have gotten the job.

But there are lots of jobs for which an aggressive personality is a legitimate job qualification, just as there are lots of jobs where a more passive, but nurturing, personality is the right fit. If the federal government prohibits employers from making hiring decisions on the basis of "gender-related characteristics," it will be prohibiting a lot of rational behavior.

---

[23] https://www.congress.gov/bill/113th-congress/senate-bill/815/text.

[24] In the proposed Employment Non-Discrimination Act of 2013 (S. 815), "sexual orientation" was defined this way: "(10) SEXUAL ORIENTATION.—The term "sexual orientation" means homosexuality, heterosexuality, or bisexuality." It does not include such things as pedophilia, necrophilia, or sexual sadism.

I rather suspect this is not what the drafters of the proposed Employment Non-Discrimination Act had in mind. But it is what they wrote. Its supporters may not have thought this out very well. One version actually passed the Senate in 2013. What were they thinking?

B. Expansions of Title VII and Why They Have Made It Risky to Add Sexual Orientation to the Already-Existing List of Race, Color, Religion, Sex and National Origin.

(1) Preferential Treatment

If there is one thing you can depend on it's that the 88th Congress banned both discrimination against women and minorities and discrimination in favor of them. It's not just that the text of Title VII makes this clear (though it does):

> It shall be an unlawful employment practice for an employer—to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin; or to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's race, color, religion, sex, or national origin.

42 U.S.C. § 2000e-2(a).

Title VII easily could have been drafted to ban "discrimination against women" or "discrimination against racial minorities." But if it had been, it almost certainly wouldn't have passed. Instead the text proudly declares that discrimination on the basis of race, color, religion, sex, or national origin is prohibited.

If the text hadn't been crystal clear, then the legislative history would have easily clarified matters. For example, when H.R. 7152 reached the floor of the House of Representatives, the very first speech in support of it was delivered by the bill's chief sponsor, Committee on the Judiciary Chairman Emanuel Celler. Part of his speech responded to arguments against the bill, one of which was that it would lead to discrimination against whites. He responded that these arguments were "entirely wrong" and stated:

> Even [a] court could not order that any preference be given to any particular race, religion or other group, but would be limited to ordering an end of discrimination. The statement that a Federal inspector could order the employment only of members of a specific racial or religious group is therefore patently erroneous.
>
> . . . The Bill would do no more than prevent . . . employers from discriminating against *or in favor* of workers because of their race, religion, or national origin.

110 Cong. Rec. 1518 (emphasis added).

Celler's sentiments were echoed repeatedly in the Senate. In their well-known interpretative memorandum on Title VII, Senators Joseph Clark and Clifford Case, bipartisan floor managers for the bill, wrote:

> Title VII would have no effect on established seniority rights. Its effect is prospective, and not retrospective. Thus, for example, if a business has been discriminating in the past and, as a result, has an all-white working force, when the title comes into effect, the employer's obligation would be simply to fill future vacancies on a nondiscriminatory basis. He would not be obliged—*or indeed permitted*—to fire whites in order to hire Negroes, or to prefer Negroes for future vacancies, or, once Negroes are hired, to give them special seniority rights at the expense of the white workers hired earlier.

110 Cong. Rec. at 7213 (emphasis added).

This is why the 5-4 decision in *United Steelworkers v. Weber*, 443 U.S. 193 (1979), was shocking to many. In *Weber*, the Court decided that, despite all this, it was permissible for Kaiser Aluminum and Chemical Corp. and the United Steelworkers to enter into a collective bargaining agreement that permitted whites to enter into their training program *only* on a one-to-one basis with African Americans (regardless of the applicants' comparative credentials and despite the fact that white applicants were more numerous).

The majority decision in Weber triggered one of the most devastating dissents in Supreme Court history:

> [B]y a tour de force reminiscent not of jurists such as Hale, Holmes and Hughes, but of escape artists such as Houdini, the Court eludes clear statutory language, "uncontradicted" legislative history and uniform precedent in concluding that employers are, after all, permitted to consider race in making employment decisions.

United Steelworkers v. Weber, 443 U.S. 193, 219, 222 (1979)(Rehnquist, J., dissenting).

Justice Rehnquist's take-no-prisoners prose showed step by step how Title VII could not fairly be construed to allow racial preferences of any kind, including those practiced by Kaiser and the United Steelworkers. *See also* Bernard D. Meltzer, *The* Weber *Case: The Judicial Abrogation of the Antidiscrimination Standard in Employment*, 47 U. Chi. L. Rev. 423 (1980).

What does *Weber* have to do with the legislative proposals that would prohibit discrimination on the basis of sexual orientation? Perhaps a lot. Americans have learned that when they pass laws that forbid discrimination, what they sometimes get are laws that give preferential treatment to the group that is perceived by those in power as the underdog. For those who oppose preferential treatment, that obviously seems bad. For those who support it, it may seem good. But that may be only at a superficial level. When executive agencies and courts interpret laws to go far beyond

what was originally intended by a statute, no one should be surprised that moderate legislators become gun shy. Further legislative action becomes more difficult.[25]

At least one version of the legislative proposal appears to specifically eschew the use of affirmative action preferential treatment. But after *Weber*, such efforts would need to be ironclad. This one doesn't seem to be.

The proposed Employment Non-Discrimination Act of 2013 (S. 815) states:

> (f) NO PREFERENTIAL TREATMENT OR QUOTAS.—Nothing in this Act shall be construed or interpreted to require or permit . . .
>
> (1) any covered entity to grant preferential treatment to any individual or to any group because of the actual or perceived sexual orientation or gender identity of such individual or group on account of an imbalance which may exist with respect to the total number or percentage of persons of any actual or perceived sexual orientation or gender identity employed by any employer, referred or classified for employment by any employment agency or labor organization, admitted to membership or classified by any labor organization, or admitted to, or employed in, any apprenticeship or other training program, in comparison with the total number of percentage of persons of such actual or perceived sexual orientation or gender identity in any community, State, section, or other area, or in the available work force in any community, State, section, or other area; or
>
> (2) the adoption of implementation by a covered entity of a quota on the basis of actual or perceived sexual orientation or gender identity.

But note that this prohibits preferential treatment only in the context of efforts to match the proportions of those hired or promoted to the proportions found in some outside "community, State, section or other area." Aggressive lawyers might claim that preferential treatment designed to reap the unspecified benefits of diversity rather than to mimic the demographics of any particular "community, State, section or other area" are permissible.

On a blank slate, I would regard this as a weak argument. But in *Regents of the University of California v. Bakke*, 438 U.S. 265 (1978), a Title VI case, Justice Powell drew exactly this distinction. In his controlling opinion, he rejected the idea that the University of California could grant preferential treatment on the basis of race to medical school applicants in order to better match the student body to the racial composition of California. But he upheld the authority of the

---

[25] *See* Daniel B. Rodriguez & Barry R. Weingast, The Positive Political Theory of Legislative History: New Perspectives on the 1964 Civil Rights Act and Its Interpretation, 151 U. Penn. L. Rev. 1417, 1535 (2003) (arguing that, after the judicial expansions of Title VII, some Members of Congress "were likely nervous about agreeing [with Members who supported those expansions] on legislative bargains, which, when they came before the courts, would be rewritten").

University of California to grant preferential treatment on the basis of race in order to reap the pedagogical benefits of diversity.

Justice Rehnquist was right. For the majority in *Weber* to come out as they did required the skills of escape artists like Houdini. Given *Bakke*, however, getting around the proposed Employment Non-Discrimination Act of 2013's ban on preferential treatment or quotas would not be nearly as difficult.

(2) Harassment

It is difficult to defend *Weber* as a matter of statutory interpretation no matter what one thinks of it as a matter of policy. The interpretation was just plain wrong, and painfully so. It would not be fair to put *Meritor Savings Bank v. Vinson*, 477 U.S. 57 (1986), in the same category. For reasons I hope to write about elsewhere, I believe the basic thrust of *Meritor Saving Bank* decision—that at least in some circumstances sexual harassment can be actionable under Title VII—is surely defensible.

The origins of the problems with current doctrine on sexual harassment are more subtle. Five years after *Meritor Savings Bank*, when the ill-conceived Civil Rights Act of 1991 made ordinary monetary damages available under Title VII, sexual harassment lawsuits became much more common, and employers became more fearful of them.

Their fear was mainly of "hostile environment" cases.[26] Employers could be liable for the *cumulative* effect of a series of many rude remarks, slights, and inconveniences, each of which might have come from a different employee (or even a customer). The only way to be sure of not being sued was (and is) to prevent as many as possible of them.

If an employee is upset at the photo of her colleague's bikini-clad wife on his desk, it is in the employer's interest to make him get rid of it.[27] If another employee doesn't like to be told by her

---

[26] The "quid pro quo" kind of sexual harassment case was easier for employers to deal with. These are the cases in which an employee is told that she (or he) must engage in sexual relations if she (or he) wishes to be hired, get a promotion, or avoid dismissal. So long as the employee can demonstrate that a similarly-situated employee of the opposite sex would not have had to submit to this, one can see why such a deal amounts to discrimination on the basis of sex. Note that the shoe can be on the other foot here as well. An employee whose sexual favors are not desired may also have a Title VII complaint, because he (or she) was not given a similar opportunity to be hired, promoted, or avoid dismissal.

To deal with the "quid pro quo" cases, employers need to make it crystal clear to their supervisory personnel that such deals will not be tolerated. As a secondary precaution, they need to make sure that employees know the rules and have someone other than their supervisor to report to if their supervisor breaks those rules.

[27] Bonnie Miller Rubin & Judy Peres, Workplace on Edge Over Harassment, Chicago Tribune (April 3, 1998)("In 1993, a University of Nebraska graduate student was forced to remove a photo of his bikini-clad wife from his desk when two fellow students complained that it offended their sensibilities").

boss that her hair looks nice today, the employer has every incentive to order him to stop.[28] And if a copy of Goya's Naked Maja hanging in the building upsets an employee, the employer's instinct is unlikely to leave it there for others to enjoy. Rather, the picture is likely to be taken down.[29] If the other employees start to complain, the safe solution is to tell them to shut up and arrange for them to take a course in sexual harassment once a year.

"'We advise employers not to focus on the legal definition of harassment, but to have zero tolerance for any behavior extraneous to the workplace. There shouldn't be any touching or sexual joking. Period,'" an employment lawyer told the *Chicago Tribune* in 1998.[30]

When these kinds of actions started to become commonplace, many Americans—indeed a majority—began to wonder if we weren't going down the wrong road. In a 1997 CNN poll, 57% of men and 52% of women agreed that "we have gone too far in making common interactions between employees into cases of sexual harassment."

Since then, the pressure to avoid saying anything that might be construed as offensive has only increased. Sometimes it had served to suppress serious discussions.[31] A recent example is the firing of software engineer James Damore at Google.

Damore wrote what was intended to be an internal discussion memorandum entitled "Google's Ideological Echo Chamber." Contrary to what some media outlets claimed, it was not an anti-diversity or misogynistic screed. In fact, it went out of its way to suggest helpful ways to make employment at Google more attractive to women.

But it dared to question whether women's underrepresentation in software engineering and in leadership positions at Google is wholly due to bias against them. It argued—alluding to a large body of scientific evidence—that fewer women than men may aspire to be software engineers. Damore was careful to acknowledge that there is plenty of variation among men and among women, but as a group, women tend to be more interested in people-oriented jobs. And while Damore's statement says nothing about particular women or particular men, especially those who already work at Google, it happens to be a true statement at the general level. It's certainly worth talking about whether that might account for some of the under-representation of women at Google.[32]

---

[28] *See Ellison v. Brady*, 924 *F.2d* 872 (9th Cir. 1991)("Well-intentioned compliments by co-workers or supervisors can form the basis of a sexual harassment cause of action . . . .").
[29] Nat Hentoff, Sexual Harassment by Francisco Goya, Washington Post (December 27, 1991).
[30] Bonnie Miller Rubin & Judy Peres, Workplace on Edge Over Harassment, Chicago Tribune (April 3, 1998).
[31] *See* David Bernstein, You Can't Say That!: The Growing Threat to Civil Liberties from Antidiscrimination Laws (2004).
[32] *See, e.g.*, Peter Singer, Why Google Was Wrong: Did James Damore Really Deserve to be Fired for What He Wrote? N.Y. Daily News (August 10, 2017).

But instead the author of the memo was fired. And one of the arguments made for his firing was that his memo violates Title VII: He is creating a hostile atmosphere for women, some observers argued; if he isn't fired, Google may be sued. *See e.g.*, Dan Eaton, Here's Why Google Had the Right to Fire that Employee over his Diversity Memo, cnbc.com (August 8, 2017)("Google Vice President of Diversity, Inclusion & Governance Danielle Brown is correct that an employee has no right to engage in workplace discourse that offends anti-discrimination laws; employees may not engage in unlawful harassment under the guise of protected concerted activity or political grievances."), *available at* https://www.cnbc.com/2017/08/08/heres-why-google-had-the-right-to-fire-that-employee-over-his-diversity-memo-commentary.html.

Some people at Google might have wanted Damore fired even if they had believed Google didn't need to worry about Title VII liability. But the culture—an intolerance of serious discussions about issues relating to sex—has been created in part because cautious people err on the side avoiding litigation. All too often that means appeasing extremists.

Google, of course, is a private entity and is not required to honor Damore's First Amendment rights. But Congress is. Insofar as Title VII liability was what drove Google's decision, Title VII (as interpreted) itself is unconstitutional.

Expanding Title VII's reach to other areas, whether it's to sexual orientation, gender identity or something else, can only compound the problem. Future discussions like that Damore tried to initiate would be squelched.

Consider the following situation: Even ten years ago, if someone had argued that New York City would pass a law requiring landlords to address tenants by the pronouns of the tenant's choice (rather than the pronouns of the landlord's choice or the pronouns that correspond to the tenant's actual anatomical sex), they would have been laughed at. But that has become a reality.[33] Would expanding Title VII cause such a rule to be applied to the workplace around the country? It isn't clear to me why it wouldn't.

---

[33] New York City Commission on Human Rights Legal Enforcement Guidance on Discrimination on the Basis of Gender Identity or Expression: Local Law No. 3 (2002); N.Y.C. Admin. Code § 8-102(23). Eugene Volokh, You Can Be Fined for Not Calling People "Ze" or "Hir," if That's the Pronoun that They Demand You Use, The Volokh Conspiracy, May 17, 2016, *available at* https://www.washingtonpost.com/news/volokh-conspiracy/wp/2016/05/17/you-can-be-fined-for-not-calling-people-ze-or-hir-if-thats-the-pronoun-they-demand-that-you-use/; Richard Thomson, Transgender Individuals and Free Speech in New York City, The Federalist Society Blog, May 16, 2016, *available at* https://www.fed-soc.org/blog/detail/?dbid=459. See also Naveed Ahsan, The Silencing of Jordan Peterson, Fair Observer (August 30, 2017)(discussing the practices of the Ontario Human Rights Commission under which "it is now punishable if individuals refuse to use non-gender pronouns such as 'ze' or 'zir' to refer to transgender people"), *available at* https://www.fairobserver.com/region/north_america/jordan-peterson-canada-transgender-rights-debate-news-51321/; Lindsey Bever, Students Were Told to Select Gender Pronouns; One Chose "Your Majesty" to Protest "Absurdity," Washington Post (October 7, 2016).

Unlike the problem of preferential treatment, the problem of harassment overreach is not treated at all in any version of the legislative proposals considered in this Report.

(3) Disparate Impact

This is another one where the Supreme Court has misapplied Title VII, transforming it from a statute that requires equal treatment into one that presumptively requires equal results. See *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971). The various iterations of the proposed Employment Non-Discrimination Act have attempted to deal with this problem.[34] But for reasons I will discuss more fully below, at least the version that passed the Senate in 2013 ultimately failed in its attempt to do so. In addition, the proposed Equality Act does allow for disparate impact claims.

To explain how all this fits together, one must start at the beginning:

While the passage of Title VII was important and historic, it was not intended to assert federal control over every aspect of the workplace. Its carefully limited purpose was to prohibit employment discrimination based on race, color, religion, sex and national origin. As Representative William M. McCulloch et al. put it:

> [M]anagement prerogatives and union freedoms are to be left undisturbed to the greatest extent possible. Internal affairs of employers and labor organizations must not be interfered with except to the limited extent that correction is required in discrimination practices.[35]

At the time, this was likely seen as an obvious, but important, point. Free enterprise had always been the engine that drove the nation's prosperity. For that and other reasons, the best way for the federal government to promote the general welfare, including the welfare of women and minorities, had usually been to allow peaceable and honest individuals the freedom to run their own business affairs. When exceptions become necessary (as they did in 1964), they were understood by most as precisely that—exceptions. They were not intended to swallow the rule.

Congressional leaders assured their colleagues that Title VII would not interfere with employer discretion to set job qualifications—so long as race, color, religion, sex and national origin were not among them. Senators Clifford Case (R-N.J.) and Joseph Clark (D-Pa.), the bill's co-managers on the Senate floor, emphasized this in an interpretative memorandum:

> There is no requirement in Title VII that employers abandon *bona fide* qualification tests where, because of differences in background and education, members of some

---

[34] The proposed Employment Non-Discrimination Act of 2013 (S. 815), *available at* https://www.congress.gov/bill/113th-congress/senate-bill/815/text. It states: "(g) NO DISPARATE IMPACT CLAIMS.—Only disparate treatment claims may be brought under this Act." For reasons why this language fails to cover disparate impact claims brought under the "gender identity" provisions of the proposal, see infra at 127.

[35] Statement of William M. McCulloch, et al., H.R. Rep. No. 914, 88th Cong., 2d Sess. (1964). McCulloch was the House Judiciary Committee's ranking member and was considered by many to have been indispensable in passing the Act.

> groups are able to perform better on these tests than members of other groups. An employer may set his qualifications as high as he likes, he may test to determine which applicants have these qualifications, and he may hire, assign, and promote on the basis of test performance.

Case & Clark Memorandum, 110 Cong. Rec. 7213.

Note that Case and Clark used the term "*bona fide* qualification tests," meaning qualification tests adopted in good faith, and not "necessary" or "scientifically valid" qualification tests. To Case and Clark the issue was whether the employer chose a particular job qualification *because* he believed it would bring him better employees or *because* he believed it would help him exclude applicants based on their race, color, religion, sex or national origin. *See also* Case & Clark Memorandum, 110 Cong. Rec. 7247 (Title VII "expressly protects the employer's right to insist that any prospective applicant, Negro or white, must meet the applicable job qualifications. Indeed, the very purpose of Title VII is to promote hiring on the basis of job qualifications, rather than on the basis of race or color.").

Congress's intention to outlaw only discriminatory treatment and not disparate impact is made clear from Title VII's central prohibition, which bans discrimination against any individual "because of such individual's race, color religion, sex, or national origin." As Richard K. Berg, one of the government lawyers who worked on Title VII's passage, wrote, to "discriminate" against an individual "because of" his "race, color, religion, sex, or national origin" always requires some level of intentionally, whether the intention is conscious or unconscious.[36]

But just in case Section 703 were to be misinterpreted, the bill was amended in the Senate at the insistence of Republican Leader Everett Dirksen—without whose support the bill likely never would have gotten past the Southern filibuster. Dirksen insisted on adding the word "intentionally" to Section 706(g), which deals with judicial power to enforce the prohibitions of Section 703. As modified, Section 706(g)(1) read:

> (1) If the court finds that the respondent has intentionally engaged in or is intentionally engaging in an unlawful employment practice charged in the complaint, the court may enjoin the respondent from engaging in such unlawful employment practice, and order such affirmative action as may be appropriate, which may include, but is not limited to, reinstatement or hiring of employees, with or without back pay . . . , or any other equitable relief as the court deems appropriate. . . .

42 U.S.C. sec. 2000e-5(g)(1).

---

[36] *See* Richard K. Berg, Equal Employment Opportunity Under the Civil Rights Act of 1964, 31 Brook. L. Rev. 62, 71 (1964) ("Discrimination is by its nature intentional. It involves both an action and a reason for the action. To discriminate 'unintentionally' on grounds of race . . . appears a contradiction in terms").

In explaining why the term "intentionally" was added here, Senator Hubert Humphrey said, "Section 706(g) is amended to require a showing of intentional violation of the title in order to obtain relief. . . . The expressed requirement of intent is designed to make it wholly clear that inadvertent or accidental discrimination will not violate the title or result in entry of court orders." 110 Cong. Rec. 12,723-28 (1964).[37]

In addition, by denying the newly-created EEOC both substantive rulemaking authority and to issue cease and desist orders, Title VII's Congressional supporters attempted to ensure Title VII's reach could not be expanded. The power to issue regulations might be interpreted to authorize limited prophylactic measures, and Congress evidently wished to make it clear that Title VII was already as broad as they intended it to be. The EEOC was to be a mediating agency *only*.

But EEOC officials soon began issuing guidances as an alternative to substantive regulations. Alfred W. Blumrosen, BLACK EMPLOYMENT AND THE LAW 52 (1971). Given most employers' eagerness to stay on the right side of the law, these guidances can be as effective (or even more effective) as regulations at influencing employer practices. An advantage from the EEOC's perspective is that they are not subject to notice and comment requirements and thus tend to receive less public scrutiny or government oversight. They are also difficult to challenge in court.[38] They are, of course, supposed to be interpretations of the Act and not extensions of it. But in practice the EEOC went much further.

Blumrosen, the EEOC's first "Chief of Conciliations" and disparate impact liability's primary architect, was unabashed in describing the extent to which the EEOC was (and in his view should be) aggressive in its interpretation of Title VII:

> Creative administration converted a powerless agency operating under an apparently weak statute into a major force for the elimination of employment discrimination. . . . [Legal education] rarely deals with the affirmative aspects of administration. Rather, the law schools provide elaborate intellectual equipment to *restrict* the efforts of administrators. Constitutional law and administrative law are still largely concerned with what government may not do, rather than with how it should decide what it may do. Students impatient with the negativism of present legal education would be better equipped as lawyers if they would focus sharply on the question of "how we can best fulfill the purposes which brought our agency into being" rather than on the question of "whether the courts will sustain this course of action."

---

[37] Dirksen's amendment and Humphrey's explanation are not in perfect harmony, since the amendment applied only to judicial remedies, while Humphrey's explanation applies generally. Dirksen might possibly have intended to foreclose courts from intervening even in the case of unconscious disparate treatment and to leave such cases entirely to the EEOC's mediation efforts. An employer who engaged in unconscious discrimination would essentially be allowed "one free bite." If the employer continued its practices after EEOC mediation efforts, it would be difficult for the employer to maintain that its actions were unconscious.

[38] The fact that Title VII makes EEOC investigations and mediations confidential, 42 U.S.C. 2000e-8(e), adds to the degree to which EEOC policymaking has tended to escape both public scrutiny and government oversight.

Id. at 53 (emphasis in original).

Blumrosen was part of the generation of civil rights policymakers profoundly influenced by the turbulence of the late 1960s—something that is easy to forget today. He urgently pushed the EEOC to interpret Title VII with an eye toward effectuating what he perceived as a higher purpose—increasing African-American employment as quickly as possible—rather than with an eye towards what the courts would be likely to uphold as consistent with Congressional intent as well as the statute's text. In particular, he pushed a "disparate impact" approach to Title VII. Under it, employer intent didn't matter. If, given the job qualification required by an employer, proportionately fewer African Americans than whites qualify, the employer is in violation of Title VII unless it can demonstrate that it essentially had no choice.

Historian Hugh Davis Graham wrote concerning this period in the EEOC's history:

> "The EEOC legal staff was aware from the beginning that a normal, traditional, and literal interpretation of Title VII could blunt their efforts [based on disparate impact theory] against employers who used either professionally developed tests or *bona fide* seniority systems. The EEOC's own official history of these early years records with unusual candor the commission's fundamental disagreement with its founding charter, especially Title VII's literal requirement that the discrimination be intentional."

Hugh Davis Graham, THE CIVIL RIGHTS ERA: ORIGINS AND DEVELOPMENT OF NATIONAL POLICY at 248-49 (1990).

In *Griggs v. Duke Power Co.*, the Supreme Court deferred to the EEOC's disparate impact approach to Title VII liability. It held, therefore, that under Title VII, "practices, procedures, or tests neutral on their face, *and even neutral in terms of intent*, cannot be maintained if they operate to 'freeze' the status quo of prior discriminatory employment practices." *Id.* (emphasis supplied). "The touchstone is business necessity," it stated. "If an employment practice which operates to exclude Negroes cannot be shown to be related to job performance, the practice is prohibited." *Id.* at 431.[39]

As explained above, this was certainly a misinterpretation of Title VII. *See* Hugh Davis Graham, THE CIVIL RIGHTS ERA: ORIGINS AND DEVELOPMENT OF NATIONAL POLICY at 387 (1990)("Burger's interpretation in 1971 of the legislative intent of Congress in the Civil Rights Act would have been greeted with disbelief in 1964"); Daniel Rodriguez & Barry R. Weingast, *The Positive Political Theory of Legislative History: New Perspectives on the 1964 Civil Rights Act and Its Interpretation*, 151 U. Penn L. Rev. 1417 (2003) (also arguing that the 88th Congress would have been astonished at the result in *Griggs*).

---

[39] The facts of Griggs may well have involved intentional discrimination. But if so, it should have been incumbent upon the plaintiffs to prove their case on that theory.

After *Griggs*, Title VII was interpreted to demand two things: (1) Employers must provide equality of opportunity to all persons regardless of race, color, sex, religion or national origin (the traditional interpretation of Title VII); and (2) In deciding upon job qualifications, employers must provide at least equal results for women and minorities unless they can prove they were driven by business necessity to do otherwise (the disparate impact interpretation). For decades, few remarked on it, but these dual requirements were at war with each other from the beginning. Equality of treatment and equality of results are very different.[40]

One problem with disparate impact theory is that all job qualifications have a disparate impact. It is no exaggeration to state that there is always some protected group that will do comparatively poorly with any particular job qualification. As a group, men are stronger than women, while women are generally more capable of fine handiwork. Chinese Americans and Korean Americans score higher on standardized math tests and other measures of mathematical ability than most other ethnic groups. Subcontinental Indian Americans are disproportionately more likely to have experience in motel management than Norwegian Americans, who more likely have experience growing durum wheat. African Americans are over-represented in many professional athletics as well as in many areas of the entertainment industry. Unitarians are more likely to have college degrees than Baptists. *See Watson v. Fort Worth Bank & Trust*, 487 U.S. 977 (1988)(recognizing that disparate impact liability applies to subjective as well as objective job qualifications).

Some of the disparities are surprising. Cambodian Americans are disproportionately likely to own or work for doughnut shops and hence are more likely to have experience in that industry when it is called for by an employer. *See* Seth Mydans, *Long Beach Journal: From Cambodia to Doughnut Shops*, N.Y. Times, May 26, 1995. The reasons behind other disparities may be more obvious: Non-Muslims are more likely than Muslims to have an interest in wine and hence develop qualifications necessary to get a job in the winemaking industry, because Muslims tend to be non-drinkers.

---

[40] The problem was compounded by establishing a stringent standard of proof for "business necessity" that few employers can dream of achieving in *Albemarle Paper Co. v. Moody*, 422 U.S. 405 (1975). The employer there had hired an expert industrial psychologist to conduct a validation study to justify its use of standardized tests to hire and promote its employees. But the Court found the expert's report was not sufficiently scientifically rigorous. Among other things, the job qualifications had not been validated at the micro-level, i.e. for each of an employer's job categories. But it is nearly impossible for any but the largest employers to generate enough data for statistically significant validation studies. Under *Albemarle*, unless a bank could scientifically prove that high-school graduates make better tellers than high-school dropouts, it could not require a high-school diploma for tellers, since proportionally more whites than African Americans possess such a diploma. Indeed, its proof would have to apply specifically to its own tellers, including its minority tellers, not just to tellers in general. It was Justice Blackmun in his concurrence who tentatively sounded the alarm: "I fear that a too-rigid application of the EEOC Guidelines will leave the employer little choice, save an impossibly expensive and complex validation study, but to engage in a subjective quota system of employment selection." 422 U.S. at 449 (Blackmun, J., concurring in the judgment). While *Wards Cove Packing Co. v. Atonio*, 490 U.S. 642 (1989), appeared to overrule *Albemarle*, the Civil Rights Act of 1991 restored the law to its pre-*Wards Cove* condition.

The result is that the labor market is anything but free and flexible. At any moment, the EEOC—an agency Congress designed to have very limited power—can declare an employer's long-standing job requirements to be a violation of Title VII.[41]

The upshot of this is that hiring and firing practices must be shrouded in secrecy. Employers seldom advertise clear job qualifications for fear they will attract a lawsuit. Performance tests, indeed any kind of innovative hiring practices, are invitations to a lawsuit. Wise employers try to be on good terms with the EEOC, knowing that when everything is potentially illegal, the name of the game is to avoid antagonizing the regulator.

Passing any version of the employment discrimination legislative proposal discussed in this Report can only make the problem worse. Even the proposed Employment Non-Discrimination Act of 2013, which specifically eschews the application of disparate impact liability, has the problem. By defining "gender identity" as "the gender-related identity, appearance, or mannerisms or other gender-related characteristics of an individual, with or without regard to the individual's designated sex at birth," the proposal embeds disparate impact into the proposal's core prohibition.

There is no way to define "gender-related" mannerisms and characteristics except by disparate impact. Not all women wear make-up or skirts, but those characteristics are more commonly associated with women than with men. Not all men sing baritone, have short hair, enjoy watching sports on television, own guns, or wear boxer shorts, but these are all characteristics that are to a greater or lesser extent more common among men than among women.

If a statute prohibits employers from discriminating on the basis of characteristics that have a disparate effect on men and women, there is no need for a separate ability to bring lawsuits based on a disparate impact theory.

II. DATA ARE NOT ALWAYS ACCURATELY AND FAIRLY PRESENTED IN THIS REPORT

There is a lot that is wrong with this Report simply from the standpoint of accurately and fairly reporting the facts. Consider, for example, the very first sentence of the very first section: "American employees spend the majority of our awake hours at work." That isn't true.[42] Assuming

---

[41] Note that disparate impact liability applies to promotions and terminations too. *See George v. Farmers Electric Cooperative, Inc.*, 715 *F.2d* 175 (5th Cir. 1983); *Wilmore v. Wilmington*, 699 *F.2d* 667 (3d Cir. 1983).

[42] Bureau of Labor Statistics, Department of Labor, American Time Use Survey—2016 Results (June 27, 2017), *available at* https://www.bls.gov/news.release/pdf/atus.pdf. The data in that report don't make it easy to calculate exactly how much time American employees spend at work. But it is possible to see or to calculate from Table 4 that full-time workers were 77% of all American workers. They worked just a hair over 5 days a week and an average of 8.15 hours per day on the days they worked (for a total of approximately 40.75 hours). Part-time workers were 33% of the workforce. On average they worked slightly less than 4 days per week and averaged 5.34 hours on the days that they worked.

that the typical American employee sleeps 8 hours a day, that leaves 112 waking hours per week. Assuming a 5-day, approximately 40-hour work week, that is less than half, even before one figures in holidays and vacations. Once one figures in part-time work, the sentence isn't close to true. The point is trivial . . . but it doesn't fill one with a lot of confidence to start the Report that way.[43]

Other errors are somewhat less trivial. Accurately reporting the results of the 2013 survey conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics somehow got botched. The report states that "3.4 percent of Americans identify themselves as gay or lesbian (1.6%), bisexual (0.7%) or 'something else' (1.1%)." The correct figures are that 2.5% percent of Americans identify themselves gay or lesbian (1.6%), bisexual (0.7%) or "something else" (0.2%).[44] Two additional categories were "I don't know" (0.4%) and refused to provide an answer (0.6%).

There are likely more such errors. But I have time to describe only one significant area. Perhaps the most troubling aspect of the report's use of data what looks a bit like a purposeful effort to hide the ball concerning income disparities. In the portion of the report entitled "Economic Impacts from Workplace Discrimination," the report recites, "On average gay men earn from 10 to 32 percent less than similarly qualified heterosexual males."[45] Rep. at 14.[46] By itself, that figure may

---

[43] After I handed in my Statement (and apparently as a result of my criticism), this problem was corrected (along with several other corrections). It is extremely unusual to make anything other than formatting changes to reports that have already voted on by the Commission, since corrected reports need to be resubmitted to the Commission.

[44] The material in the text is as of the date the Commission approved the report. After the due date of the Commission's statements, but before the deadline for rebuttal material, I learned that the staff planned to alter the passage to read, "A 2013 survey conducted by the Center for Disease Control and Prevention's National Center for Health Statistics found that 3.4 percent of Americans identify themselves as gay or lesbian (1.6 percent), bisexual (0.7 percent) or 'other' (1.1 percent)." This is still wrong. Individuals who refuse to answer the question (0.6 percent) or who have reported that they don't know (0.4 percent) did not "identify" themselves as "other." Even those who identify themselves as "something else" may simply mean that they are celibate. Beyond all this, the staff should never make substantive changes to a report after it has been adopted by the Commission without a Commission vote to accept those changes.

[45] When the Report says these studies compare gay men to "similarly qualified heterosexual males" it means that they controlled for things like whether the individuals covered in the study had a high school diploma, some college, a college degree or advanced degree and whether they reside in a metropolitan area. The studies also attempt roughly to control for broad job categories. Only then do the numbers begin to suggest that gay men might be "underpaid" relative to heterosexual men.

But the qualifications controlled for are far too rough to be fair. Not all college degrees are equal. An electrical engineering or computer science degree will ordinarily result in a much higher starting salary than a degree in psychology or communications.

Similarly, the efforts to control for job category are rudimentary. For example, one article divided up individuals into "executive," "specialist," "low-skilled workers," and "everyone else." Nathan Berg & Donald Lien, Measuring the Effect of Sexual Orientation on Income: Evidence of Discrimination?, 20 Contemp. Econ. Pol'y 394 (2002)(Berg & Lien also controlled for race, experience, experience squared, union membership, region of the country, urban status and educational attainment). *See also* John M. Blandford, The Nexus of Sexual Orientation and Gender in the Determination of Earnings, 56 Indus. & Lab. Rel. Rev. 622, 638-39 (2003)(making the point that controls for job category are rudimentary in these studies).

[46] Curiously, the Report does not cite the actual studies it (indirectly) is referring to. Rather, it cites an article that attempts to summarize those studies. Rep. at 14, n.70 (citing M.V. Lee Badgett, Holming Lau, Brad Sears, Deborah

seem to some to indicate discrimination. But a closer examination shows that things are much more complicated.[47]

The Report's sin is one of omission. First of all, it fails to make clear that comparisons between lesbians and heterosexual women run strongly in the opposite direction: ***On average, lesbians substantially out-earn heterosexual women.*** Instead, the Report states only that several studies "*show that lesbian or bisexual women* ***do not earn less*** *than heterosexual women*." Rep. at 50 (boldface added).

For example, in *The Nexus of Sexual Orientation and Gender in the Determination of Earnings*, among full-time workers, the median income for Lesbian/Bisexual women was almost 18% more than that for married or unmarried women.[48] Similarly, *An Investigation into Sexual Orientation Discrimination as an Explanation for Wage Differences* found "women living with partners of the same sex tend to have higher earnings than otherwise similar women."[49] *The Earnings Effects of Sexual Orientation* came to a similar conclusion—that lesbian/bisexual orientation is associated with about a 20% wage premium.[50] There is no shortage of such studies.[51] In *Measuring the Effect*

Ho, Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination, Williams Institute (June 2007), *available at* https://williamsinstitute.law.ucla.edu/research/discrimination/bias-in-the-workplace-consistent-evidence-of-sexual-orientation-and-gender-identity-discrimination/.

[47] Gay men are more likely to have college and advanced degrees than heterosexual men. In addition, gay men are more likely to live in metropolitan areas, where wage scales are higher (and living expenses are also higher). *See, e.g.*, Christopher Carpenter, Samuel Eppink, Does it Get Better? Recent Estimates of Sexual Orientation and Earnings in the United States, *available at* http://onlinelibrary.wiley.com/doi/10.1002/soej.12233/full. The studies referred to by the Report attempt to control for these factors. Some early surveys found that gay men out-earn heterosexual men when such factors are not controlled for. *See, e.g.*, Steve Teichner, Results of Polls, San Francisco Examiner A-19 (June 6, 1989).

[48] John M. Blandford, The Nexus of Sexual Orientation and Gender in the Determination of Earnings, 56 Indus. & Lab. Rel. Rev. 622, 633 (2003). Comparisons are between full-time workers.

[49] Suzanne Heller Clain & Karen Leppel, An Investigation into Sexual Orientation Discrimination as an Explanation for Wage Differences, 33 Applied Econ. 37 (2001). Heller & Leppel noted that Badgett came to the opposite conclusion in 1995 (*i.e.* that lesbian and bisexual women earned less than heterosexual women). They state, however, that Badgett's "finding was not consistently statistically significant across specifications" and that "Badgett's sample included only 34 (4.9%) lesbian or bisexual women, . . . so insignificant results are not surprising." *Id.* at 37. *See* M.V. Lee Badgett, The Wage Effects of Sexual Orientation Discrimination, 48 Indus. & Lab. Rel. Rev. 726 (1995).

[50] Dan A. Black, Hoda R. Makar, Seth G. Sanders & Lowell J. Taylor, The Earnings Effects of Sexual Orientation, 56 Indus. & Lab. Rel. Rev. 449, 463 (2003)("Lesbian/bisexual orientation appears to raise earnings of women by about 20%, a result that is both economically and statistically significant"). Comparisons are between full-time workers. "While gays and lesbians had levels of education similar to those of their heterosexual counterparts, they were half as likely to be married, they were more likely to live in the West and Northeast, and they were more likely to live in large cities. Following Badgett, we use regression analysis to control for these background differences." *Id.* at 452.

[51] *See* Christopher S. Carpenter, Self-Reported Sexual Orientation and Earnings: Evidence from California, 58 Indus. & Lab. Rel. Rev. 258, 263 (2005)("[L]esbian full-time workers report higher average earnings last month ($3,816) than do female unmarried bisexuals ($3,247), married bisexuals ($3,329), unmarried heterosexuals ($3070), or married heterosexuals ($3,631)"). This California-based study had interesting results for men too: Gay men earned more than heterosexual men. The authors wrote: "Among full-time working men, married straight men report the highest average earnings last month, $5,207, followed by gay men ($4,504), bisexual married men ($4,076), unmarried straight men ($3,518), and unmarried bisexual men ($3,382)." *Id.* at 263. But if one combines the heterosexual married men (n=8,810) and heterosexual unmarried men (n=7,158) categories, one gets an average

of Sexual Orientation on Income: Evidence of Discrimination?, the authors found that lesbians, on average, earn more than 30% more than heterosexual women.[52]

Why is that important? The data on lesbian earnings put the data on gay men's earnings in an entirely different light. The Report asks us to take a leap of logic. It tries to suggest that if, once certain basic credentials are controlled for, heterosexual men earn more than gay men, then it must be because of discrimination against gay men. But if lesbians substantially out-earn heterosexual women after such rudimentary controls are put into place, ***there needs to be an explanation for why. If we are to assume adjusted wage disparities prove gay men are being discriminated against, employers discriminate against gay men, then why don't we assume that employers are discriminating in favor of lesbians?*** The most logical explanation for all this is that the initial premise is wrong and that there is a lot more going on with these numbers than discrimination. Indeed, discrimination may not be playing any role at all.

The Report paraphrases Badgett et al. for its attempt at an explanation for why lesbians, in the Report's language "do not earn less than heterosexual women":

> Badgett et al., argue that this does not imply the absence of employment discrimination. They argue that these findings suggest that since lesbians may not be constrained by the same gender expectations that result from being in relationships with men, they may make different decisions than heterosexual women (*e.g.* choosing to delay or not have children, invest more into training, go into male-dominated professions) which may hide effects of discrimination.

Report at 48.

Well, yes, of course. But the Report doesn't seem to realize it has given away the store. Just as lesbians may make different career choices, so might gay men. They may choose a career in nursing instead of a career in mechanical engineering. They may choose not to work overtime in order to earn the money necessary to put a down payment on a five-bedroom house that will fit the children. They may choose to engage in a high-risk entrepreneurial activity—like opening a new restaurant—because they don't expect to be having to support a family in the near future. Just as the fact that lesbians earn more than heterosexual women doesn't eliminate the possibility that they have been discriminated against, the fact the gay men earn less (at least after rudimentary

---

income for heterosexual men of $4,450, which is less than the income for gay men (although greater than the income for the two bisexual categories).

[52] Nathan Berg & Donald Lien, Measuring the Effect of Sexual Orientation on Income: Evidence of Discrimination?, 20 Contemp. Econ. Pol'y 394 (2002). *See also* Christopher S. Carpenter & Samuel T. Eppink, Does It Get Better?: Recent Estimates of Sexual Orientation and Earnings in the United States, 84 Southern Econ. J. 426, 426 (2017)(calling the finding that self-identified lesbians earn significantly more than comparable heterosexual women "well-documented" and reproducing that finding yet again).

controls are used) doesn't prove they have been discriminated against. There can be lots of other explanations.

If we want to understand the situation, we need to be looking at the different jobs that gay and heterosexual men are undertaking. There is certainly evidence gay men are disproportionately attracted to certain jobs. "Numerous scholars have noted the disproportionately high number of gay and lesbian workers in certain occupations" and that "common to both gay men and lesbians is a propensity to concentrate in occupations that provide task independence or require social perceptiveness, or both."[53]

We also need to be looking at differences in college major choice. It is not easy to come up with solid empirical data on the differences in college major choices between gay and heterosexual men. But there is lots of data about the differences in college major choices between women and men. For example, according to the American Enterprise Institute, electrical engineering majors (82% of whom are male) can expect to earn an average of $70,000 in their first 5 years of work. By contrast, psychology majors (only 23.3% of whom are male) can expect only $42,000.[54] Given these differences, it would be surprising if gay and heterosexual men made precisely the same college major choices.[55]

In addition, we need to know which households are rearing children. Who has primary responsibility for providing monetary support for children and who doesn't? Who has primary responsibility for providing direct supervision for children?

The kind of information necessary to undertake such a study is hard to come by. But that is why President Eisenhower and the 85th Congress established the Commission in the first place—in order to conduct research on civil rights issues that otherwise might not get undertaken. Instead of conducting that research, the Commission chose to simply present other people's research on income disparities without proper context.

Here is what John Blandford had to say on the subject in *The Nexus of Sexual Orientation and Gender in the Determination of Earnings* (a study that found both that gay/bisexual men are paid

---

[53] Andras Tilcsik, Michel Anteby, and Carly R. Knight, "Concealable Stigma and Occupational Segregation: Toward a Theory of Gay and Lesbian Occupations, 60 Administrative Science Quarterly 446 (2015), *available at* http://www.michelanteby.net/files/manteby/files/concealable_stigma.pdf. Although Tilcsik et al. argue that bias against gays does influence these preferences—*e.g.* people who are concerned about being discriminated against are more likely to prefer occupations where they are often able to work independently—the mechanism described in their study is more complex than simple "discrimination drives gays out of certain jobs."

[54] Mark J. Perry, Highest-Paying College Majors, Gender Composition of Students Earning Degrees in those Fields and the Gender Pay Gap, American Enterprise Institute (October 19, 2016), *available at* http://www.aei.org/publication/highest-paying-college-majors-gender-composition-of-students-earning-degrees-in-those-fields-and-the-gender-pay-gap/.

[55] I am not aware of any claims that major choices of gay and heterosexual males are identical. But most of the discussions of the issue involve at least in part informal observations. *See* Manil Suri, Why Is Science So Straight?, N.Y. Times (September 4, 2015).

less than heterosexual men and that lesbian/bisexual women are paid more than heterosexual women):

> The evidence described in this study strains the credibility of the argument that measured wage differentials between heterosexual workers and gay, lesbian, and bisexual workers are owing solely to workplace attitudes about homosexuality. Defending that explanation would require explaining how workplace attitudes could penalize non-heterosexual male workers while simultaneously awarding lesbian and bisexual female workers with a substantial premium. Certainly, workplace attitudes toward sexual orientation may have a gender component; that is, bias against homosexuality and bisexuality may be more strongly expressed against persons of one gender than of another. Nonetheless, it seems unlikely that the wage effects would differ in sign rather than merely in magnitude.
>
> A more probable explanation for the disparate earnings effects of sexual orientation across genders may be found in treating workplace bias as but one orientation-related factor influencing earnings outcomes. Workplace bias that might negatively affect the wages of lesbian and bisexual women appears to be offset by other labor market factors. Most influential among these factors are subtle occupational clustering effects not adequately captured by the two-digit controls in this study or by the one-digit controls employed elsewhere (Badgett 1995). Case-level analysis of occupational patterns associated with sexual orientation points to trends that are both highly nuanced and gender-specific, suggesting that parameter estimates may over-estimate the direct effect of orientation on earnings. Lesbian and bisexual women are revealed to be unusually successful in gaining employment in largely male-dominated—and typically better-remunerated—occupational categories. For gay and bisexual men, in contrast, over-representation in female-identified occupations likely further depresses returns to human capital attributes relative to other male workers.[56]

There are further anomalies in the literature that should give pause those who would rush to judgment about the prevalence of discrimination. For example, among heterosexual males, married men, cohabiting men, and single men have been repeatedly shown to earn very different wages, with married men far outdistancing cohabiting men who in turn do better than single men.[57] And this is true even when age (or years of work experience) and other factors are controlled for. Yet few argue that the differences are caused by discrimination.

---

[56] John M. Blandford, The Nexus of Sexual Orientation and Gender in the Determination of Earnings, 56 Indus. & Lab. Rel. Rev. 622, 638-39 (2003).

[57] *See, e.g.*, Sylvia A. Allegretto & Michelle M. Arthur, An Empirical Analysis of Homosexual/Heterosexual Male Earnings Differentials: Unmarried and Unequal?, 54 Indus. & Lab. Rel. Rev. 631 (2001)(finding that gay men in unmarried partnered relationships earn on average 15.6% less than otherwise similar married heterosexual men, but the come in only 2.4% lower than otherwise similar unmarried partnered heterosexual men); Donna K. Ginther & Madeline Zavodny, Is the Male Marriage Premium Due to Selection?: The Effect of Shotgun Weddings on the Return to Marriage, 14 J. Population Econ. 313 (2001); Sander Korenman & David Neumark, Does Marriage Really Make Men More Productive?, 26 J. Human Res. 282 (1991).

The premium for married men over single or co-habiting men is comparable to the gap between gay and heterosexual men. Yet no one has ever suggested that the reason is that employers are discriminating against co-habiting men or single men. The actual reasons are likely more complex. Among them we might find the following: (1) High-income men have an easier time finding women willing to marry them; (2) The same attributes that are conducive to success in creating and maintaining stable relationships at home are also conducive to success in one's professional life and; (3) Men who have or plan to have children are more likely to seek out higher paying jobs and work long hours to support them rather than seek out the jobs they find most interesting or spend their extra time at leisure activities.

Finally, it is important to point out that the most recent empirical studies on income disparities between gay and heterosexual men have been turning out very different from the studies cited in the article that the Report cites for its conclusion that "on average gay men earn from 10 to 32 percent less than similarly qualified heterosexual males." Indeed, the most recent empirical study of which I am aware—*Does It Get Better?: Recent Estimates of Sexual Orientation and Earnings in the United States*—comes to precisely the opposite conclusion: ***Gay men employed full time on average earn almost 10% more than comparable heterosexual men***. [58]

The findings of that study—conducted by Christopher Carpenter and Samuel T. Eppink—are broadly consistent with some other recent research. For example, in *The Disappearing Gay Income Penalty*, Geoffrey Clarke and Purvi Sevak examined data from the National Health and Nutrition Examination Surveys (NHANES) from 1988 to 2007.[59] They found that while men who reported same-sex sexual activity had lower household income than otherwise similar heterosexual men during the earlier part of the time frame they examined, by the end of that time frame the situation was reversed with the average gay man's earnings topping those of similar heterosexual men. Similarly, Marieka Klawitter's meta-analysis of all published studies on sexual orientation and earnings indicated that both the lesbian premium and gay male penalty were decreasing over time.[60]

One possible explanation for the disappearing wage penalty for gay men is that the stigma associated with being gay. As Carpenter & Eppink put it:

---

[58] This finding was significant at 5%. Christopher S. Carpenter & Samuel T. Eppink, Does It Get Better?: Recent Estimates of Sexual Orientation and Earnings in the United States, 84 Southern Econ. J. 426, 432, tbl. 2 (2017). The authors were working with a database in which individuals had self-identified as either gay, bisexual, other sexual orientation, do not know sexual orientation, or heterosexual, had refused the sexual orientation question, or the sexual orientation information was missing from the data. They controlled for the month of the year in which the answers were given. They also controlled for age and its square, race, Hispanic ethnicity, level of educational attainment, relationship status, young children in the household, older children in the household, region of the country, number of years on the job and its square, firm size, and sector of employment. They also used 26 industry dummies and 26 occupation dummies.

[59] Geoffrey Clarke & Purvi Sevak, The Disappearing Gay Income Penalty, 121 Econ. Letters 542 (2013).

[60] Marieka Klawitter, Meta-Analysis of the Effects of Sexual Orientation on Earnings, 54 Indus. Rel.: J Econ. & Soc'y 4 (2015)(analyzing all such studies up until 2012).

> Improved attitudes toward the lesbian, gay, bisexual, and transgender (LGBT) communities have been some of the most striking and rapid social changes in the United States in the past several decades. These improved attitudes are perhaps most evident in the well-documented shift in public attitudes regarding same-sex marriage: The proportion of adults in the United States who favored same-sex marriage increased from 35 to 55% from 2001 to 2016, the year after the U.S. Supreme Court granted nationwide legal access to same-sex marriage in *Obergefell v. Hodges* in 2015. And historical data from the General Social Survey suggest that these shifts in attitudes began in the early 1990s: while in 1991 fully 72% of adults considered homosexual behavior "always wrong," the associated share reporting this view in 2010 fell to 44%. The share of adults saying homosexual behavior was "not wrong at all" increased over this same period from 14 to 41%.[61]

Ultimately, however, Carpenter & Eppink express doubt that changing attitudes is what is behind their result. They point out that changing attitudes might be expected to decrease the "penalty" for gay men's earnings, but it is not clear why it would produce a premium or why gay men would continue to have lower employment rates than heterosexual men. In addition, changing attitudes would be expected to help lesbians too (by increasing the premium they have over heterosexual women). Yet the findings in the article are instead that the premium has continued at pretty much the same level.[62]

---

[61] Carpenter & Eppink at 426.
[62] Carpenter & Eppink at 436.

Rebuttal of Commissioner Peter Kirsanow

Commissioner Yaki writes: "Our nation's LGBT population has a vulnerability unique among all those ***whom the Commission is mandated to protect***: it is the only class ***under our jurisdiction*** which lacks the shelter of at least one powerful, civilian, federal statutory protection."[1]

This is wrong. LGBT matters as such are not within the Commission's jurisdiction, which is one reason the Commission had not examined this issue before. The Commission's authorizing statute provides, "The Commission shall investigate allegations in writing under oath or affirmation relating to deprivations—because of color, race, religion, sex, age, disability, or national origin; or as a result of any pattern or practice of fraud; of the right of citizens of the United States to vote and have votes counted".[2] Sexual orientation or gender identity are nowhere mentioned. I understand that my colleagues think this is an important issue that needs to be addressed.[3] Fair enough. But it is not within our jurisdiction.[4]

Constitutional and Secular Concerns Regarding ENDA

It is indisputable that some individuals hold positions regarding LGBT issues out of pure animus. It is also indisputable that there is no system equivalent to Jim Crow that is designed to prevent LGBT people from participating in society. The Commission majority's findings testify to this fact:

> It has not been difficult for some private companies to adopt and implement workplace policies or practices that prohibit discrimination on the basis of sexual orientation and/or gender identity. As of 2016, 92 percent of Fortune 500 companies included sexual orientation and 82 percent included gender identity in their equal employment opportunity policies. Businesses that support these policies note such practices are beneficial to their businesses by attracting the most qualified workforce and increasing productivity.[5]

Had such an overwhelming majority of companies voluntarily adopted similar policies regarding race in 1964, passage of Title VII of the 1964 Civil Rights Act would have been far less

---

[1] Statement of Commissioner Yaki at 90.

[2] 42 U.S.C. § 1975a.

[3] Statement of Commissioner Karen Narasaki at851 ("international human rights laws complement and reinforce our nation's laws by recognizing that 'all human beings are born free and equal in dignity and rights' and therefore LGBT people are entitled to the numerous protections afforded by human rights laws, including the right to be free from discrimination."). It doesn't really matter what international human rights laws say. We are the *Civil* Rights Commission, not the *Human* Rights Commission, and our jurisdiction extends only to the *civilly*-recognized rights listed in our originating statute.

[4] Before Commissioner Yaki cites *Pricewaterhouse* and "sexual orientation discrimination as sex-stereotyping discrimination" to me, *see* discussion of *Pricewaterhouse*, *infra* at 141-43.

[5] Commission Findings at 76; *see also* Statement of Commissioner David Kladney at 83-84.

consequential. Indeed, if EEO policies had so abounded in the early Sixties, passage of Title VII may not have been a legislative imperative. As Roger Clegg from the Center for Equal Opportunity stated in his testimony, it actually is unclear whether Congress has the constitutional authority to prohibit discrimination on the basis of sexual orientation or gender identity. But then, constitutionality seems an increasingly trivial impediment to government action. Congress had the authority to enact the 1964 Civil Rights Act because discrimination against African-Americans was pervasive and, in significant parts of the country, inescapable.[6] LGBT discrimination is not comparable to the pervasive racial discrimination that prompted and gave constitutional authority to passage of the 1964 Civil Rights Act.

My colleagues appear to hold that Title VII ought to evolve into a "general civility code," which the Supreme Court sought to avoid in its decision in *Oncale v. Sundowner*.[7] The Supreme Court cautioned in *Oncale* that any sex-discrimination claims brought under Title VII must be ***because of*** sex, and that "We have never held that workplace harassment, even harassment between men and women, is automatically discrimination because of sex merely because the words used have sexual content or connotations."[8] The report approvingly cites an EEOC decision that a transgender individual was discriminated against on the basis of her sex because coworkers continued to address her using masculine pronouns.[9] The problem with determining that this is discrimination on the basis of sex is the person's sex is *literally* male. It may be a breach of decorum, sensibility, civility, and good manners to refer to the person using masculine pronouns, but it is not *sex* discrimination.

The EEOC and some courts have claimed that discrimination against transgender individuals is sex discrimination prohibited by the "sex stereotyping" interpretation of Title VII, because "A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes."[10] If a person is protected by the sex stereotyping theory, it is because he or she supposedly is not conforming to gender stereotypes. For example, a man wearing makeup and a dress or a woman taking testosterone to grow a beard do not conform to gender stereotypes. But a woman would not be transgressing gender stereotypes by wearing a dress, and a man would not be transgressing gender stereotypes by growing a beard.[11] So it cannot perforce

---

[6] Written Statement of Roger Clegg at 2-3.

[7] *Oncale v. Sundowner Offshore Services, Inc.*, 523 U.S. 75 (1998).

[8] *Id.* at 80. This is also strong evidence that my colleagues are wrong in interpreting our jurisdiction over sex discrimination as encompassing discrimination on the basis of sexual orientation and gender identity.

[9] *Bost v. Sam's East, Inc.*, Charge No. 430-2014-01900 (E.E.O.C. 2017), at http://transgenderlegal.org/media/uploads/doc_729.pdf.

[10] *Macy v. Holder*, 2012 WL 1435995 (E.E.O.C. 2012), at 9, *quoting Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011).

[11] *See E.E.O.C. v. R.G. & G.R. Funeral Homes, Inc.*, 201 F.Supp.3d 837, 840 (E.D.Mich. 2016).

(a) The EEOC claims the Funeral Home fired Stephens for failing to conform to the masculine gender stereotypes expected as to work clothing and that Stephens has a Title

be discrimination on the basis of sex to refer to a transgender person by the name or pronouns of his or her birth sex, when the only reason this person purportedly is protected by Title VII is because the person is not conforming to gender stereotypes.[12] We are in a wilderness of mirrors.

All of this reveals that it would be helpful for the Supreme Court to revisit *Pricewaterhouse v. Hopkins*, and possibly *Oncale v. Sundowner*. In recent years, *Pricewaterhouse* has been used by the EEOC and some courts to attempt to transform sexual orientation and gender identity into protected classes.[13] Abuses of authority by federal agencies are by this time unremarkable, as is judicial activism. The fact that some courts are now discovering that transgenderism is encompassed within Title VII and Title IX[14] should alert everyone that they are legislating from the bench.[15]

> VII right *not to be subject to gender stereotypes* in the workplace. Yet the EEOC has not challenged the Funeral Home's sex-specific dress code, that requires female employees to wear a skirt-suit and requires males to wear a pants-suit with a neck tie. Rather, the EEOC takes the position that Stephens has a Title VII right to "dress as a woman" (*i.e.*, dress in a stereotypical feminine manner) while working at the Funeral Home, in order to express Stephens's gender identity. If the compelling interest is truly in eliminating gender stereotypes, the Court fails to see why the EEOC couldn't propose a gender-neutral dress code as a reasonable accommodation that would be a *less restrictive* means of furthering that goal under the facts presented here. But the EEOC has not even discussed such an option, maintaining that Stephens must be allowed to wear a skirt-suit in order to *express* Stephens's gender identity. If the compelling governmental interest is truly in *removing or eliminating* gender stereotypes in the workplace in terms of clothing (*i.e.*, making gender "irrelevant"), the EEOC's chosen manner of enforcement in this action does not accomplish that goal.

[12] As the Eastern District of Michigan has noted, this is because "As a practical matter, the EEOC . . . has been proceeding as if gender identity or transgender status is a protected class under Title VII," when this is most assuredly not the case. *E.E.O.C. v. R.G. & G.R. Funeral Homes, Inc.*, 201 F.Supp.3d 837, 860 (E.D. Mich. 2016).

[13] *Fabian v. Hospital of Central Conn.*, 172 F.Supp.3d 509, 522-23 (D.Conn. 2016)("The acknowledgement in *Price Waterhouse* that discrimination by means of gender stereotyping is discrimination 'because of sex' under Title VII eventually led to a significant shift in the direction of decisions examining alleged discrimination on the basis of transgender identity.").

[14] *Johnston v. Univ. of Pittsburgh of Com. System of Higher Educ.*, 97 F.Supp.3d 657, 674 (W.D.Penn. 2015)("nearly every federal court that has considered the question in the Title VII context has found that transgendered individuals are not a protected class under Title VII.").

[15] Former Judge Richard Posner at least had the honesty to admit that this is what judges are doing when they transform sexual orientation and gender identity into protected characteristics. *Hively v. Ivy Tech Com. Coll. of Ind.*, 853 F.3d 339, 357 (7th Cir. 2017)(Posner, J., concurring).

> (b) The majority opinion states that Congress in 1964 "may not have realized or understood the full scope of the words it chose." This could be understood to imply that the statute forbade discrimination against homosexuals but the framers and ratifiers of the statute were not smart enough to realize that. I would prefer to say that theirs was the then-current understanding of the key word—sex. "Sex" in 1964 meant gender, not sexual orientation. What the framers and ratifiers understandably didn't understand was how attitudes toward homosexuals would change in the following half century. They shouldn't be blamed for that failure of foresight. *We* understand the words of Title VII differently not because we're smarter than the statute's framers and ratifiers but because we live in a different era, a different culture. Congress in the 1960s did not foresee the sexual

If my colleagues are correct that these policies are both easy to implement and beneficial to the bottom line, most companies will adopt these policies in short order. Many have.

But they should not be compelled into doing so by judges contorting the plain text of the law to include classifications not set forth by Congress, and by federal agencies that rewrite laws through regulations and subregulatory guidance.[16]

LGBT As A Defined Class

My colleagues and the report repeatedly refer to "LGBT" as a class. In the report and often in public discourse, there is no differentiation between the four groups. Perhaps there is no rational basis for differentiation. But the report seems to make a presumption, unsupported by any empirical analysis whatsoever, that employment and workplace considerations applicable to lesbians are identical to those applicable to gays are identical to those applicable to bisexuals are identical to those applicable to transsexuals. Yet if Congress were to pass ENDA-like legislation, there is a reasonable likelihood the four different groups would not be treated as one indistinguishable mass.

Religious Liberty Concerns Regarding ENDA

There are many people who bear no ill-will toward LGBT persons as persons, but who also, for religious reasons, and in good faith, disagree with the choice to engage in a same-sex relationship or to present as a sex other than their birth sex.[17] Religious liberty will be diminished and

---

revolution of the 2000s. What our court announced in *Doe v. City of Belleville*, 119 F.3d 563, 572 (7th Cir. 1997), is what Congress had declared in 1964: "the traditional notion of 'sex.' "

(c) I would prefer to see us acknowledge openly that today we, who are judges rather than members of Congress, are imposing on a half-century-old statute a meaning of "sex discrimination" that the Congress that enacted it would not have accepted. This is something courts do fairly frequently to avoid statutory obsolescence and concomitantly to avoid placing the entire burden of updating old statutes on the legislative branch. *We should not leave the impression that we are merely the obedient servants of the 88th Congress (1963–1965), carrying out their wishes. We are not.* We are taking advantage of what the last half century has taught. [emphasis added]

[16] Commissioner Heriot has written persuasively that Title IX's prohibition on sex discrimination does not encompass gender identity. It is even less likely that Title VII includes a prohibition on gender identity discrimination. The Americans with Disabilities Act explicitly excludes transgenderism from its coverage. *See Johnson v. Fresh Mark*, 337 F.Supp.2d 996, 1001 (N.D. Ohio 2003), *quoting* 42 U.S.C. § 12211(b)(1).

[17] Russell Moore, "What the Transgender Debate Means for the Church," RussellMoore.com, Feb. 23, 2017 (Dr. Moore is the President of the Southern Baptist Convention's Ethics & Religious Liberty Commission), http://www.russellmoore.com/2017/02/23/transgender-debate-means-church/; "USCCB Committee Chairmen Applaud the Repeal of 'Dear Colleague Letter on Transgender Students," U.S. Conference of Catholic Bishops, Feb. 24, 2017 ("Pope Francis has taught that 'biological sex and the socio-cultural role of sex (gender) can be distinguished but not separated' (Amoris Laetitia, no. 56)"), http://www.usccb.org/news/2017/17-045.cfm; *E.E.O.C. v. R.G. & G.R. Funeral Homes, Inc.*, 201 F.Supp.3d 837, 848 (E.D.Mich. 2016)("It is also undisputed that Rost sincerely believes that the "Bible teaches that a person's sex (whether male or female) is an immutable God-given gift and that it is wrong for a person to deny his or her God-given sex." . . . Rost believes that he "would be violating

vulnerable if Congress enacts ENDA or similar legislation. The Commission says in its recommendations:

> The Commission strongly supports religious freedom and nondiscrimination on the basis of religion. Title VII offers a workable model for protecting religious freedom in the context of federal statutory nondiscrimination protections in the workplace. In *Hosanna-Tabor Evangelical Lutheran Church and School v. Equal Employment Opportunity Commission* the Supreme Court also unanimously endorsed the common law ministerial exemption, which recognizes the right of religious groups to select their own ministers and clergy. No further expansion of exceptions to nondiscrimination protections in the workplace are necessary or warranted to balance the rights to freedom of religion and to nondiscrimination on the bases either of religion or LGBT status.

My colleagues' individual statements suggest that "strongly supports" may be overstating the matter a bit. The Chair refers to concerns over conflicts between religious liberty and nondiscrimination as "the fallacy of that putative conflict"—before stating:

> A teacher's decision to tell a devout Catholic girl she would go to hell for dating another girl lowlights the error in the assumption that LGBT persons are not simultaneously persons of faith—and underscores the distinct (and in our system of laws profoundly unconstitutional) harm that privileging one understanding of faith over another can visit on people. The teachers and administrators at that school were and are free to disapprove of same sex relationships, and even of the status of being LGBT, on religious or other bases; they were and are not, however, free to act on that disapproval in ways that harmed the students as people or as learners. Likewise in an employment context, our laws should protect LGBT employees from discrimination while also protecting all of our religious freedom.[18]

The school to which Chair Lhamon refers is a public school.[19] I see nothing in her statement, however, that suggests that she would see the matter differently if it were at a private religious school. In his statement, Commissioner Yaki attacks recent guidance from the Attorney General, describing it as "rid[ing] the Hobby Lobby toboggan as it boldly careens down a slippery slope declaring—in the apparent absence of statutory or judicial authority—'RFRA protects the exercise of religion by individuals and by corporations, companies, associations, firms, partnerships, societies, and joint stock companies.'"[20]

God's commands" if he were to permit one of the Funeral Home's male funeral directors to wear the skirt-suit uniform for female directors while at work because Rost "would be directly involved in supporting the idea that sex is a changeable social construct rather than an immutable God-given gift.").

[18] Statement of Chair Catherine Lhamon at 81.

[19] ACLU of Southern California Stands Up for Gay and Lesbian High School Students Harassed by School Officials on Basis of Sexual Orientation, ACLU of Southern California, Oct. 28, 2004, https://www.aclusocal.org/en/news/aclu-southern-california-stands-gay-and-lesbian-high-school-students-harassed-school-officials.

[20] Statement of Commissioner Yaki at 104 (quoting U.S. Department of Justice Memorandum at 4).

Commissioner Yaki contends that the Attorney General's interpretation is not based in statutory or judicial authority. Apparently it escaped Commissioner Yaki's notice that Justice Alito's analysis in *Hobby Lobby* ***begins*** with settling RFRA's definition of a "person":

> RFRA applies to "a person's" exercise of religion, 42 U.S.C. §§ 2000bb-1(a), (b), and RFRA itself does not define the term "person." We therefore look to the Dictionary Act, which we must consult "[i]n determining the meaning of any Act of Congress, unless the context indicates otherwise." 1 U.S.C. § 1.
>
> Under the Dictionary Act, "the wor[d] 'person' . . . Include[s] corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals. *Ibid; see FCC v. AT & T Inc.*, 131 S.Ct. 1177, 1182-1183(2011)('We have no doubt that 'person,' in a legal setting, often refers to artificial entities. The Dictionary Act makes that clear"). Thus, unless there is something about the RFRA context that "indicates otherwise," the Dictionary Act provides a quick, clear, and affirmative answer to the question whether the companies involved in these cases may be heard.
>
> We see nothing in RFRA that suggests a congressional intent to depart from the Dictionary Act definition, and HHS makes little effort to argue otherwise. We have entertained RFRA and free-exercise claims brought by nonprofit corporations, *see Gonzales v. O Centro Espírita Beneficente Uniao do Vegetal*, 546 U.S. 418 (2006) (RFRA); *Hosanna-Tabor Evangelical Lutheran Church and School v. EEOC*, 132 S.Ct. 694 (2012) (Free Exercise); *Church of the Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520 (1993) (Free Exercise), and HHS concedes that a nonprofit corporation can be a "person" within the meaning of RFRA. *See* Brief for HHS in No. 13–354, at 17; Reply Brief in No. 13–354, at 7–8.
>
> This concession effectively dispatches any argument that the term "person" as used in RFRA does not reach the closely held corporations involved in these cases. No known understanding of the term "person" includes *some* but not all corporations. The term "person" sometimes encompasses artificial persons (as the Dictionary Act instructs), and it sometimes is limited to natural persons. But no conceivable definition of the term includes natural persons and nonprofit corporations, but not for-profit corporations.[20] *Cf. Clark v. Martinez*, 543 U.S. 371, 378, 125 S.Ct. 716, 160 L.Ed.2d 734 (2005) ("To give th[e] same words a different meaning for each category would be to invent a statute rather than interpret one"). [citations omitted]

In other words, the Attorney General's definition of a "person" has *both* statutory and judicial support. It is taken verbatim from the Dictionary Act, which the Supreme Court stated in Hobby Lobby provided the correct definition of "person" in RFRA.

If this is what the Commission majority thinks when it is in strong support of religious freedom, I hate to think what it thinks in its less sanguine moments. Title VII provides:

> Notwithstanding any other provision of this subchapter, (1) it shall not be an unlawful employment practice for an employer to hire and employ employees, for

> an employment agency to classify, or refer for employment any individual, for a labor organization to classify its membership or to classify or refer for employment any individual, or for an employer, labor organization, or joint labor-management committee controlling apprenticeship or other training or retraining programs to admit or employ any individual in any such program, on the basis of his religion, sex, or national origin in those certain instances where religion, sex, or national origin is a *bona fide* occupational qualification reasonably necessary to the normal operation of that particular business or enterprise, and (2) it shall not be an unlawful employment practice for a school, college, university, or other educational institution or institution of learning to hire and employ employees of a particular religion if such school, college, university, or other educational institution or institution of learning is, in whole or in substantial part, owned, supported, controlled, or managed by a particular religion or by a particular religious corporation, association, or society, or if the curriculum of such school, college, university, or other educational institution or institution of learning is directed toward the propagation of a particular religion.[21]

Title VII's protections for religious liberty require a painstaking case-by-case examination of the circumstances surrounding each claim.[22] Although the exact contours of Title VII's religious employer exemption are disputed, in some circumstances it is interpreted to apply only to cases of discrimination on the basis of religion, not discrimination on the basis of another protected characteristic that is motivated by a religious belief.[23] Under this narrow construction, a Catholic school could fire a teacher who left the Catholic faith, but could not fire a teacher who entered into a civil same-sex marriage if that teacher continued to maintain that she was a member of the Catholic faith. This appears to be what is contemplated by Professor Alan Brownstein, who explained in his written statement, "[T]he Title VII amendment permitting religious discrimination in hiring cannot justify discrimination on the basis of other characteristics prohibited by Title VII, such as race or gender. . . . Pursuant to this understanding, religious organizations operated by faiths whose beliefs condemn homosexual conduct could not discriminate against gay or lesbian job applicants on the ground that the very conduct of such individuals which identified them as members of a protected class violated the dictates of the employer's faith."[24]

---

[21] 42 U.S.C. § 2000e-2(e).

[22] *Spencer v. World Vision, Inc.*, 633 F.3d 723, 729 (9th Cir. 2011)("In sum, when confronted with a section 2000e-1 case, *Townley* and *Kamehameha* require us to analyze, on a case-by-case basis, whether the 'general picture' of an organization is 'primarily religious,' taking into account '[a]ll significant religious and secular characteristics.'"); *E.E.O.C. v. Kamehameha Schools/Bishop Estate*, 990 *F.2d* 458, at n. 7 (9th Cir. 1993)("In view of the narrow reach of the § 2000e-1 exemption, it is not surprising that we have found no case holding the exemption to be applicable where the institution was not wholly or partially owned by a church.").

[23] *Herx v. Diocese of Fort Wayne-South Bend, Inc.*, 772 F.3d 1085, 1087 (7th Cir. 2014).

[24] Written Statement of Alan Brownstein at 3. It should be noted that the discrimination at issue is on the basis of behavior or conduct, not identity, status, or immutable characteristics.

There are no major faiths in the United States that include racial superiority as one of their tenets. There are likely some branches of major faiths that hold views regarding gender roles that are at odds with popular opinion.[25] The vast majority of Christians have no objections to married women working outside the home. Whether or not that would have occurred without federal interference is a fair question, and whether forcing churches to change their views regarding the roles of men and women is an appropriate exercise of governmental power is another.

This is the problem with only providing Title VII's religious exemption in an ENDA-like bill, even for religious employers. If the principal of a Catholic school fired a black Catholic school teacher because of her race, the principal's actions would not be in accord with the teaching of the Catholic Church. If the principal fired a teacher who entered into a same-sex marriage, even though the teacher claimed to be Catholic and knew that the Catholic Church teaches that same-sex marriage is not marriage at all, the principal would not be defying Catholic teaching. And the ability to fire teachers and other employees in these situations is important, because actions speak louder than words.[26] A divorced woman who remarries without receiving an annulment undercuts the Church's teaching that marriage is permanent.[27] An individual who is in a civil same-sex marriage undermines the Church's teaching regarding both the indispensability of a sacramental marriage and the necessity that the spouses be male and female. For the government to come into either case and insist that the school continue to employ the teacher because the teacher identifies as Catholic is an intrusion upon church discipline and an enervation of the faith. Perhaps, to avoid this, the Church can issue a formal excommunication to the employee, although even that is arguably not a declaration that the individual is not Catholic, but rather that he is a Catholic in bad standing. But perhaps the Church hopes to bring the individual to repent of his or her sins, and thus hesitates to impose the ultimate penalty. But the Church still cannot employ this person, because to do so appears to condone his or her *behavior* and thus cause scandal.[28] These are not questions into

---

[25] Popular opinion does not always proceed in the direction one would think or prefer, however. W. Bradford Wilcox and Samuel Sturgeon, "Why would millennial men prefer stay-at-home wives? Race and feminism.", Wash. Post, Apr. 5, 2017 ("the overall trend in the GSS and another survey, Monitoring the Future, is consistent with the idea that a growing minority of younger millennials hold a more traditional view on this male breadwinner-female homemaker item.").

[26] *See Herx v. Diocese of Ft.Wayne-South Bend Inc.*, 48 F.Supp.1168, 1177 (N.D. Ind. 2014).

> (d) Mrs. Herx contends that the Diocese's admission that it didn't renew her contract because she underwent in vitro fertilization treatments creates a triable fact issue as to sex discrimination because the only people who could be terminated for that reason are pregnant women and women trying to become pregnant. . . .According to Mrs. Herx, forbidding non-ministerial employees from undergoing in vitro fertilization discriminates against women because men don't (and can't) undergo the procedure.

[27] *See Little v. Wuerl*, 929 *F.2d* 944 (3rd Cir. 1991).

[28] The term "scandal" has a particular theological meaning within the Catholic Church. *See* CATECHISM OF THE CATHOLIC CHURCH, 2284, 2286, *available at* http://www.vatican.va/archive/ENG0015/_P80.HTM.

> (e) Scandal is an attitude or behavior which leads another to do evil. The person who gives scandal becomes his neighbor's tempter. He damages virtue and integrity; he may even

which the government may intrude, because the government is essentially substituting its own judgment regarding theology and morality for that of the Church. The government is arrogating to itself the authority to decide who is a Catholic in good standing, or a Southern Baptist, or a Jew.[29] This is similar to the New York legislature enacting a statute that transferred the administration of churches from the Russian Orthodox Church to an American metropolitan district.[30] The government is weighing in on an ecclesiastical dispute because it is politically aligned with one branch of the dispute.[31] That is impermissible.[32]

If the contraception mandate included in HHS's ACA-implementing regulations taught us anything, it demonstrated that efforts to make religious organizations and institutions violate their consciences quickly descend into hair-splitting examinations of exactly who is paying for what and where to draw the lines of complicity in what a religion considers sinful behavior.

We live in a time when the country is sharply divided along almost every line imaginable—politics, race, income, sex, religion, and anything that distinguishes one human being from another. It appears there may be no way to bridge many of these divides, because the differences of opinion go the heart of what one holds most dear. My colleagues' solution is for traditionalists to capitulate to secular imperatives, even giving up the modest First Amendment right to be politically incorrect or impolite by referring to someone by the pronouns associated with his birth sex rather than his preferred gender identity.[33] My solution is more modest: follow the Constitution.

> draw his brother into spiritual death. Scandal is a grave offense if by deed or omission another is deliberately led into a grave offense. . . .
>
> (f) Scandal can be provoked by laws or institutions, by fashion or opinion.

[29] *Little* at 948.

> (g) The *Maguire* case demonstrates the even graver dangers courts face when asked to rule on religious discrimination that does not follow clear denominational lines. In that sex discrimination case, a Catholic university claimed that it had refused to hire plaintiff as a theology professor because she held views on abortion that disqualified her from being a Catholic. The court properly decided that any scrutiny of that claim would violate both the free exercise and establishment clauses.

[30] *Kedroff v. St. Nicholas Cathedral of Russian Orthodox Church in North America*, 344 U.S. 94, 97-99 (1952).

[31] *Id.* at 109-110.

[32] *Id.* at 114-115 (quoting *Watson v. Jones*, 13 Wall 728-79 (1871)).

> (h) The right to organize voluntary religious associations to assist in the expression and dissemination of any religious doctrine, and to create tribunals for the decision of controverted questions of faith within the association, and for the ecclesiastical government of all the individual members, congregations, and officers within the general association, is unquestioned. All who unite themselves to such a body do so with an implied consent to this government, and are bound to submit to it. But it would be a vain consent and would lead to the total subversion of such religious bodies, if any one aggrieved by one of their decisions could appeal to the secular courts and have them reversed.

[33] *Bost v. Sam's East, Inc.*, Charge No. 430-2014-01900 (E.E.O.C. 2017), at http://transgenderlegal.org/media/uploads/doc_729.pdf.

[*This page intentionally left blank*]

Surrebuttal of Commissioner David Kladney

Commissioners Kirsanow and Heriot object to the idea that LGBT people deserve federal employment protections against employers targeting them for their orientation or gender identity. They claim such protections would be too burdensome for employers and are not needed because discrimination on the basis of sexual orientation or gender identity is not a pervasive problem. Commissioner Heriot has taken my words, that "discrimination [against LGBT persons] is wrong each and every time it happens" to mean I would support laws against any employment decision which is morally wrong but, in her words "idiosyncratic." Commissioner Kirsanow has taken my praise of the business community for voluntarily adopting LGBT protections to argue that no legal protections are needed. Finally, Commissioner Heriot has taken my note that businesses derive many benefits from government (for example, through using the corporate form) and it is therefore proper to hold them to account with nondiscrimination requirements to mean I would think it proper to impose my understanding of American values on every company.

I write simply to state that these arguments are quite obviously not the case. I see discrimination against LGBT persons as a pervasive, destructive problem. I do believe it is wrong in each instance, but we are far from a day when it could be said to be idiosyncratic. I find it impossible that a fair observer of our society could come to the conclusion that LGBT persons are not systematically disadvantaged in ways heterosexual people are not. The report speaks for itself in cataloguing the existing literature on employment discrimination, but should these existing statistics not be sufficient for Commissioners Heriot and Kirsanow, I suggest they indicate their strong support for the Commission's recommendation: "Workplace discrimination data should be collected through the inclusion of sexual orientation and gender identity questions in population-based surveys of the workforce such as the Census, American Community Survey, and surveys fielded by the Bureau of Labor Statistics and other agencies."

In a thought experiment to a world where discrimination against LGBT people were vanishingly rare, Commissioner Heriot proposes that firing someone for their LGBT status would be no more offensive on a societal level than firing someone for an arbitrary reason such as the person's first name or sports team affiliation. That is not our world. In our world, LGBT people face negative employment consequences for their status, as do people of color and people of other protected statuses. In fact, employers use "idiosyncratic" reasons as pretext to hide their discrimination. Such discrimination abrogates our belief in a meritocracy. The only true open question is whether as a society we find it tolerable for LGBT people to suffer because others disapprove of them. I believe it is consistent with American values to protect people on this basis, and while I do not believe every business should be required to adopt my understanding of American values in every respect, I do believe it behooves this country to acknowledge the history of discrimination against LGBT people along with the current realities of employment discrimination and adopt employment protections. Voluntary adoption of employment protections by many companies is insufficient for

the simple reason that these policies are unenforceable, and thus offer cold comfort to those who face discrimination.

Commissioner Kirsanow uses the bulk of his rebuttal to argue for the incompatibility of LBGT employment protections with religious liberty. I disagree with Commissioner Kirsanow on this point, but write simply to say, counter to his assertions, the Commission does strongly support religious freedom and nondiscrimination on the basis of religion. Nothing in this report states otherwise, and the Commission's history demonstrates support for the tenets of religious freedom and nondiscrimination. Disagreement as to the contours of religious protections in particular instances does not indicate an abandonment of Constitutional and statutory religious protections.

TAB 181-4

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

PUBERTY SUPPRESSION THERAPY
GENERALLY ACCEPTED PROFESSIONAL MEDICAL STANDARDS (GAPMS)
DETERMINATION REPORT WITH RECOMMENDATION

Date: September 14, 2016

To: Justin Senior, Deputy Secretary for Medicaid

From: Bureau of Medicaid Policy

Subject: **Puberty Suppression Therapy**

PURPOSE

In order for the use of puberty suppression therapy to be covered under the Florida Medicaid program, it must meet medical necessity criteria as defined in Rule 59G-1.010, Florida Administrative Code (F.A.C.), and be funded through the General Appropriations Act of Chapter 216, Florida Statutes (F.S.).

Pursuant to the criteria set forth in Rule 59G-1.010, F.A.C., the use of puberty suppression therapy must be consistent with generally accepted professional medical standards (GAPMS) as determined by the Medicaid program, and not experimental or investigational.

In accordance with the determination process established in Rule 59G-1.035, F.A.C., the Deputy Secretary for Medicaid will make the final determination as to whether the use of puberty suppression therapy is consistent with generally accepted professional medical standards and not experimental or investigational.

If it is determined that puberty suppression therapy is consistent with generally accepted professional medical standards, this report will be supplemented with an addendum which analyzes additional factors to determine whether this health service should be covered under the Florida Medicaid program.

REPORT WITH RECOMMENDATION

This report with recommendation is presented as the summary assessment considering the factors identified in Rule 59G-1.035, F.A.C., based on the collection of information from credible sources of reliable evidence-based information. The intent is to provide a brief analysis with justification in support of the final recommendation.

The analysis described in this report includes:

- A high level review of relevant disease processes.
- An overview of the health service information.
- Clearance from the government regulatory body (e.g., Food and Drug Administration).

2727 Mahan Drive • Mail Stop # 20
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Pl. Trial Ex. 240

- Evidence based clinical practice guidelines.
- A review of the literature considered by the relevant medical community or practitioner specialty associations from credible scientific evidence-based literature published in peer reviewed journals and consensus of coverage policy from commercial and other state Medicaid insurers.

HEALTH SERVICE SUMMARY

Hormones

Hormones are important chemical messengers in the body that effectively transfer signals and instructions from one set of cells to another. Hormones are secreted into the bloodstream by a collection of glands inside the body referred to as the endocrine system. A gland is a group of cells that produces and secretes chemicals into the body. The major glands that make up the endocrine system include the hypothalamus, pituitary gland, thyroid and parathyroid, adrenals, pineal body, and the ovaries and testes.

In a laboratory setting, hormones are produced synthetically and are prescribed by physicians to treat disease or hormone deficiencies. An instance where synthetic hormones may be needed is when an individual has their thyroid gland surgically removed; a practitioner may prescribe synthetic thyroid hormones to replace those that their body can no longer produce.

Over 50 different hormones have been identified in the human body, and more are still being discovered. Hormones influence and regulate practically every cell, tissue, organ, and function of the body, including growth, development, metabolism, homeostasis, and sexual and reproductive function.[20]

Reproductive Hormones

The hormones commonly considered as reproductive hormones in the body are testosterone, estrogen, and progesterone. Testosterone is often referred to as a male hormone, and estrogen and progesterone are often referred to as female hormones. However, there are no exclusively male or female hormones that have been identified. The physical manifestations of gender result from differences in the amounts of individual hormones in the body and differences in their patterns of secretion, first in utero and then again during puberty. In other words, testosterone, estrogen, and progesterone are produced by men and women, but in differing amounts and in different patterns.[20]

Reproductive Hormone Suppression Therapy

There are many disease processes in which increased levels of reproductive hormones are released. They include, but are not limited to, prostate cancer, breast cancer, severe endometriosis, and central precocious puberty. To address the over-secretion of reproductive hormones, several drugs have been developed to aid in reducing hormone levels, including those hormones released during puberty.

For the purposes of this report, an analysis is being performed on the use of hormone treatment to suppress puberty. Currently, there are a number of drugs used to suppress puberty, which all use gonadotropin-releasing hormone (GnRH) agonists. Agonists function to stop receptors from connecting with the appropriate transmitter. For a hormone to perform its primary function in the

brain and body it must find the correct receptor to transmit its response; the GnRH agonists prevent this natural cycle.[20]

Government Regulatory Body Approval

The Food and Drug Administration (FDA) has approved three drugs for the use in children for the purpose of puberty suppression therapy, as follows:

- Lupron[44]
  - Indications for use: Palliative treatment of advanced prostatic cancer and central precocious puberty in children of both sexes.
- Synarel[47]
  - Indications for use: Central precocious puberty (gonadotropin-dependent precocious puberty) in children of both sexes and endometriosis.
- Supprelin[46]
  - Indications for use: Central precocious puberty in both sexes.

Each of these drugs has specific indications for use and dosing information. Additionally, these medications have approved off-label uses. This permits usage in other than the approved FDA indications. These approved off-label uses are compiled in three compendia: American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (or its successor publications), and DRUGDEX Information System.[7] The drugs specified above are authorized in the respective compendia to treat the following conditions:

- Lupron:
  - Breast cancer
  - In vitro fertilization
  - Ovarian cancer
  - Premenstrual syndrome
  - Prostate cancer
  - Prostate cancer, Neoadjuvant treatment
  - Uterine leiomyoma
- Synarel:
  - Benign prostatic hyperplasia
  - Contraception, Female; prophylaxis
  - Contraception, Male; prophylaxis
  - Crohn's disease
  - Hirsutism
  - In vitro fertilization
  - Uterine leiomyoma
- Supprelin:
  - Acute intermittent porphyria
  - Endometriosis
  - Female infertility; Adjunct
  - Polycystic ovary syndrome
  - Uterine leiomyoma

While all of these drugs may be utilized to treat other conditions, as indicated above and specified in the compendia, none of them are authorized or specified in the compendia for use in treating individuals diagnosed with gender dysphoria.[7]

LITERATURE REVIEW

This analysis summarizes information obtained from scientific literature published in credible peer-reviewed journals related to the use of puberty suppression therapy. This section also briefly cites the positions from the relevant medical societies, and summarizes the key articles referenced in support of their positions.

Central Precocious Puberty

Central precocious puberty (CPP) develops due to premature pubertal changes and rapid bone development. CPP is associated with lower adult height and increased risk for development of psychological problems.

Reproductive hormone suppression therapy (also referred to as puberty suppression therapy in this document) has been the standard of care for CPP for the last 15-20 years. The standard treatment for CPP is GnRH analogs. Although there are many different analogs with different routes of administration, the primary agent in the United States for many years was depot intramuscular injections administered every four weeks, but in the last ten years, a subdermal or under the skin implant has been developed, which has been shown to be effective for up to two years.[17, 39, 41]

In a recent study, researchers explored the difference in cognitive function, behavior, emotional reactivity, and psychosocial problems between young females treated with GnRH and age-matched controls. They concluded that young females treated with GnRH do not differ in their cognitive functioning, behavioral, and social problems from their same age peers. However, they did find a significant difference in heart rate that increased with treatment duration and suggested a follow-up study with an emphasis on cardiac health.[05]

Gender Dysphoria

Gender dysphoria is an individual's affective or cognitive discontent with their assigned gender (gender at birth).[14] Gender dysphoria refers to the distress that may accompany the incongruence between the individual's experienced or expressed gender and their assigned gender. Evidence of this distress is the hallmark of the disorder. The diagnostic criteria are divided into a category for children and a category for adolescents and adults. The disorder is manifested differently as an individual ages or enters different developmental stages. Both categories require marked incongruence between the individual's experienced or expressed gender and their assigned gender of at least a six months' duration and clinically significant distress or impairment in social, school (occupation for adults), or other important areas of functioning.[14]

Diagnostic criteria in children include: a strong desire to be the other gender or an insistence that they are the other gender; a preference for wearing clothing associated with the other gender; preference for cross gender roles in simulated play; preference for toys games, or activities usually associated with the other gender; preference for playmates of the other gender; and the dislike of their sexual anatomy. The prevalence of this diagnosis among the general population ranges from 0.005% to 0.014% in males and 0.002% to 0.003% in females.[14]

Studies have shown that the majority of children (80%) diagnosed with gender dysphoria will not continue to be gender dysphoric after puberty.[31]

In adolescents and adults, diagnostic criteria include: a strong desire to be and to be treated as the other gender and a strong desire to have the sex characteristics of the other gender (or in the case of adolescents, the wish to prevent the development of their assigned gender's characteristics).[14]

Gender dysphoria is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization.[14] Adolescents that do not receive treatment during this already vulnerable period of development might engage in risky or self-harming behaviors , such as self-harm, self-mutilation, suicidal ideation, or suicide.[22]

For the 20% of children who persist in their feelings of gender dysphoria, clinicians may begin to explore alternative treatment approaches beyond psychotherapy after the onset of puberty, including medical interventions such as the use of GnRH analogs to suppress puberty.[38] The use of puberty suppression therapy is used as a diagnostic aid in adolescents contending with gender dysphoria.[6, 10, 11, 24, 31, 50] The use of GnRH analogs is generally prescribed in adolescents ages 12-16. In addition to puberty suppression therapy, a physician may also begin to prescribe cross-sex hormones, though the latter does not generally begin until the ages of 16-18.[10, 11]

The use of GnRH analogs will delay reproductive development in this population. However, there remains a great deal of concern and lack of consensus in the medical community of the potential risks, including: misdiagnosis, sterilization, adverse medical effect on the metabolic and endocrine system, impaired bone mass and brain development, etc.[51, 6] To date, there have been no randomized controlled clinical trials on the use of GnRH analogs in the treatment of gender dysphoria (on large cohorts) that have been shown to be efficacious with tolerable side effects. This is in large part due to the small number of patients diagnosed with gender dysphoria, which makes any statement on the general efficacy of a treatment approach challenging.[31] However, there have been case-studies (qualitative) that have been conducted that review the outcomes on small cohorts. These studies have concluded that there are limited negative side effects from the use of puberty suppression drugs in adolescents contending with gender dysphoria.[54, 55]

Clinicians who support the use of puberty suppression therapy in the treatment of gender dysphoria argue that the risks of misdiagnosis are significantly reduced if the treatment is delayed until the initiation of puberty. They also contend that this treatment may relieve emotional distress in the individual (including reducing suicidal ideation in severe cases) and may "buy time" for the child to explore their feelings of gender dysphoria without contending with physical changes that cannot be undone (e.g., breast development).[22] Most treatment protocols recommend extensive psychological evaluations/assessments and psychotherapy by mental health professionals prior to the initiation of medical interventions. This is especially important given the changing thoughts and feelings of prepubescent children versus adolescents with persistent gender dysphoria and in adolescents presenting with co-morbid conditions.

It is important to note that most of the literature reviewed in development of this analysis concluded that more systematic research is required to determine the long-term efficacy of medical treatment for adolescents with gender dysphoria.[21, 24, 25, 28, 50, 51]

Evidence-Based Clinical Practice Guidelines

The American Academy of Pediatrics published a consensus statement on the use of GnRH analogs in children in March 2009. They concluded that GnRH use was undisputed in the treatment of CPP early-onset (less than six years old). However, the use of GnRH for conditions other than CPP requires additional investigation and cannot be suggested routinely.[3] The consensus statement does not specifically address the use of GnRH in the treatment of gender dysphoria.

The Endocrine Society published guidelines for the endocrine treatment of transsexual persons. The Society concluded that transsexual persons seeking to develop the physical characteristics of the desired gender require safe, effective hormone regimen that will 1) suppress endogenous hormone secretion determined by the person's genetic/biological sex and 2) maintain sex hormone levels within the normal range for the person's desired gender. They recommend that a mental health professional make the referral and participate in ongoing care and an endocrinologist must confirm the diagnostic criteria. They do not recommend endocrine treatment of prepubertal children. The recommendations are as follows:

- Treatment of transsexual adolescents (Tanner stage two, generally achieved around the age of 12 years) by suppressing puberty with GnRH analogues until the age of 16 years.
- Initiation of cross-sex hormones at the age of 16 years with continued suppression of biological sex hormones.
- Maintaining physiologic levels of gender-appropriate sex hormones and monitoring for known risks throughout adulthood.[19, 18, 32]

In making these recommendations, however, the Endocrine Society identified the strength of the evidence used to support its conclusions. For all of the recommendations listed above, the Society acknowledged the strength of the evidence as low or very low.

COVERAGE POLICY

Federal Regulations

Federal regulations for Medicaid specify that a state may limit coverage of a drug with respect to the treatment of a specific disease or condition for an identified population (if any) based on the drug's labeling, if it does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary. In addition, states may exclude a drug when the prescribed use of the drug is not for a medically accepted indication, either approved by the FDA or supported by information from the appropriate compendia. These guidelines apply to a state's administration of its Medicaid prescribed drug benefit in both managed care and non-managed care delivery systems.

States are also required to implement a drug use review program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and are not likely to result in adverse medical results. The program is required to assess data on drug use against predetermined standards, consistent with the following:

1. Compendia, consisting of the following:
   a. American Hospital Formulary Service Drug Information;
   b. United States Pharmacopeia-Drug Information (or its successor publications); and
   c. the DRUGDEX Information System; and
2. The peer-reviewed medical literature.

Federal law requires states to provide services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. This is known as the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d (a). As such, services for recipients under the age of 21 years exceeding any coverage limitations specified within a state's policies maybe approved, if medically necessary.

Florida Medicaid

In order to be reimbursed by Florida Medicaid, a drug must be medically necessary and either (a) prescribed for medically accepted indications and dosages found in the drug labeling or drug compendia in accordance with section 1927(k) (6) of the Social Security Act, or (b) prior authorized by a qualified clinical specialist approved by the Agency for Health Care Administration (Agency).[1]

The criteria that are utilized under the Florida Medicaid program in the authorization of drugs for off-label purposes are as follows:

1. Documentation submitted with trial and failure or intolerance to all FDA- approved medications for the indication **AND**
2. Phase III clinical studies published in peer review journals to support the non-FDA approved use **AND**
3. Usage supported by publications in peer reviewed medical literature **and** one or more citations in at least one of the following compendia:
   a. American Hospital Formulary Service Drug Information (AHFS)
   b. United States Pharmacopeia-Drug Information (or its successor publications)
   c. DRUGDEX Information System[1]

Florida Medicaid covers reproductive hormone suppression therapy (including puberty suppression therapy) for all FDA approved indications/uses or when the information in the appropriate compendium supports the use of the drug in the treatment of the specific disease state or condition. Since the use of GnRH agonists are not FDA approved or listed in the appropriate compendia for the treatment of gender dysphoria, Florida Medicaid does not authorize these drugs for such uses. However, children/adolescents diagnosed with gender dysphoria are eligible to receive an array of other medical and behavioral health interventions (e.g., individual and family therapy, psychological evaluations/assessments, other medical evaluation and management services) necessary to address their presenting signs and symptoms.

Health plans contracted to provide services under the Florida Medicaid Statewide Medicaid Managed Care program are required to cover all prescription drugs listed in the Agency's Medicaid Preferred Drug List (PDL). In addition, the health plan's prior authorization criteria and protocols may not be more restrictive than those used by the Agency as indicated in the Florida Statutes, the Florida Administrative Code, the Medicaid State Plan and those posted on the Agency website.

Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Medical necessity in the State of Florida must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

If a service exceeds the coverage described within a Florida Medicaid policy or the associated fee schedule, a request (along with all supporting documentation) may be submitted to the Agency or its designee for review.

Medicare

Medicare covers reproductive hormone suppression for all FDA approved use. The *Medicare Benefit Policy Manual*, Chapter 15, page 15, subsection 50.4.2, discusses the unlabeled use of a drug. The policy states that "FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice."[5] However, because Medicare covers primarily elderly adults and disabled adults, its coverage policies have little or no application in this analysis.

State Medicaid Programs

All state Medicaid programs cover reproductive hormone suppression therapy for the approved FDA indications and when the criteria for off-label use are met. Some state Medicaid programs are also adopting coverage policies that allow for reimbursements of puberty suppression therapy in adolescents diagnosed with gender dysphoria. It appears at this time as though most states do not cover this service although that may change over time. This report highlights the coverage policies for four Medicaid programs that do cover the service, as follows:

1. Colorado Medicaid covers behavioral health services, GnRH analogs/agonists, cross-sex hormone therapy, gender confirmation surgery, and pre and post-operative care.
2. Maryland Medicaid covers GnRH treatment if the recipient has a diagnosis of gender dysphoria.
3. Rhode Island Medicaid covers behavioral health services, pharmacological and hormonal therapy to delay physical changes of puberty, and pharmacological and hormonal therapy that is non-reversible and produces masculinization or feminization. Some services require prior authorization.
4. Washington State Medicaid covers behavioral health services, puberty suppression therapy, hormonal therapy, and gender reassignment surgery.

GENERALLY ACCEPTED PROFESSIONAL MEDICAL STANDARDS RECOMMENDATION

Puberty suppression therapy is considered a health service that is consistent with generally accepted professional medical standards for the approved FDA indications (i.e., central precocious puberty) and for off-label use when supported by citations in at least one of the compendia. Since Florida Medicaid already provides coverage of puberty suppression therapy in the treatment of central precious puberty and for use in treating the conditions cited in the compendia, no further policy coverage analyses are needed to supplement this report on this point.

Based upon the available published literature, it is inconclusive whether puberty suppression therapy is considered a health service that is consistent with generally accepted professional medical standards in the treatment of gender dysphoria. Most of the studies published thus far on the use of puberty suppression in gender dysphoric children/adolescents have concluded that further systematic research is required to determine the long-term safety and efficacy of this approach and there remains a lack of consensus within the medical community on its appropriateness (both from an ethical and safety perspective). As the research on this topic continues to evolve, more conclusive evidence may emerge that supports the long-term efficacy and effectiveness of this treatment approach. At any time, a follow-up analysis can be performed that could change this recommendation.

EPSDT Considerations:

While the Agency cannot make a blanket determination on puberty suppression therapy for gender dysphoria, we also cannot categorically exclude this treatment for children. Clinical guidelines from the Endocrine Society do recommend this therapy for certain adolescents, albeit based upon a combination of weak and very weak evidence. In certain circumstances, the risks of not treating an adolescent may be worse than the potential long-term consequences of treatment. Moreover, it is noted extensively in the literature that adolescents contending with gender dysphoria often experience a myriad of emotional, physical, and societal challenges. Unresolved, the distress can manifest into a host of behavioral health problems including depression, anxiety, and suicidal ideation and self-mutilation. Florida pays for services for children when they protect life and /or prevent significant disability or harm, in accordance with the state's medical necessity definition.

Given these concerns, while it is not recommended that any further analyses be conducted to expand Florida Medicaid's coverage of puberty suppression therapy beyond those indications/uses approved by the FDA or authorized in the appropriate compendium, it is recommended that any individualized request for such therapy be reviewed as a part of the Agency's special services process. Consistent with EPSDT requirements, the request can be evaluated on an individualized basis to determine if the service is medically necessary (e.g. it is administered to protect life and/or prevent significant disability, such as to prevent suicide or self-mutilation) to ensure that all less invasive interventions have been exhausted, and to ensure that this treatment approach presents as the best alternative given the adolescent's psychological state and presenting signs and symptoms.

✓ **Concur** ____ **Do not Concur**

Comments:

Tom Wallace for Justin Senior

Deputy Secretary for Medicaid (or designee)

9/15/16

Date

TAB 181-24

Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	September 20, 2016 September 18, 2017 November 17, 2017

SPECIAL SERVICES CRITERIA
PUBERTAL SUPPRESSION WITH GONADOTROPIN-RELEASING HORMONE ANALOG AGENT FOR GENDER DYSPHORIA

LENGTH OF AUTHORIZATION: THREE MONTHS

CLINICAL CRITERIA:
Gender dysphoria is defined as distress or discomfort caused by a discrepancy between a person's assigned sex at birth and a person's gender identity. Unresolved, the distress or discomfort can manifest into a host of behavioral health problems including depression, anxiety, suicidal ideation and self-mutilation. The purpose of pubertal suppression is to alleviate suffering caused by the development of secondary sex characteristics, in order to provide time to make a balanced decision regarding the actual gender reassignment.[1]

REVIEW CRITERIA:
- A comprehensive mental health evaluation is required and must include the diagnosis of gender dysphoria, using the current Diagnostic and Statistical Manual of Mental Disorders-5 by a mental health professional (MHP) licensed in accordance with s. 490 or s. 491, Florida Statutes (supporting documentation required).[2]
- The diagnosis must be confirmed by an endocrinologist.[2]
- The MHP clinical notes must reflect the MHP's professional judgment that not treating the patient is likely to be worse than the potential long-term consequences of the treatment. The treatment must be medically necessary (e.g. it is administered to protect life and/or prevent significant disability, such as to prevent suicide or self-mutilation), and must ensure that the pubertal suppression treatment approach presents as the best alternative given the patient's psychological state and presenting signs and symptoms (supporting documentation required).
- The patient must have been in psychotherapy for a minimum of six months since diagnosed with gender dysphoria prior to consideration for pubertal suppression therapy.
- Females and males must have reached a Tanner stage 2 or Tanner stage 3 prior to consideration of pubertal suppression therapy and have confirmed pubertal levels of estradiol and testosterone.
- If treatment is being prescribed for adolescents under the age of 12, additional documentation is required to support the request.
- The MHP clinical notes must address the patient's readiness for pubertal suppression treatment and ensure psychotherapy will continue to be offered while on pubertal suppression therapy.[3]
- Parental consent is required during treatment for patients under the age of 18.[4] The patient and the legal guardian/parents must demonstrate knowledge and understanding of the expected

Pl. Trial Ex. 257

Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	September 20, 2016 September 18, 2017 November 17, 2017

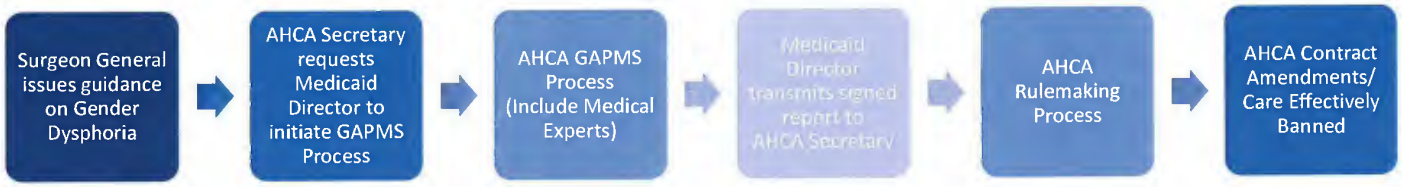
outcomes of suppression of pubertal hormones including the reversible and irreversible effects of pubertal suppression therapy (supporting documentation required).[2]

- Documentation must include evidence that other psychiatric or medical comorbidities that may interfere with the diagnostic work-up or treatment have been ruled out.[3]
- Documentation of treatment adherence is required.

[1]The Standards of Care for Gender Identity Disorders (5th Ed) Harry Benjamin International Gender Dysphoria Association, Inc. Available at: http://www.tc.umn.edu/~colem001/hbigda/hstndrd.htm Accessed September 9, 2016
[2]Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab 2009; 94:3132-3154
[3] Vance SR, Ehrensaft D, Rosenthal SM, et al. Psychological and Medical Care of Gender Nonconforming Youth Pediatrics 2014; 134:1184-1192
[4] Cavanaugh T Cross-Sex Hormone Therapy. Available at: http://www.lgbthealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf Accessed September 9, 2016

TAB 182-35

Gender Dysphoria/Transgender Health Care Non-Legislative Pathway

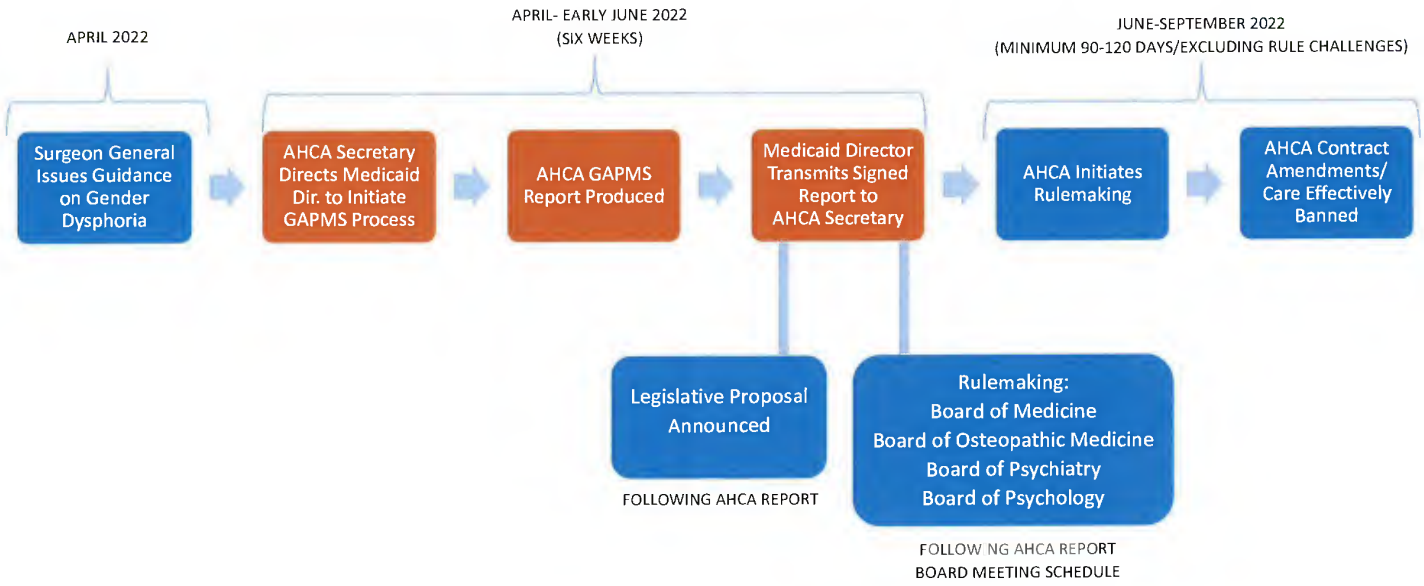


EOG_008240

Pl. Trial Ex. 295

TAB 182-36

Gender Dysphoria/Transgender Health Care Policy Pathway



^ GAPMS: Determining Generally Accepted Professional Medical Standards

EOG_008241

Pl. Trial Ex. 296

TAB 182-38

Medicaid Policy Routing and Tracking Form

Date:	6/1/2022
Assignment Title:	GAPMS Report
Assignment Type:	GAPMS
Final Due Date:	6/2/2022
Extensions:	No
Reassigned:	No
Reassigned to:	
Reassigned from:	
Date of Completion:	
Assignment Summary (brief):	GAPMS review for services
Attachment(s):	Attachment Document.docx Please upload your draft documents/responses
Section:	Canadian Prescription Drug Importation Program
Prepared By:	Brackett, Matt
Position:	Other
Preparer Phone:	850-412-4151
Preparer Room Number:	2249

Reviewed by and Routing Timeline(s):

MB for DVP

Name	Title	Start Date	End Date	Date Received	Todays Date and Initial		Approval
Devona (D.D.) Pickle	AHC Administrator	6/1/2022	6/1/2022	6/1/22	6/1/22		☑
Ann Dalton	Bureau Chief	6/1/2022	6/1/2022	6/1/22	6/1/22	AD	☑
Jason Weida	ADS Policy/Quality	6/1/2022	6/1/2022	6/1/22	6/1/22	JW	☑
Tom Wallace	Deputy Secretary for Medica	6/2/2022	6/2/2022	6/1/22	6/2/22	TW	☑
							☐
							☐
							☐

Notes:

Edits	Edits
Edit 1	Edit 2
Edit 3	Edit 4

Pl. Trial Ex. 297

Florida Medicaid

Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria

June 2022

Ron DeSantis, Governor
Simone Marstiller, Secretary

Contents

Introductory Remarks and Abstract

Generally Accepted Professional Medical Standards

The Secretary of the Florida Agency for Health Care Administration requested that the Division of Florida Medicaid review the treatment of gender dysphoria for a coverage determination pursuant to Rule 59G-1.035, Florida Administrative Code (F.A.C.) (See Attachment A for the Secretary's Letter to Deputy Secretary Tom Wallace). The treatment reviewed within this report included "sex reassignment treatment," which refers to medical services used to obtain the primary and/or secondary physical sexual characteristics of a male or female. As a condition of coverage, sex reassignment treatment must be "consistent with generally accepted professional medical standards (GAPMS) and not experimental or investigational" (Rule 59G-1.035, F.A.C., see Attachment B for the complete rule text).

The determination process requires that "the Deputy Secretary for Medicaid will make the final determination as to whether the health service is consistent with GAPMS and not experimental or investigational" (Rule 59G-1.035, F.A.C.). In making that determination, Rule 59G-1.035, F.A.C., identifies several factors for consideration. Among other things, the rule contemplates the consideration of "recommendations or assessments by clinical or technical experts on the subject or field" (Rule 59G-1.035(4)(f), F.A.C.). Accordingly, this report attaches five assessments from subject-matter experts:

- **Attachment C:** Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.
- **Attachment D:** James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.
- **Attachment E:** Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.
- **Attachment F:** Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.
- **Attachment G:** G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

Abstract

Available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health.

Five clinical and technical expert assessments attached to this report recommend against the use of such interventions to treat what is categorized as a mental health disorder (See attachments):

- **Health Care Research:** Brignardello-Petersen and Wiercioch performed a systematic review that graded a multitude of studies. They conclude

that evidence supporting sex reassignment treatments is low or very low quality.

- **Clinical Psychology:** Cantor provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements.
- **Plastic Surgery:** Lappert provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest.
- **Pediatric Endocrinology:** Van Meter explains how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation.
- **Bioethics:** Donovan provides additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent.

Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational.

Health Service Summary

Gender Dysphoria

Frequently used to describe individuals whose gender identity conflicts with their natural-born sex, the term gender dysphoria has a history of evolving definitions during the past decades (Note: This report uses the term "gender" in reference to the construct of male and female identities and the term "sex" when regarding biological characteristics). Prior to the publication of the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the American Psychiatric Association (APA) used the diagnosis of gender identity disorder (GID) to describe individuals who sought to transition to the opposite gender. However, behavioral health clinicians sought a revision after determining that using GID created stigma for those who received the diagnosis. This is despite the APA having adopted GID to replace the previous diagnosis of transsexualism for the exact same reason (APA, 2017).[1]

When crafting its new definition and terminology, the APA sought to remove the stigma of classifying as a disorder the questioning of one's gender identity by focusing instead on the psychological distress that such questioning can evoke. This approach argues that individuals seeking behavioral health and transition services are doing so due to experiencing distress and that gender non-conformity by itself is not a mental health issue. This led to the adoption of gender dysphoria in 2013 when the APA released the DSM-V. In addition to using a new term, the APA also differentiated the diagnosis between children and adolescents and adults, listing different characteristics for the two age groups (APA, 2017).

According to the DSM-V, gender dysphoria is defined as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." As for the criteria to receive the diagnosis, the APA issued stricter criteria for children than adolescents and adults. For the former, the APA states that a child must meet six out of eight behavioral characteristics such as having "a strong desire to be of the other gender or an insistence that one is the other gender" or "a strong preference for cross-gender roles in make-believe or fantasy play." The criteria for adults and adolescents are less stringent with individuals only having to meet two out of six characteristics that include "a strong desire to be the other gender" or "a strong desire to be rid of one's primary and/or secondary sexual characteristics." The APA further notes that these criteria can also apply to young adolescents (DSM-V, 2013).

In 2021, the Merck Manual released a slightly different definition for gender dysphoria, citing that the condition "is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the

[1] The concept of gender being part of identity and disconnected from biological sex originated during the mid-twentieth century and was publicized by psychologist John W. Money. His research asserted that gender was a complete social construct and separate from biology, meaning that parents and/or caregivers could imprint on a young child (under three years) the identity of a boy or girl. In 1967, Money's theories led to a failed experiment on twin boys where physicians surgically transitioned one to appear as a girl. The twin that underwent sex reassignment never fully identified as a female. However, Money never publicly acknowledged this and reported the experiment as a success. Furthermore, he promoted his conclusions across the scientific community, concealing what actually unfolded. As a result, Money's ideas on gender fluidity served as a basis for performing procedures on children with hermaphroditic features or genital abnormalities. The case reveals how the understanding of a concept (e.g., gender) at any given time can lead to incorrect medical decisions with irreversible consequences (Gaetano, 2015).

sex assigned at birth." Additionally, the Merck Manual further states that "gender dysphoria is a diagnosis requiring specific criteria but is sometimes used more loosely for people in whom symptoms do not reach a clinical threshold" (Merck Manual, 2021). This definition is largely consistent with the DSM-V but does not emphasize the distress component to the same extent.[2]

Like other behavioral health diagnoses classified in the DSM-V, gender dysphoria has the following subtypes:

- **Early-Onset Gender Dysphoria:** This subtype begins during childhood and persists through adolescence into adulthood. It can be interrupted by periods where the individual does not experience gender dysphoria signs and may classify as homosexual (DSM-V, 2013).
- **Late-Onset Gender Dysphoria:** Occurring after puberty or during adulthood, this subtype does not begin until late adolescence and can emerge following no previous signs of gender dysphoria. The APA attributes this partially to individuals who did not want to verbalize their desires to transition (DSM-V, 2013).

Further studies have identified additional subtypes of gender dysphoria. In 2018, Lisa Littman introduced the concept of a rapid-onset subtype. Classified as rapid-onset gender dysphoria (ROGD), it features characteristics such as sudden beginnings during or following puberty. However, it differs from the DSM-V definitions because ROGD is associated with other causes such as social influences (e.g., peer groups, authority figures, and media). In other words, adolescents who had no history of displaying typical gender dysphoria characteristics go through a sudden change in identity following intense exposure to peers and/or media that heavily promotes transgender lifestyles (Littman, 2018). While more long-term studies are needed to confirm whether ROGD is a temporary or long-term condition, Littman's study has initiated discussions regarding potential causes of gender dysphoria as well as introduced a potential subtype.

Additionally, the frequent use of gender dysphoria in clinical and lay discourse has led to a fracturing of the definition. Studies on the topic frequently do not apply the DSM-V's criteria for the diagnosis and overlook certain key features such as distress. In a 2018 review by Zowie Davy and Michael Toze, the authors evaluated 387 articles that examine gender dysphoria and noted stark departures from the APA's definition. They further asserted that the APA intended to "reduce pathologization" by establishing a new definition for gender dysphoria in the DSM-V. This in turn would reduce diagnoses, although as Davy and Toze note, the tendency for the literature to diverge from the APA's definition may result in increased numbers of individuals classified as having gender dysphoria when they do not meet the DSM-V's criteria (Davy and Toze, 2018). This further raises the question of whether individuals are receiving potentially irreversible treatments for the condition when they might not actually have it.

The current usage of gender dysphoria is the result of discussions spanning across decades as demonstrated in the past editions of the DSM. Until 2013, the APA considered having gender identity issues a mental disorder by itself regardless of the presence of psychological distress. That perspective has since shifted to only consider the adverse psychological effects of questioning one's gender as a disorder. In addition, the APA considers gender as part of one's identity, which is not subject to a diagnosis. Whether the APA has shifted its terminology and criteria for gender identity issues due to

[2] Following the release of the Florida Department of Health's guidelines for treating gender dysphoria, Merck removed its definition for "gender dysphoria" from the Merck Manual (Fox News, 2022).

emerging clinical data or cultural changes is another question. In 1994, the APA replaced transsexualism with gender identity disorder as part of the "effort to reduce stigma" (APA, 2017). This raises questions about what influences decisions to revise definitions and criteria; is it social trends or medical evidence?

Behavioral Health Issues Co-Occurring with Gender Dysphoria

Because gender dysphoria pertains directly to the distress experienced by an individual who desires to change gender identities, secondary behavioral health issues can co-occur such as depression and anxiety. If left untreated, these conditions can lead to the inability to function in daily activities, social isolation, and even suicidal ideation. Studies do confirm that adolescents and adults with gender dysphoria report higher levels of anxiety, depression, and poor peer relationships than the general population (Kuper et al, 2019). Other associated conditions include substance abuse, eating disorders, and compulsivity. A significant proportion of individuals with gender dysphoria also have autism spectrum disorder (ASD) (Saleem and Rizvi, 2017). Although the number reporting secondary issues is increased, individuals diagnosed with gender dysphoria do not necessarily constitute the entire population that is gender non-conforming (i.e., does not identify with natal sex), and no information is available breaking down the percentage of those who are non-conforming with gender dysphoria and those who are non-conforming with no distress. Additionally, available research raises questions as to whether the distress is secondary to pre-existing behavioral health disorders and not gender dysphoria. This is evident in the number of adolescents who reported anxiety and depression diagnoses prior to transitioning (Saleem and Rizvi, 2017).

Furthermore, conventional treatments for secondary behavioral health issues are available. These include cognitive behavioral therapy, medication, and inpatient services. The APA reports that treatments for these are highly effective with 80% to 90% of individuals diagnosed with depression responding positively (APA, 2020). In addition, a high percentage of adolescents diagnosed with gender dysphoria had received psychiatric treatment for a prior or co-occurring mental health issue. A 2015 study from Finland by Kaltiala-Heino et al noted that 75% of children seeking sex reassignment services had been treated by a behavioral health professional (Kaltiala-Heino et al, 2015).

Diagnosing Gender Dysphoria

Prior to the publication of the DSM-V, diagnosing individuals experiencing gender identity issues followed a different process. Behavioral health clinicians could assign the diagnosis based on gender non-conformance alone. That has changed since 2013. Today, non-conforming to one's gender is part of personal identity and not a disorder requiring treatment. This change has led professional associations to shift the diagnostic criteria for gender dysphoria to focus on the distress caused by shifting identities (DSM-V, 2013).

For adolescents, the APA identifies "a marked incongruence between one's experienced/expressed gender and natal sex, of at least 6 months' duration" as the core component of gender dysphoria (DSM-V, 2013). What the APA does not elucidate is the threshold for "marked." This raises questions as to whether practitioners exercise uniformity when applying the diagnostic criteria or if they do so subjectively. For example, the WPATH's *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* provides guidance on the processes mental health practitioners should use when assessing for gender dysphoria but offers no benchmarks for meeting diagnostic criteria (WPATH, 2012).

Such processes include evaluating for gender non-conforming behaviors and other co-existing mental disorders like anxiety or depression. This involves not only interviewing the adolescent but also the family in addition to reviewing medical histories. WPATH also asserts that gender dysphoria assessments need to account for peer relationships, academic performance, and provide information of potential treatments. This last component is necessary because it might affect an individual's choices regarding transitioning, particularly if the information does not correspond to the desired outcome (WPATH, 2012).

The diagnosis of gender dysphoria is a relatively recent concept in mental health, being the product of decades of discussion and building upon previous definitions. Instead of treating gender non-conformity as a disorder, behavioral health professionals acknowledge it as part of one's identity and focus on addressing the associated distress. Considering the new criteria, this changes the dynamics of the population who would have qualified for a diagnosis before 2013 and those who would today. Given that desiring to transition into a gender different from natal sex no longer qualifies as a disorder, behavioral health professionals are treating distress and referring adolescents and adults to therapies that are used off-label and pose irreversible effects.

Current Available Treatments for Gender Dysphoria

At present, proposed treatment for gender dysphoria occurs in four stages, beginning with psychological services and ending with sex reassignment surgery. As an individual progresses through each stage, the treatments gradually become more irreversible with surgical changes being permanent. Because of the increasing effects, individuals must have attempted treatment at the previous stage before pursuing the next one (Note: late adolescents and adults have already completed puberty and do not require puberty blockers). Listed in order, the four stages are as follows:

- **Behavioral Health Services:** Psychologists and other mental health professionals are likely the first practitioners individuals with gender dysphoria will encounter. In accordance with clinical guidelines established by the World Professional Association for Transgender Health (WPATH)[3], behavioral health professionals are supposed to "find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment." WPATH further discourages services for attempting to change someone's gender identity. Instead, it instructs practitioners to assess for the condition and readiness for puberty blockers or cross-sex hormones while offering guidance to function in a chosen gender. WPATH does assert that the clinicians do need to treat any other underlying mental health issues secondary or co-occurring with gender dysphoria (WPATH, 2012). However, the organization provides conflicting guidance because it also advises practitioners to prescribe cross-sex hormones on demand (Levine, 2018).
- **Puberty Suppression:** Used only on individuals in the earliest stages of puberty (Tanner stage 2), preventing pubertal onset provides additional time to explore gender identities before the physical characteristics of biological sex develop. This treatment is intended to reduce distress and anxiety related to the appearance of adult sexual physical features. To suppress puberty, pediatric endocrinologists inject gonadotropin releasing hormone (Gn-RH) at specific intervals (e.g., 4 weeks or 12 weeks). The Gn-RH suppresses gonadotropin receptors that allow for the

[3] The World Professional Association for Transgender Health asserts that it is a professional organization. However, it functions like an advocacy group by allowing open membership to non-clinicians (WPATH, 2022).

development of primary and secondary adult sexual characteristics. Prior to receiving puberty suppression therapy, individuals must have received a diagnosis of gender dysphoria and have undergone a mental health evaluation (Kyriakou et al, 2020).

- **Cross-Sex Hormones:** For adults and late adolescents (16 years or older), the next treatment phase recommended is taking cross-sex hormones (e.g., testosterone or estrogen) to create secondary sex characteristics. In men transitioning into women, these include breast development and widening around the pelvis. Women who transition into men experience deeper voices, redistribution of fat deposits, and growing facial hair. According to the Endocrine Society, late adolescents who qualify for cross-sex hormones must have a confirmed diagnosis of gender dysphoria from a mental health practitioner with experience treating that population. Some physical changes induced by these hormones are irreversible (Endocrine Society, 2017).
- **Sex Reassignment Surgery:** Sometimes referred to as "gender affirming" surgery, this treatment does not consist of just one procedure but several, depending on the desires of the transitioning individual. Primarily, sex reassignment procedures alter the primary and secondary sexual characteristics. Men transitioning into women (trans-females) undergo a penectomy (removal of the penis), orchiectomy (removal of the testes), and vulvoplasty (creation of female genitals). Other procedures trans-females may undergo include breast augmentation and facial feminization. For women that transition into men (trans-males), procedures include mastectomy (removal of the breasts), hysterectomy (removal of the uterus), oophorectomy (removal of the ovaries), and phalloplasty (creation of male genitals). Because of the complexities involved in phalloplasty, many trans-males do not opt for this procedure and limit themselves to mastectomies. Additionally, the effects of sex reassignment surgery, such as infertility, are permanent (WPATH, 2012).

While some clinical organizations assert that they are the standard of care for gender dysphoria, the U.S. Food and Drug Administration (FDA) currently has not approved any medication as clinically indicated for this condition (Unger, 2018). Although puberty blockers and cross-sex hormones are FDA approved, the FDA did not approve them for treating gender dysphoria, meaning that their use for anything other than the clinical indications listed is off-label (American Academy of Pediatrics, 2014). As for surgical procedures, the FDA does not evaluate or approve them, but it does review all surgical devices (FDA, 2021). In addition, the Endocrine Society concedes that its practice guidelines for sex reassignment treatment does *not* constitute a "standard of care" and that its grades for available services are low or very low (Endocrine Society, 2017).[4]

[4] Disagreement over how to treat gender dysphoria, gender identity disorder, and transsexualism has persisted since sex reassignment surgery first became available in the 1960s. In a 2006 counterargument, Paul McHugh highlights how individuals seeking surgery had other reasons that extended beyond gender identity, including sexual arousal and guilt over homosexuality. In addition, he asserts that undergoing sex reassignment procedures did not improve a patient's overall behavioral health and that providing a "surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it" (McHugh, 2006).

Literature Review: Introduction

Currently, an abundance of literature and studies on gender dysphoria is available through academic journals, clinical guidelines, and news articles. Similar to other mental health issues, the material addresses a broad range of topics consisting of available treatments, etiology (i.e., causes), risks, benefits, and side effects. Although most stories reported by the media indicate that treatments such as cross-sex hormones and sex reassignment surgery are the most effective, research reveals that numerous questions still exist. These include what are the long-term health effects of taking cross-sex hormones, what are the real causes of gender dysphoria, and how many individuals that transition will eventually want to revert to their natal sex. Additionally, much of the available research is inconclusive regarding the effectiveness of sex reassignment treatments with multiple studies lacking adequate sample sizes and relying on subjective questionnaires. While much of the scientific literature leans in favor of cross-sex hormones and surgery as options for improving the mental health of individuals with gender dysphoria, it does not conclusively demonstrate that the benefits outweigh the risks involved, either short or long-term. What studies do reveal with certainty is that sex reassignment surgery and cross-sex hormones pose permanent effects that can result in infertility, cardiovascular disease, and disfigurement. All of this indicates that further research is necessary to validate available treatments for gender dysphoria. Thus, physicians, who recommend sex reassignment treatment, are not adhering to an evidence-based medicine approach and are following an eminence-based model.

The following literature review addresses the multiple facets of this condition and presents areas of ongoing debate and persisting questions. Beginning with the condition's etiology and continuing with evaluations of puberty blockers, cross-sex hormones, and surgery, the review explains each area separately and in context of gender dysphoria at large. Additionally, the review provides an analysis on available research on mental health outcomes as well as the condition's persistence into adulthood. Taken as a whole, the available studies demonstrate that existing gender dysphoria research is inconclusive and that current treatments are used to achieve cosmetic benefits while posing risky side effects as well as irreversible changes.

Literature Review: Etiology of Gender Dysphoria

What causes gender dysphoria is an ongoing debate among experts in the scientific and behavioral health fields. Currently, the research indicates that diagnosed individuals have higher proportions of autism spectrum disorder (ASD), history of trauma or abuse, fetal hormone imbalances, and co-existing mental illnesses. Also, experts acknowledge that genetics may factor into gender dysphoria. Another potential cause is social factors such as peer and online media influence. At the moment, none of the studies provides a definite cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative. However, the research does raise questions about whether treatments with permanent effects are warranted in a population with disproportionately high percentages of ASD, behavioral health problems, and trauma.

In a 2017 literature review by Fatima Saleem and Syed Rizvi, the authors examine gender dysphoria's numerous potential causes and the remaining questions requiring further research. In conclusion, the pair indicate that associations exist between the condition and ASD, schizophrenia, childhood abuse, genetics, and endocrine disruption chemicals but that more research is needed to improve understanding of how these underlying issues factor into a diagnosis. Throughout the review, Saleem and Rizvi identify the following as potential contributing elements to the etiology of gender dysphoria:

- **Neuroanatomical Etiology:** During fetal development, the genitals and brain develop during different periods of a pregnancy, the first and second trimesters respectively. Because the processes are separate, misaligned development is possible where the brain may have features belonging to the opposite sex. The authors identify one study where trans-females presented with a "female-like putamen" (structure at the base of the brain) when undergoing magnetic resonance imaging (MRI) scans.[5]
- **Psychiatric Associations:** Saleem and Rizvi identify multiple studies reporting that individuals with gender dysphoria have high rates of anxiety and depressive disorders with results ranging as high as 70% having a mental health diagnosis. In addition, the pair note that schizophrenia may also influence desires to transition. However, the review does not assess whether the mental health conditions are secondary to gender dysphoria.
- **Autism Spectrum Disorder:** Evidence suggests a significant percentage of individuals diagnosed with gender dysphoria also have ASD. The authors note that the available studies only establish a correlation and do not identify mechanisms for causation.
- **Childhood Abuse:** Like the above causes, Saleem and Rizvi note that those with gender dysphoria tended to experience higher rates of child abuse across all categories, including neglect, emotional, physical, and sexual.
- **Endocrine Disruptors:** Although this cause still requires substantial research, it is a valid hypothesis regarding how phthalates found in plastics can create an imbalance of testosterone in fetuses during gestation, which can potentially lead to gender dysphoria. The authors point to one study that makes this suggestion.

[5] Research on neuroanatomical etiology for gender dysphoria remains highly speculative due to limitations of brain imaging (Mayer and McHugh, 2016). In addition, neuroscience demonstrates that exposures to certain environments and stimuli as well as behaviors can affect brain changes (Gu, 2014). Furthermore, available research indicates that male and female brains have different physical characteristics but cannot be placed in separate categories due to extensive overlap of white/grey matter and neural connections (Joel et al, 2015).

Saleem and Rizvi's review reveal that gender dysphoria's etiology can have multiple factors, most of which require treatments and therapies not consisting of cross-sex hormones or surgery. (Saleem and Rizvi, 2017).

Out of the research on the condition's etiology, a large portion focuses on the correlation with ASD. One of the more substantial studies by Van der Miesen et al published in 2018 evaluates 573 adolescents and 807 adults diagnosed with ASD and compares them to 1016 adolescents and 846 adults from the general population. The authors' findings note that adolescents and adults with ASD were approximately 2.5 times more likely to indicate a desire of becoming the opposite sex. Although the methodology used to reach this conclusion consisted of surveys where respondents had a choice of answering "never," "sometimes," or "often," the results correspond with those of similar studies. Van der Miesen et al also indicate that most responses favoring a change in gender responded with "sometimes." Additionally, the authors do not state how many in their sample group actually had a gender dysphoria diagnosis. (Van der Miesen et al, 2018).

Another study by Shumer et al from 2016 utilizes a smaller sample size (39 adolescents) referred to an American hospital's gender clinic. Unlike Van der Miesen et al's research, Shumer et al evaluate subjects with a diagnosis of gender dysphoria for possible signs of ASD or Asperger's syndrome. Their findings revealed that 23% of patients presenting at the clinic would likely have one of the two conditions. Possible explanations for the high percentage are the methods used to gather the data. Shumer et al requested a clinical psychologist to administer the Asperger Syndrome Diagnostic Scale to the parents of the sample patients, four of whom already had an ASD diagnosis. The authors conclude that the evidence to support high incidence of gender dysphoria in individuals with ASD is growing and that further research is needed to determine the specific cause (Shumer et al, 2016).

Research indicating a strong correlation between ASD and gender dysphoria is not the only area where new studies are emerging. Discussions about the effects of prenatal testosterone levels are also becoming more prevalent. One such example is Sadr et al's 2020 study that looks at the lengths of the index and ring fingers (2D:4D) of both left and right hands of 203 individuals diagnosed with gender dysphoria. The authors used this method because prenatal testosterone levels can affect the length ratios of 2D:4D. By comparing the ratios of a group with gender dysphoria to a cohort from the general population, Sadr et al could assess for any significant difference. Their results indicated a difference in trans-females who presented with more feminized hands. For trans-males, the difference was less pronounced. The results for both groups were slight, and the meta-analysis that accompanies the study notes no statistically significant differences in multiple groups from across cultures. However, Sadr et al further assert that the evidence strongly suggests elevated prenatal testosterone levels in girls and reduced amounts in boys may contribute to gender dysphoria, requiring additional research (Sadr et al, 2020).

In addition to biological factors and correlations with ASD, researchers are exploring psychological and social factors to assess their role in gender dysphoria etiology. This literature examines a range of potential causative agents, including child abuse, trauma, and peer group influences. One such study by Kozlowska et al from 2021 explores patterns in children with high-risk attachment issues who also had gender dysphoria. The authors wanted to assess whether past incidents of abuse, loss, or trauma are associated with higher rates of persons desiring to transition. As a basis, Kozlowska et al cite John Bowlby's research on childhood brain development, noting that the process is not linear and depends

heavily on lived experiences. The study further acknowledges that biological factors combined with life events serve as the foundation for the next developmental phase and that early poor-quality attachment issues increase the risk for psychological disorders in adolescence and adulthood. Such disorders include mood and affective disorders, suicidal ideations, and self-harm. Kozlowska et al also cite other studies that indicate a high correlation between gender dysphoria and "adverse childhood events" and further assert that the condition "needs to be conceptualized in the context of the child's lived experience, and the many different ways in which lived experience is biologically embedded to shape the developing brain and to steer each child along their developmental pathway" (Kozlowska et al, 2021).

For their study, Kozlowska et al recruited 70 children diagnosed with gender dysphoria and completed family assessments going back three generations. This in-depth level was necessary to ascertain any and all events that could affect a child's developmental phases. Additionally, the researchers individually assessed the diagnosed children. To establish comparisons, Kozlowska et al performed assessments on a non-clinical group and a mixed-psychiatric group. Their results demonstrate that children with gender dysphoria have significantly higher rates of attachment issues as well as increased reports of "adverse childhood events" such as trauma (e.g., domestic violence and physical abuse). Furthermore, the authors indicate that a high proportion of families reported "instability, conflict, parental psychiatric disorder, financial stress, maltreatment events, and relational ruptures." These results led Kozlowska et al to conclude that gender dysphoria can be "associated with developmental pathways – reflected in at-risk patterns of attachment and high rates of unresolved loss and trauma – that are shaped by disruptions to family stability and cohesion." The study also cites that treatment requires "a comprehensive biopsychosocial assessment with the child and family, followed by therapeutic interventions that address, insofar as possible, the breadth of factors that are interconnected with each particular child's presentation" (Kozlowska et al, 2021).

This recent study raises questions regarding the medical necessity of gender dysphoria treatments such as puberty blockers and cross-sex hormones for adolescents. If high percentages of children diagnosed with gender dysphoria also have histories of trauma and attachment issues, should conventional behavioral health services be utilized without proposing treatments that pose irreversible effects? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects (i.e., the watchful waiting approach)?

Aside from the notion that childhood abuse and adversity can potentially cause gender dysphoria, other possible explanations such as social factors (e.g., peer influences and media) may be contributing factors. Research on rapid onset gender dysphoria (ROGD) links this phenomenon to peer and social elements. In an analysis utilizing parent surveys, Lisa Littman asserts that the rapid rise of ROGD is not associated with the traditional patterns of gender dysphoria onset (i.e., evidence of an individual's gravitation to the opposite sex documented over multiple years) but rather exposure to "social and peer contagion." Littman uses this term in the context of definitions cited in academic literature, stating that "social contagion is the spread of affect or behaviors through a population" and that "peer contagion is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially undermine their own development or harm others." Examples of the latter's negative effects include depression, eating disorders, and substance abuse. What prompted this study is a sudden increase of parents reporting their daughters declaring themselves to be transgender without any previous signs of gender dysphoria. Littman also indicates

that these parents cite that their daughters became immersed in peer groups and social media that emphasized transgender lifestyles (Littman, 2018).

In addition to identifying characteristics of ROGD, the study examines social media content that provides information to adolescents regarding how to obtain cross-sex hormones through deception of physicians, parents, and behavioral health professionals. Such guidance includes coaching on how to fit a description to correspond to the DSM-V and pressures to implement treatment during youth to avoid a potential lifetime of unhappiness in an undesirable body. Littman further states that "online content may encourage vulnerable individuals to believe that non-specific symptoms and vague feelings should be interpreted as gender dysphoria." The study also notes that none of the individuals assessed using the parental surveys qualified for a formal diagnosis using the DSM-V criteria (Littman, 2018).

The survey responses revealed similar data to Kozlowska et al's study with 62.5% of the adolescents having a mental health or neurodevelopmental disorder. Furthermore, the responses indicate a rapid desire to bypass behavioral health options and pursue cross-sex hormones. 28.1% of parents surveyed stated that their adolescents did not want psychiatric treatments. One parent even reported that their daughter stopped taking prescribed anti-depressants and sought advice only from a gender therapist. Littman's research further reveals that 21.2% of parents responded that their adolescent received a prescription for puberty blockers or cross-sex hormones at their first visit (Littman, 2018). These responses indicate that practitioners do not uniformly follow clinical guidelines when making diagnoses or prescribing treatment.

In the discussion, Littman proposes two hypotheses for the appearance of ROGD. The first states that social and peer contagion is one of the primary causes, and the second asserts that ROGD is a "maladaptive coping mechanism" for adolescents dealing with emotional and social issues. While the surveyed parents did not report early signs of gender dysphoria, a majority noted that their daughters had difficulty in handling negative emotions. Littman concludes that ROGD is distinct from gender dysphoria as described in the DSM-V and that further research is needed to assess whether the condition is short or long-term (Littman, 2018). What the study does not explore, but raises the question, is what proportion of those being treated for gender dysphoria are adolescents with ROGD.

Littman's study along with the others reveal that the causes of gender dysphoria are still a mystery and could have multiple biological and social elements. Because of this ongoing uncertainty, treatments that pose irreversible effects should not be utilized to address what is still categorized as a mental health issue. That allows adequate opportunity for individuals to receive treatment for co-existing mental disorders, establish their gender dysphoria diagnoses, and understand how cross-sex hormones and surgery will alter the appearance of their bodies as well as long-term health.

Literature Review: Desistance of Gender Dysphoria and Puberty Suppression

The World Professional Association for Transgender Health (WPATH) and the Endocrine Society both endorse the use of gonadotropin releasing hormones (Gn-RH) to suppress puberty in young adolescents who have gender dysphoria. Both organizations state that the treatment is safe and fully reversible. In addition, they state that delaying pubertal onset can provide extra time for adolescents to explore the gender in which they choose to live. The associations further state that puberty suppression is necessary to prevent the development of primary and secondary sexual characteristics that can inhibit successful transitions into adulthood (WPATH, 2012; Endocrine Society, 2017). Of the two groups, WPATH offers clinical criteria an individual should meet to qualify for puberty suppression such as addressing psychological co-morbidities and assessing whether gender dysphoria has intensified (WPATH, 2012).

Neither organization explains that the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects. Both organizations neglect to mention that using Gn-RH for gender dysphoria by altering the appearance is not an FDA-approved clinical indication. Furthermore, the research used to justify puberty suppression is low or very-low quality and little information is available on long-term effects (Hruz, 2019). Additionally, in his assessment, Quentin Van Meter explained that physical differences between central precocious puberty and natural onset puberty demonstrate that Gn-RH does not have permanent adverse effects for those treated for the former but can for the latter such as insufficient bone-mineral density and neural development (Van Meter, 2022). Also, as recently as May 17, 2022, during a U.S. Senate Committee on Appropriations hearing, Lawrence Tabak, acting director of the National Institutes of Health, responded to Senator Marco Rubio, acknowledging that no long-term studies are available evaluating the effects of puberty blockers when used for gender dysphoria (U.S. Senate Committee on Appropriations, 2022).

Currently, some studies provide weak support for this treatment but leave too many questions as to its effectiveness and medical necessity, especially considering how many children decide against transitioning. In addition, puberty blockers halt development of primary and secondary sexual characteristics and deny opportunities for adolescents to adapt and become comfortable with their natal sex. Instead, puberty blockers can serve as a potential "gateway drug" for cross-sex hormones by denying them the experience of physically maturing (Laidlaw et al, 2018).

A 2013 study by Steensma et al offers data on the percentage of children who opt not to transition after experiencing gender dysphoria. The authors follow 127 adolescents (mean age of 15 during the evaluation period) for four years who had been referred to a Dutch gender dysphoria clinic. Out of this cohort, 47 (37%; 23 boys and 24 girls) continued experiencing the condition and applied for sex reassignment treatment. The other 80 adolescents never returned to the clinic. Because this clinic was the only one that treated gender dysphoria in the Netherlands, Steensma et al assumed that those who did not return no longer desired transitioning. The study indicates one of the key predictors for persisting gender dysphoria was the age of first presentation. Older adolescents that started going to the clinic were more likely to persist, while younger adolescents tended not to follow through. Steensma et al provide further insight into other predicting factors, particularly on how each individual views his or her gender identity. The authors note that adolescents who "wished they were the other sex" were more likely to become desisters and that those who "believed that they were the other sex" persisted

and later sought sex reassignment treatment (Steensma et al, 2013). While the study focuses on factors that contribute to the condition's persistence or desistance, it raises the question as to whether puberty suppression is necessary when age plays such an important role regarding the decision to transition.

WPATH and the Endocrine Society state that the primary reason for initiating pubertal suppression is not to treat a physical condition but to improve the mental health of adolescents with gender dysphoria. However, available research does not yield definitive results that this method is effective at addressing a mental health issue. The "gold standard" for medical studies is the randomized-controlled trial (RCT). Because RCTs utilize large sample sizes, have blind testing groups (i.e, placebos), and use objective controls, they can offer concrete conclusions and shape the array of established treatments. In addition, RCTs require comparisons between cohort outcomes and ensure that participants are randomly assigned to each group. These measures further reduce the potential for bias and subjectivity (Hariton and Locascio, 2018).

Presently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available. Instead, the limited number of published studies on the topic utilize small sample sizes and subjective methods (Hruz, 2019). A 2015 article by Costa et al is one such example. The study asserts that "psychological support and puberty suppression were both associated with an improved global psychological functioning in gender dysphoric adolescents." To reach this conclusion, the authors selected 201 children diagnosed with the condition and divided them into two groups, one to receive psychological support only and the other to get puberty blockers in addition to psychological support. Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control. To assess whether puberty suppression is an effective treatment, the authors administered two self-assessments (Utrect Gender Dysphoria Scale and Children's Global Assessment Scale)[6] to the groups at 6-month intervals during a 12-month period. Because the study relies heavily on self-assessments, the conclusions are likely biased and invalid. Another problem that is also present and common throughout articles supporting puberty suppression is the short-term period of the study. Costa et al's conclusions may not be the same if additional follow-ups occurred three or five years later (Costa et al, 2015). This further raises the question whether low-quality studies like Costa et al's should serve as the basis for clinical guidelines advising clinicians to prescribe drugs for off-label purposes.

Aside from questionable research, information regarding the full physical effects of puberty suppression is incomplete. In a 2020 consensus parameter prepared by Chen et al, 44 experts in neurodevelopment, gender development, and puberty/adolescence reached a conclusion stating that "the effects of pubertal suppression warrant further study." The basis for this was that the "full consequences (both beneficial and adverse) of suppressing endogenous puberty are not yet understood." The participating experts emphasized that the treatment's impact on neurodevelopment in adolescents remains unknown. Chen et al explain that puberty-related hormones play a role in brain development as documented in animal studies and that stopping these hormones also prevents neurodevelopment in addition to sexual maturation. The authors further raise the question whether normal brain development resumes as if it had not been interrupted when puberty suppression ceases. Because this

[6] Behavioral health practitioners use the Children's Global Assessment Scale (CGAS) to measure child functioning during the evaluation process to determine diagnoses. Available evidence indicates that the CGAS is not effective for evaluating children who experienced trauma and presented with mental health symptoms (Blake et al, 2006).

question remains unanswered, it casts doubt on the veracity of organizations' assertions that puberty suppression is "fully reversible" (Chen et al, 2020).

In addition to the unanswered questions and low-quality research, puberty suppression causes side effects, some of which have the potential to be permanent. According to a 2019 literature review by De Sanctis et al, most side effects associated with Gn-RH are mild, consisting mostly of irritation around injection sites. However, clinicians have linked the drug to long-term conditions such as polycystic ovarian syndrome, obesity, hypertension, and reduced bone mineral density. While reports of these events are low and the authors indicate that Gn-RH is safe for treating central precocious puberty (Note: De Sanctis et al do not consider gender dysphoria in their analysis), the review raises questions about whether off-label use to treat a psychological condition is worth the risks (De Sanctis et al, 2019).

Furthermore, De Sanctis et al cite studies noting increased obesity rates in girls who take Gn-RH but that more research is needed to gauge the consistency. Additionally, the authors note that evidence is strong regarding reduced bone mineral density during puberty suppression but indicate that the literature suggests it is reversible following treatment (De Sanctis et al, 2019). While research leans toward the reversibility of effects on bone mineral density, the quantity of studies available on this subject are limited. Also, no long-term research has been completed on how puberty suppression affects bone growth. This is significant because puberty is when bone mass accumulates the most (Kyriakou et al, 2020). One example of a complication involving bone growth and Gn-RH is slipped capital femoral epiphysis. This condition occurs when the head of the femur (i.e., thighbone) can slip out of the pelvis, which can eventually lead to osteonecrosis (i.e., bone death) of the femoral head. Although the complication is rare, its link to puberty suppression indicates that the "lack of adequate sex hormone exposure" could be a cause (De Sanctis et al, 2019).

The current literature on puberty suppression indicates that using it to treat gender dysphoria is off-label, poses potentially permanent side effects, and has questionable mental health benefits. The limited research and lack of FDA approval for that clinical indication prompt questions about whether medications with physically altering effects should be used to treat a problem that most adolescents who experience it will later overcome by conforming to their natal sex. Additional evidence is required to establish puberty suppression as a standard treatment for gender dysphoria.

Literature Review: Cross-Sex Hormones as a Treatment for Gender Dysphoria

Currently, the debate surrounding the use of cross-sex hormones to treat gender dysphoria revolves around their ability to improve mental health without causing irreversible effects. It is not about whether taking cross-sex hormones can alter someone's appearance. The evidence demonstrating the effectiveness of cross-sex hormones in achieving the secondary sexual characteristics of the opposite sex is abundant. Also, the overall scientific consensus concludes that individuals who take cross-sex hormones will reduce the primary sexual function of his or her natal sex organs. What researchers continue evaluating are the short and long-term effects on mental health, impacts on overall physical health, and how the changes affect the ability to detransition. Of these, benefits to mental health overshadow the other discussions. Prescribers of cross-sex hormones focus so heavily on behavioral health outcomes that they de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death (Hruz, 2020). Some clinical guidelines such as WPATH's do not even indicate that some of the changes are irreversible.

Like puberty suppression, the Endocrine Society and WPATH provide guidance on administering cross-sex hormones to individuals with gender dysphoria. Both organizations state that this treatment should not be administered without a confirmed diagnosis of gender dysphoria and only after a full psychosocial assessment. In addition, behavioral health practitioners must ensure that any mental comorbidities are not affecting the individual's desire to transition. WPATH and the Endocrine Society further state that clinicians should administer hormone replacements such as testosterone and Estradiol (estrogen) in gradual phases, where the dose increases over several months. For trans-females, the organizations state that progesterone (anti-androgen) is also necessary to block the effects of naturally produced testosterone (WPATH, 2012; Endocrine Society, 2017). When taking cross-sex hormones, trans-males need increased doses for the first six months. After that, the testosterone's effects are the same on lower doses. Once started, individuals cannot stop taking hormones unless they desire to detransition (Unger, 2016).

Although the two groups provide similar guidance, they vary on statements that can have significant impact on long-term outcomes, particularly regarding age. According to WPATH's standards, 16 years is the general age for initiating cross-sex hormones, but the organization acknowledges that the treatment can occur for younger individuals depending on circumstances (WPATH, 2012). This differs from the Endocrine Society, which states no specific age for appropriateness and explains the disagreements in assigning a number. The group highlights that most adolescents have attained sufficient competence by age 16 but may not have developed adequate abilities to assess risk (Endocrine Society, 2017). This raises the question whether adolescents can make sound decisions regarding their long-term health. Additionally, the varying guidance raises an issue with WPATH not only using age 16 as a standard but also indicating that younger adolescents are capable of making that choice.

WPATH's guidance also does not stress the irreversible nature of cross-sex hormones, citing the treatment as "partially reversible" and not indicating which changes are permanent. Furthermore, parts of WPATH's information are misleading and directly conflict with guidance issued by clinics and other sources. One such example consists of WPATH stating that "hormone therapy *may* (emphasis added) lead to irreversible changes." This statement is misleading in light of existing research, which indicates that multiple physical changes are permanent. In addition, WPATH claims that certain effects of cross-

sex hormones such as clitoral enlargement can last one to two years when it is actually irreversible (UCSF, 2020). WPATH also does not explain the risks to male fertility, noting that lowered sperm count or sterility is "variable." The University of California at San Francisco (UCSF) provides starkly different information by stating that trans-females should expect to become sterile within a few months of starting cross-sex hormones. UCSF also advises trans-females to consult a sperm bank if they may want to father children after transitioning (WPATH, 2012; UCSF, 2020). Below is a chart that outlines the effects of cross-sex hormones and identifies which ones are reversible or permanent.

Physical Changes Effectuated by Cross-Sex Hormones	
Physical Changes in Trans-Males (Female-to-Male Transitions)	
Physical Change	**Reversible or Irreversible**
Oily Skin or Acne	Reversible
Facial and Body Hair Growth	Irreversible
Male-Pattern Baldness	Irreversible
Increased Muscle Mass	Reversible
Body Fat Redistribution	Reversible
Ceasing of Menstruation	Reversible
Enlarged Clitoris	Irreversible
Vaginal Atrophy	Reversible
Deepening of Voice	Irreversible
Physical Changes in Trans-Females (Male-to-Female Transitions)	
Body Fat Redistribution	Reversible
Decreased Muscle Mass	Reversible
Skin Softening or Decrease in Oiliness	Reversible
Lower Libido	Reversible
Fewer Spontaneous Erections	Reversible
Male Sexual Dysfunction	Possibly Irreversible
Breast Growth	Irreversible
Decrease in Testicular Size	Reversible
Decrease in Sperm Production or Infertility	Likely Irreversible
Slower Facial and Body Hair Growth	Reversible

Sources: UCSF, 2020; WPATH, 2012; Endocrine Society, 2017[7]

The above chart demonstrates that trans-males and trans-females experience different effects from cross-sex hormones that can cause myriad issues in later life. For example, trans-males who opt to detransition may face challenges related to permanent disfigurement (e.g., facial hair and deepened voices). Trans-females, on the other hand, may not endure the same issues pertaining to visible physical changes but might become despondent over being unable to reproduce. This can occur regardless of whether the transitioning individual is satisfied with sex reassignment. Given that the clinical guidelines do not provide uniform information on the permanent effects of cross-sex hormones, clinicians are unable to make sound recommendations to patients. This treatment can supposedly alleviate symptoms

[7] This chart consists of conclusions regarding physical changes made by three different clinical organizations. If one organization determined that a physical change was irreversible, that was sufficient to meet the criteria to be listed as "irreversible" in the chart.

of distress. However, cross-sex hormones' permanent effects also have the potential to cause psychological issues.

Arguments favoring cross-sex hormones assert that the desired physical changes can alleviate mental health issues in individuals with gender dysphoria but do not consider that hormones used in this manner, like puberty blockers, are off-label. While the FDA has approved estrogen and testosterone for specific clinical indications (e.g., hypogonadism), it has not cleared these drugs for treating gender dysphoria. Additionally, these arguments do not acknowledge that the U.S. Drug Enforcement Administration (DEA) lists testosterone as a Schedule III controlled substance, meaning that it has a high probability of abuse (DEA, 2022). Furthermore, evidence of psychological benefit from cross-sex hormones is low-quality and relies heavily on self-assessments taken from small sample groups (Hruz, 2020).

A 2019 study by Kuper et al seeks to demonstrate that adolescents desiring cross-sex hormones have elevated rates of depression, anxiety, and challenges with peer relationships. To make their findings, the authors provided questionnaires to 149 adolescents who presented at a gender clinic in Dallas, Texas and concluded that half of the sample group experienced increased psychological issues. One problem with the study is that it relies on parent or self-assessments such as the Youth-Self Report, Body-Image Scale, and the Child Behavior Checklist. While these assessments have strong reliability, the sample is cross-sectional, consisting of gender dysphoric individuals who presented for an initial visit at the clinic. Also, Kuper et al do not directly link these psychological symptoms to gender dysphoria but rather insinuate a strong connection. Without an analysis of the longitudinal histories of the participants, the study cannot demonstrate whether gender dysphoria was a direct cause of the psychological issues, which could possibly result from trauma, abuse, or family dysfunction. Kuper et al's study only presents weak correlation between adolescents who report symptoms of distress and gender dysphoria. While the authors do not claim that the participants' psychological problems caused the condition, they fail to explicitly state that no demonstrable relationship exists and explain that their findings are "broadly consistent with the previous literature" (Kuper et al, 2019).

Additionally, a more comprehensive literature review from 2019 by Nguyen et al evaluates the effect of cross-sex hormones on mental health outcomes. Although the authors argue that the evidence supports the treatment, they do note that available studies use "uncontrolled observational methods" and "rely on self-report." The review also asserts that "future research should focus on applying more robust study designs with large sample sizes, such as controlled prospective cohort studies using clinician-administered ratings and longitudinal designs with appropriately matched control groups." All of these are characteristics of RCTs. While Nguyen et al highlight flaws in the studies in their conclusion, they do not emphasize them in their analysis, opting to focus primarily on results. Another problem with the studies selected for the review is the short-term periods for evaluation. Out of 11 studies Nguyen et al discuss, only one tracks its participants for 24 months. The others only follow their cohorts for 6 or 12 months (Nguyen et al, 2019). Without long-term data to support assertions that cross-sex hormones substantially improve the mental health of individuals with gender dysphoria, the review cannot make definitive conclusions on the treatment's benefits.

Basing their stances on this low-quality evidence, clinical associations such as the American Academy of Pediatrics (AAP) and the American Psychology Association endorse the use of cross-sex hormones as treatments for gender dysphoria. In particular, the AAP discourages use of the term "transition" and

asserts that medical treatments used to obtain secondary characteristics of the opposite sex are "gender affirming." This decision mirrors the DSM-V's interpretation of gender being part of identity. The AAP further states that taking cross-sex hormones is an "affirmation and acceptance of who they (i.e., patient) have always been" (AAP, 2018). The American Psychological Association also takes a similar stance in its *Resolution on Gender Identity Change Efforts* by asserting that medical treatments such as puberty suppression, cross-sex hormones, and surgery improve mental health and quality of life and reinforce the notion that transitioning and seeking sex reassignment therapies do not constitute a psychological disorder (American Psychological Association, 2021). Stances like these can substantially influence practitioners and their treatment recommendations. Given that low-quality evidence serves as the basis for supportive positions, this raises questions about whether clinicians can make informed decisions for their patients that will promote the best outcomes.

James Cantor published a critique in 2020 of the AAP's endorsement of "gender affirming" treatments, arguing that the organization did not base its recommendations on established medical evidence. He asserts that the AAP's position is based on research that does not support intervention but rather supports "watchful waiting" because most transgender youths desist and identify as their natal sex during puberty. Cantor further argues that the AAP not only disregards evidence but also cites "gender affirming" interventions as the only effective method. To conclude, he states the organization is "advocating for something far in excess of mainstream practice and medical consensus" (Cantor, 2020).

Given those evidentiary problems, those who rely on the AAP's endorsement as a basis for "gender affirming" treatments are practicing eminence-based medicine as opposed to evidence-based medicine. Eminence-based medicine refers to clinical decisions made by relying on the opinions of prominent health organizations rather than relying on critical appraisals of scientific evidence (Nhi Le, 2016). While it is true that the AAP has more knowledge than a lay person and a degree of credibility in the medical community, the opinions of such organizations are not valid unless they are based on quality evidence.

Research on sex reassignment also does not adequately address the reasons for and prevalence of detransitioning. Although no definite numbers are available regarding the percentage of transgender people who decide to detransition, research indicates that roughly 8% decide to return to their natal sex. The reasons range from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria. In a 2020 study by Lisa Littman, 101 people who had detransitioned provided their basis for doing so. Out of the sample group, 96% had taken cross-sex hormones and 33% had sex reassignment surgery. The average age for transitioning was 22 years, and the mean duration for the transition was 4 years. This indicates that even allowing additional time beyond the recommended age of 16 years can still lead to regrets. The study also raises the question as to whether individuals who transitioned at 16 or younger wanted to detransition in greater numbers. The author further offers reasons why these individuals sought cross-sex hormones and surgery, which include having endured trauma (mental or sexual), homophobia (challenged to accept oneself as a homosexual), peer and media influences, and misogyny (applicable only to trans-males). To obtain the results, the participants responded to a survey that asked about their backgrounds (e.g., reasons for transitioning, mental health comorbidities), and motivations for detransitioning. Littman noted that half of the women (former trans-males) had a mental health disorder and/or had experienced trauma within a year of deciding to transition. Men (former trans-females) reported much lower numbers of behavioral health issues and trauma after de-transitioning. Additionally, 77% of men surveyed identified as the opposite gender prior to transition, whereas just 58% of women had (Littman, 2020).

Of the reasons cited for detransitioning, the majority (60%) noted that they became more comfortable with their natal sex. Other reasons included concerns over complications from the treatments, primarily cross-sex hormones, and lack of improved mental health. Other less-cited explanations include concerns about workplace discrimination and worsening physical health. The study also notes that approximately 36% of participants experienced worse mental health symptoms. Based on the findings, Littman concludes that more research is needed in tracking the transgender population to obtain accurate percentages of those who decide to detransition and that men and women reported varying reasons for deciding to transition and later return to their natal sex. The author notes that higher rates of trauma and peer group influences might have contributed to women's decisions, which Littman attributes partially to rapid onset gender dysphoria (Littman, 2020). What the study also indicates is that cross-sex hormones are not a validated treatment for gender dysphoria. Nearly all of the participants had taken them and decided against maintaining the physical changes. Given that the majority of surveyed detransitioners cited that they were comfortable with their biological sex, the study indicates that gender dysphoria is not necessarily a lifelong issue. This necessarily raises doubts about whether cross-hormones, which cause permanent physical damage, is justified.

In addition to the psychological factors, cross-sex hormones pose significant long-term health risks to transitioning individuals. Currently, little information is available given that researchers have not had adequate time to study the effects in this population. However, use of hormones for other conditions has yielded data on how these drugs can affect the body and the cardiovascular system in particular. Because of the high dosages required to achieve physical change and the need to continuously take the drugs, cross-sex hormones can potentially harm quality of life and reduce life expectancy for transitioning individuals. According to Dutra et al, trans-females are three times more likely to die from a cardiovascular event than the general population. In their 2019 literature review, Dutra et al examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that use of estrogen or testosterone can increase risks for cardiovascular disease. Throughout their review, Dutra et al cite examples of trans-females having higher triglyceride levels after 24 months of cross-sex hormones and how researchers halted a study on estrogen due to an increase in heart attacks among participants. Another article the authors reference indicates a higher risk for thromboembolisms (i.e., blood clots) in trans-females. For trans-males, Dutra et al explain that research shows significant increased risk for hypertension, high cholesterol, obesity, and heart attacks. One study noted that trans-males have a four times greater risk of heart attack compared to women identifying as their natal sex. Dutra et al conclude that most transgender individuals are younger than 50 and that more studies are needed as this population ages. They do note that available studies indicate that cross-sex hormones pose dangers to long-term cardiovascular health (Dutra et al, 2019).

In sum, the literature reveals that the evidence for cross-sex hormones as a treatment for gender dysphoria is weak and insufficient. Between the permanent effects, off-label use, and consequences to long-term health, cross-sex hormones are a risky option that does not promise a cure but does guarantee irreversible changes to both male and female bodies. Additionally, the inadequate studies serving as the basis for recommendations by clinical associations can lead to providers making poorly informed decisions for their patients. Research asserting that taking cross-sex hormones improves mental health is subjective and short-term. More studies that utilize large sample sizes and appropriate

methods is required before the medical profession should consider cross-sex hormones as one of gender dysphoria's standard treatments.

Literature Review: Sex Reassignment Surgery

The final phase of treatment for gender dysphoria is sex reassignment surgery. This method consists of multiple procedures to alter the appearance of the body to resemble an individual's desired gender. Some procedures apply to the genitals (genital procedures) while others affect facial features and vocal cords (non-genital procedures). While the surgery creates aesthetical aspects, it does not fully transform someone into the opposite biological sex. Transgender persons who undergo the procedures must continue taking cross-sex hormones to maintain secondary sexual characteristics. Additionally, all physical changes are irreversible, and the success rate of a surgery varies depending on the procedure and the population. For example, surgeries for trans-females have much better results than those for trans-males. Complications such as post-operative infections can also arise with the urinary tract system. However, sex reassignment surgery supposedly can provide drastic, if not complete, relief from gender dysphoria (Endocrine Society, 2017). The following is a list of procedures (both genital and non-genital) for trans-females and trans-males that create physical features of the desired sex.

Procedures for Trans-Females

- **Genital Surgeries:** These consist of penectomy (removal of the penis), orchiectomy (removal of the testicles), vaginoplasty (construction of a neo-vagina), clitoroplasty (construction of a clitoris), and vulvoplasty (construction of a vulva and labia). To perform, a surgeon begins by deconstructing the penis and removing the testicles. The penile shaft and glans are repurposed to serve as a neo-vagina and artificial clitoris (Note: These are not actual female genitalia but tissue constructed to resemble female anatomy). If the shaft tissue is insufficient, the surgeon may opt to use a portion of intestine to build a neo-vagina. The scrotum serves as material for fashioning a vulva and labia. In addition to constructing female genitalia, the surgeon reroutes the urethra to align with the neo-vagina. Genital surgeries for trans-females result in permanent sterility (Bizic et al, 2014).
- **Chest Surgery:** To attain full breasts, trans-females can undergo enlargement. The procedure is similar to breast augmentation for women where a surgeon places implants underneath breast tissue. Prior to surgery, trans-females need to take cross-sex hormones for roughly 24 months to increase breast size to get maximum benefit from the procedure (Endocrine Society, 2017).
- **Cosmetic and Voice Surgeries:** Designed to create feminine facial features, fat deposits, and vocal sounds, these procedures are secondary to genital procedures and intended to alter trans-females' appearances to better integrate into society as a member of the desired gender (WPATH, 2012).

Procedures for Trans-Males

- **Mastectomy:** This is the most performed sex reassignment surgery on trans-males because cross-sex hormones and chest-binding garments are often insufficient at diminishing breasts. To remove this secondary sexual characteristic, trans-males can undergo a mastectomy where a surgeon removes breast tissue subcutaneously (i.e., under the skin) and reconstructs the nipples to appear masculine. The procedure can result in significant scarring (Monstrey et al, 2011).
- **Genital Surgeries:** Unlike the procedures for trans-females, genital surgeries for trans-males are more complex and have lower success rates. Consisting of hysterectomy, oophorectomy

(removal of the ovaries), vaginectomy (removal of the vagina), phalloplasty (construction of a penis), and scrotoplasty (construction of prosthetic testicles), a team of surgeons must manufacture a penis using skin from the patient (taken from an appendage) while removing the vagina and creating an extended urethra. The functionality of the artificial penis can vary based on how extensive the construction was. Attaining erections requires additional surgery to implant a prosthesis, and the ability to urinate while standing is often not achieved. Genital procedures for trans-males result in irreversible sterility (Monstrey et al, 2011).

- **Cosmetic Surgeries:** Similar to trans-females, these procedures create masculine facial features, fat deposits, and artificial pectoral muscles. They aid trans-males with socially integrating as their desired gender. Surgery to deepen voices is also available but rarely performed (WPATH, 2012).

Because sex reassignment surgery is irreversible, the criteria for receiving these procedures is the strictest of all gender dysphoria treatments. WPATH and the Endocrine Society suggest rigorous reviews of patient history and prior use of other therapies before approving. Furthermore, the two organizations recommend that only adults (18 years old) undergo sex reassignment surgery.[8] WPATH and the Endocrine Society also recommend ensuring a strongly documented diagnosis of gender dysphoria, addressing all medical and mental health issues, and at least 12 months of cross-sex hormones for genital surgeries. Although the organizations agree on most criteria, they differ on whether hormones should be taken prior to mastectomies. WPATH asserts that hormones should not be a requirement, whereas the Endocrine Society advises up to 2 years of cross-sex hormones before undergoing the procedure (WPATH, 2012; Endocrine Society, 2017). What this indicates is that trans-males might undergo breast removal without having first pursued all options if their clinician adheres to WPATH's guidelines, which can lead to possible regret over irreversible effects.

As with cross-sex hormones, sex reassignment surgery's irreversible physical changes can potentially show marked mental health improvements and prevent suicidality in people diagnosed with gender dysphoria. In April 2022, the chair of the University of Florida's pediatric endocrinology department, Dr. Michael Haller, advocated for the benefits of "gender affirming" treatments (WUSF, 2020). However, the available evidence calls such statements into question. Recent research assessing both cross-sex hormones and sex reassignment surgery indicate that the effects on "long-term mental health are largely unknown." In studies regarding the benefits of surgery, the results have the same weaknesses as the research for the effectiveness of cross-sex hormones. These include small sample sizes, self-report surveys, and short evaluation periods, all of which are insufficient to justify recommendations for irreversible treatments (Bränström et al, 2020).

Two studies conducted in Sweden provide insight on the effectiveness of sex reassignment surgery in improving the behavioral health of transgender persons. Because Sweden has a nationalized health system that collects data on all residents, this country can serve as a resource to assess service utilization and inpatient admissions. Both studies, one by Dhejne et al from 2011 and another by Bränström et al published in 2020, assessed individuals who had received sex reassignment surgery and examined outcomes over several decades. Dhejne et al's findings indicate that sex reassignment

[8] Although practice guidelines indicate the minimum age to undergo sex reassignment surgery is 18, available evidence demonstrates that mastectomies have been performed on adolescent girls as young as 13 who experience "chest dysphoria" (Olson-Kennedy et al, 2018).

procedures do not reduce suicidality. The authors explained that individuals who underwent sex reassignment surgery were still more likely to attempt or commit suicide than those in the general population. This study is unique because it monitored the subjects over a long period of time. Dhejne et al note that the transgender persons tracked for the study did not show an elevated suicide risk until ten years after surgery (Dhejne et al, 2011). Given that a high proportion of research follows sex reassignment patients for much shorter timeframes, this evidence indicates that surgery might have little to no effect in preventing suicides in gender dysphoric individuals over the long run.

In addition to having an increased suicide risk, Dhejne et al discuss how individuals who underwent sex reassignment procedures also had higher mortality due to cardiovascular disease. The authors do not list the specific causes but establish the correlation. Given that cross-sex hormones can damage the heart, the increased risk could be related to the drugs and not the surgery. Furthermore, the study explains that the tracked population had higher rates of psychiatric inpatient admissions following sex reassignment. Dhejne et al established this by examining the rates of psychiatric hospitalizations in these individuals prior to surgery and noted higher utilization in the years following the procedures. These results are in comparison to the Swedish population at large. While the study contradicts other research emphasizing improvements in mental health issues, it has its limitations. For example, the sample size is small. Dhejne et al identified only 324 individuals who had undergone sex reassignment surgery between 1973 and 2003. In addition, the authors noted that while the tracked population had increased suicide risks when compared to individuals identifying as their natal sex, the rates could have been much higher if the procedures were not available (Dhejne et al 2011). What this study postulates is that sex reassignment surgery does not necessarily serve as a "cure" to the distress resulting from gender dysphoria and that ongoing behavioral health care may still be required even after a complete transition.

Bränström et al's study evaluating the Swedish population used a larger sample (1,018 individuals who had received sex reassignment surgery) but tracked them for just a ten-year period (2005 to 2015).[9] Unlike Dhejne et al, the authors did not track suicides and focused primarily on mood or anxiety disorder treatment utilization. Their results indicate that transgender persons who had undergone surgery utilized psychiatric outpatient services at lower rates and were prescribed medications for behavioral health issues at an annual decrease rate of 8%. Bränström et al also did not limit comparisons to Sweden's overall population and factored in transgender persons who take cross-sex hormones but have not elected to have surgery. Those results still presented a decrease in outpatient mental health services. However, Bränström et al note that individuals only on cross-sex hormones showed no significant reduction in that category, which calls into question claims regarding effectiveness of cross-sex hormones in ameliorating behavioral issues.

The Bränström et al study prompted numerous responses questioning its methodology. The study lacked a prospective cohort or RCT design, and it did not track all participants for a full ten-year period (Van Mol et al, 2020). These criticisms resulted in a retraction, asserting that Bränström et al's conclusions were "too strong" and that further analysis by the authors revealed that the new "results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related

[9] Although Bränström et al claim to follow individuals for a ten-year period, peer reviews of the research revealed that this was not the case, noting the authors had varying periods of tracking, ranging from one to ten years (Van Mol et al, 2020).

health care visits or prescriptions or hospitalizations following suicide attempts in that comparison" (Kalin, 2020).

There are multiple explanations for why the Bränström et al study reached different results than the Dhejne et al study. For starters, Bränström et al tracked a larger sample group over a later period (2005 to 2015 as opposed to 1973 to 2003) during which gender dysphoria underwent a dramatic shift in definition. Also, Dhejne et al did not see elevated suicides until after ten years, raising the question as to whether sex reassignment surgery has temporary benefits on mental health rather than long-term or permanent benefits. Like the other Swedish study, Bränström et al's findings are a correlation and do not specifically state that the procedures cause reduced psychiatric service utilization (Bränström et al, 2020).

A 2014 study by Hess et al in Germany evaluated satisfaction with sex reassignment procedures by attempting to survey 254 trans-females on their quality of life, appearance, and functionality as women. Out of the participants selected, only 119 (47%) returned completed questionnaires, which Hess et al indicate is problematic because dissatisfied trans-females might not have wanted to provide input. The results from the collected responses noted that 65.7% of participants reported satisfaction with their lives following surgery and that 90.2% indicated that the procedures fulfilled their expectations for life as women. While these results led Hess et al to conclude that sex reassignment surgery generally benefits individuals with gender dysphoria, the information is limited and raises questions (Hess et al, 2014). Such questions include whether the participants had mental health issues before or after surgery and did their satisfaction wane over time. Hess et al only sent out one questionnaire and not several to ascertain consistency over multiple years. Questions like these raise doubts about the validity of the study. Although Hess et al's research is just one study, numerous others utilize the same subjective methods to reach their conclusions (Hruz, 2018).

In his assessment, Patrick Lappert contributes additional insight on the appropriate clinical indications for mastectomies, noting that removal of breast tissue is necessary following the diagnosis of breast cancer or as a prophylactic against that disease. He cites that this basis is verifiable through definitive laboratory testing and imaging, making it an objective diagnosis, whereas gender dysphoria has no such empirical methods to assess and depends heavily on the patient's perspective. Also, Lappert notes that trans-males who make such decisions are doing so on the idea that the procedure will reduce their dysphoria and suicide risk. However, they are making an irreversible choice based on anticipated outcomes supported only by weak evidence, and thus cannot provide informed consent (Lappert, 2022).

The literature is inconclusive on whether sex reassignment surgery can improve mental health for gender dysphoric individuals. Higher quality research is needed to validate this method as an effective treatment. This includes studies that obtain detailed participant histories (e.g., behavioral diagnoses) and track participants for longer periods of time. These are necessary to evaluate the full effects of treatments that cause irreversible physical changes. In addition, sex reassignment procedures can result in severe complications such as infections in trans-females and urethral blockage in trans-males. Health issues related to natal sex can also persist. For example, trans-males who undergo mastectomy can still develop breast cancer and should receive the same recommended screenings (Trum et al, 2015). Until more definitive evidence becomes available, sex reassignment surgery should not qualify as a standard treatment for gender dysphoria.

Literature Review: Quality of Available Evidence and Bioethical Questions

Quality of Available Evidence

Clinical organizations that have endorsed puberty suppression, cross-sex hormones, and sex reassignment surgery frequently state that these treatments have the potential to save lives by preventing suicide and suicidal ideation. The evidence, however, does not support these conclusions. James Cantor notes that actual suicides (defined as killing oneself) are low, occur at higher rates for men, and that interpretations of available research indicate a blurring of numbers between those with gender dysphoria and homosexuals (Cantor, 2022). Although information exists that contradicts certain arguments, media outlets continue to report stories emphasizing the "lifesaving" potential of sex reassignment treatment. A May 2022 story by NBC announced survey results under the headline "Almost half of LGBTQ youths 'seriously considered suicide in the past year'" (NBC, 2022). This is a significant claim that can have a sensational effect on patients and providers alike, but how strong is the evidence supporting it? Almost all of the data backing this assertion are based on surveys and cross-studies, which tend to yield low-quality results (Hruz, 2018). In addition, how many gender dysphoric individuals are seeing stories in the media and not questioning the narrative? Because research on the effectiveness of treatments is ongoing, a debate persists regarding their use in the adolescent and young-adult populations, and much of it is due to the low-quality studies serving as evidence.

In their assessment, Romina Brignardello-Petersen and Wojtek Wiercioch examined the quality of 61 articles published between 2020 and 2022 (Note: See Attachment A for the full study). They identified research on the effectiveness of puberty blockers, cross-sex hormones, and sex reassignment surgery and assigned a grade (high, moderate, low, or very low) in accordance with the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. Out of the articles reviewed, all with a few exceptions received grades of low or very low quality when demonstrating outcomes regarding improvements in mental health and overall satisfaction with transitioning. For puberty blockers, Brignardello-Petersen and Wiercioch identified low quality evidence for alleviating gender dysphoria and very low quality for reducing suicidal ideation. The authors also had nearly identical findings for cross-sex hormones. However, they noted moderate quality evidence for the likelihood of cardiovascular side effects. Regarding surgery, Brignardello-Petersen and Wiercioch graded articles that examined overall satisfaction and complication rates. None of the studies received grades higher than low quality. These findings led the authors to conclude that "there is great uncertainty about the effects" of sex reassignment treatments and that the "evidence alone is not sufficient to support" using such treatments. Among the studies graded was one the U.S. Department of Health and Human Services cited in its information on "gender affirming" treatments. The authors noted this research had a "critical risk of bias" and was of low quality (Brignardello-Petersen and Wiercioch, 2022).

For his part, James Cantor provided a review of available literature, which addresses studies on etiology, desistance, effectiveness of puberty blockers and cross-sex hormones, suicidal behaviors, and clinical association and international guidelines. Throughout his analysis, Cantor cites weak evidence, poor methodologies (e.g., retrospective versus prospective studies), and lack of professional endorsements in research that indicates the benefits of sex reassignment treatment. Additionally, he notes that improvements in the behavioral health of adolescents who take cross-sex hormones can be attributed to the counseling they receive concurrently and that suicidality is not likely to result from gender

dysphoria but from co-occurring mental disorders. The reasoning behind the third point is based on the blending of suicide and suicidality, which are two distinct concepts. The former refers specifically to killing oneself, and the second regards ideation and threats in attempts to receive help. Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males. His other conclusions indicate that young children who experience gender identity issues will most likely desist by puberty, that multiple phenomena can cause the condition, and that Western European health services are not recommending medical intervention for minors. The basis for these statements is the paucity of high to moderate quality evidence on the effectiveness of sex reassignment treatments and numerous studies demonstrating desistance (Cantor, 2022).

Despite the need for stronger studies that provide definitive conclusions, many practitioners stand by the recommendations of the AAP, Endocrine Society, and WPATH. This is evident in a letter submitted to the *Tampa Bay Times*, which was a rebuttal to the Florida Department of Health's (DOH) guidance on treatment for gender dysphoria (Note: The guidance recommends against using puberty blockers, cross-sex hormones, or surgery for minors) (DOH, 2022). The authors, led by six professors at the University of Florida's College of Medicine, state that recommendations by clinical organizations are based on "careful deliberation and examination of the evidence by experts." However, evaluations of these studies show otherwise. Not only does the available research use cross-sectional methods such as surveys, but it provides insufficient evidence based on momentary snapshots regarding mental health benefits. These weak studies are the foundation for the clinical organizations' guidelines that the University of Florida professors tout as a gold standard. In addition, the letter's authors state that DOH's guidance is based on a "non-representative sample of small studies and reviews, editorials, opinion pieces, and commentary" (Tampa Bay Times, 2022). That statement misses the point when it comes to evidence demonstrating whether treatments with irreversible effects are beneficial because the burden of proof is on those advocating for this treatment, not on those acknowledging the need for further research. This raises the question concerning how much academic rigor these professors are applying to practice guidelines released by clinical organizations and whether they also apply the same level of rigor to novel treatments for other conditions (e.g., drugs, medical devices).

Another example of a lack of rigor is a 2019 article by Herman et al from the University of California at Los Angeles (UCLA) that evaluated responses to a 2015 national survey on transgender individuals and suicide. Unlike other studies, this one utilized a large cohort with 28,000 participants from across the U.S. responding. However, the researchers used no screening criteria and did not randomly select individuals. In addition, responses consisted entirely of self-reports with no supporting evidence to even prove a diagnosis of gender dysphoria. Although Herman et al conclude that the U.S. transgender population is at higher risk for suicidal behaviors, the authors' supporting evidence is subjective and serves as a weak basis. Additionally, the survey results do not establish gender dysphoria as a direct cause of suicide or suicidal ideation. The questions required participants to respond about their overall physical and mental health. Out of those that indicated "poor" health, 77.7% reported suicidal thoughts or attempts during the previous year, whereas just 29.1% of participants in "excellent" health had. These percentages indicate that causes beyond gender dysphoria could be affecting suicidal behaviors. Other reasons cited include rejection by family or religious organizations and discrimination. The authors also acknowledge that their findings are broad, not nationally representative, and should serve as a basis for pursuing future research (Herman et al, 2019).

Yet another example is a study published in 2022 by Olson et al tracks 300 young children that identify as transgender over a 5-year period, and asserts low probabilities for detransitioning, while supporting interventions such as puberty blockers. The authors found that children (median age of 8 years) who identified as a gender that differed from their natal sex were unlikely to desist at a rate of 94% and conclude that "transgender youth who socially transitioned at early ages" will continue "to identify that way." While this appears to contradict earlier studies that demonstrate most young adolescents who change gender identities return to their "assigned gender at birth," the authors note differences and limitations with the results. For example, Olson et al notes that they did not verify whether the participants met the DSM-V's diagnostic criteria for gender dysphoria and that the children's families supported the decisions to transition. Instead, the authors relied on a child's chosen pronouns to classify as transgender. Also, Olson et al acknowledged that roughly 66% of the sample was biologically male. This is particularly significant considering that the majority of transitioning adolescents in recent years were natal females. Another issue with the study includes the median age at the end of follow-up (13 years), which is when boys begin puberty. Furthermore, the authors cite that the participants received strong parental support regarding the transitions, which constitutes positive reinforcement (Olson et al, 2022). Other research demonstrates that such feedback on social transitioning from parents and peers can prevent desistance following pubertal onset (Zucker, 2019). Despite these limitations, the New York Times announced the study's publication under the headline "Few Transgender Children Change Their Minds After 5 Years" (New York Times, 2022). Such a title can add to the public's perception that gender dysphoria requires early medical intervention to address.

Bioethical Questions

The irreversible physical changes and potential side effects of sex reassignment treatment raise significant ethical questions. These questions concern multiple bioethical principles including patient autonomy, informed consent, and beneficence. In a 2019 article, Michael Laidlaw, Michelle Cretella, and Kevin Donovan argue that prescribing puberty blockers or cross-sex hormones on the basis that they will alleviate psychological symptoms should not be the standard of care for children with gender dysphoria. Additionally, the three authors assert that such treatments "constitute an unmonitored, experimental intervention in children without sufficient evidence of efficacy or safety." The primary ethical question Laidlaw, Cretella, and Donovan pose is whether pushing physical transitioning, particularly without parental consent, violates fully informed consent (Laidlaw et al, 2019).

In accordance with principles of bioethics, several factors must be present to obtain informed consent from a patient. These consist of being able to understand and comprehend the service and potential risks, receiving complete disclosure from the physician, and voluntarily providing consent. Bioethicists generally do not afford the ability of giving informed consent to children who lack the competence to make decisions that pose permanent consequences (Varkey, 2021). Laidlaw, Cretella, and Donovan reinforce this point regarding sex reassignment treatment when they state that "children and adolescents have neither the cognitive nor the emotional maturity to comprehend the consequences of receiving a treatment for which the end result is sterility and organs devoid of sexual function" (Laidlaw et al, 2019). This further raises the question whether clinicians who make such treatment recommendations are providing full disclosure about the irreversible effects and truly obtaining informed consent.

Another issue is the conflict between consumerism and the practitioner's ability to provide appropriate care. Consumerism refers to patients learning about treatments through media/marketing and requesting their health care provider to prescribe it, regardless of medical necessity. Considering that social media is rife with individuals promoting "gender affirmative" drugs and surgeries, children are making self-assessments based on feelings they may not understand and that can lead to deep regret in the future (Littman, 2018). This can contribute to patients applying pressure on their doctors to prescribe medications not proven safe or effective for the condition. Consumerism can also affect bioethical compliance because it constrains clinicians from using their full "knowledge and skills to benefit the patient," which is "tantamount to a form of patient abandonment and therefore is ethically indefensible" (Varkey, 2021).

In his assessment, G. Kevin Donovan explains the bioethical challenges related to sex reassignment treatment, emphasizing the lack of informed consent when administering these services. He asserts that gender dysphoria is largely a self-diagnosis practitioners cannot verify with empirical tests (e.g., labs and imaging) and that providing such treatments is experimental. Because of the lack of consent and off-label use of puberty blockers and cross-sex hormones, Donovan raises the question as to how "experienced and ethical physicians so mislead others or be so misled themselves?" He further attributes this phenomenon to societal and peer pressures that influence self-diagnosis and confirm decisions to transition. As a result, these pressures lead to individuals wanting puberty blockers, cross-sex hormones, and surgery. Donovan goes on to identify several news stories where embracing sex reassignment treatment is a "cult-like" behavior. To conclude, he links these factors back to the failure to obtain informed consent from transgender patients and how that violates basic bioethical principles (Donovan, 2022).

Coverage Policies of the U.S. and Western Europe

U.S. Federal Level Coverage Policies

Medicare: In 2016, the Centers for Medicare and Medicaid Services (CMS) published a decision memo announcing that Medicare Administrative Contractors (MACs) can evaluate sex reassignment surgery coverage on a "case-by-case" basis.[10] CMS specifically noted that the decision memo is not a National Coverage Determination and that "no national policy will be put in place for the Medicare program" (CMS, 2016). This memo was the result of CMS reviewing over 500 studies, reports, and articles to the validity of the procedures. Following its evaluation, CMS determined that "the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . small sample sizes, lack of validated assessment tools, and considerable (number of participants in the studies) lost to follow up." In 2017, CMS reinforced this position with a policy transmittal that repeated the 2016 memo's criteria (CMS, 2017).

The basis for Medicare's decision is that the "clinical evidence is inconclusive" and that "robust" studies are "needed to ensure that patients achieve improved health outcomes." In its review of available literature, CMS sought to answer whether there is "sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria." After evaluating 33 studies that met inclusion criteria, CMS's review concludes that "not enough high-quality evidence" is available "to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively." Additionally, out of the 33 studies, just 6 provided "useful information" on the procedures' effectiveness, revealing that their authors "assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies" that "did not demonstrate clinically significant changes or differences in psychometric test results" following sex reassignment surgery (CMS, 2016).

U.S. Department of Defense – Tricare: Tricare does not cover sex reassignment surgery, but it will cover psychological services such as counseling for individuals diagnosed with gender dysphoria and cross-sex hormones when medically necessary (Tricare, 2022).[11]

U.S. Department of Veterans Affairs: The U.S. Department of Veterans Affairs (VA) does not cover sex reassignment surgery, although it will reimburse for cross-sex hormones and pre- and post-operative care related to transitioning. Because the VA only provides services to veterans of the U.S. armed forces, it cannot offer sex reassignment treatment to children (VA, 2020).[12]

---

[10] The Centers for Medicare and Medicaid Services is part of the U.S. Department of Health and Human Services. Its primary functions are to administer the entire Medicare system and oversee federal compliance of state Medicaid programs. In addition, CMS sets reimbursement rates and coverage criteria for the Medicare program.
[11] Tricare is the insurance program that covers members of the U.S. armed forces and their families. This includes children of all ages.
[12] The U.S. Department of Veterans Affairs oversees the Veterans Health Administration (VHA), which consists of over 1,000 hospitals, clinics, and long-term care facilities. As the largest health care network in the U.S., the VHA provides services to veterans of the U.S. armed forces.

State-Level Coverage Policies

Florida: In April 2022, DOH issued guidance for the treatment of gender dysphoria, recommending that minors not receive puberty blockers, cross-sex hormones, or sex reassignment surgery.[13] The justification offered for recommending against these treatments is that available evidence is low-quality and that European countries also have similar guidelines. Accordingly, DOH provided the following guidelines:

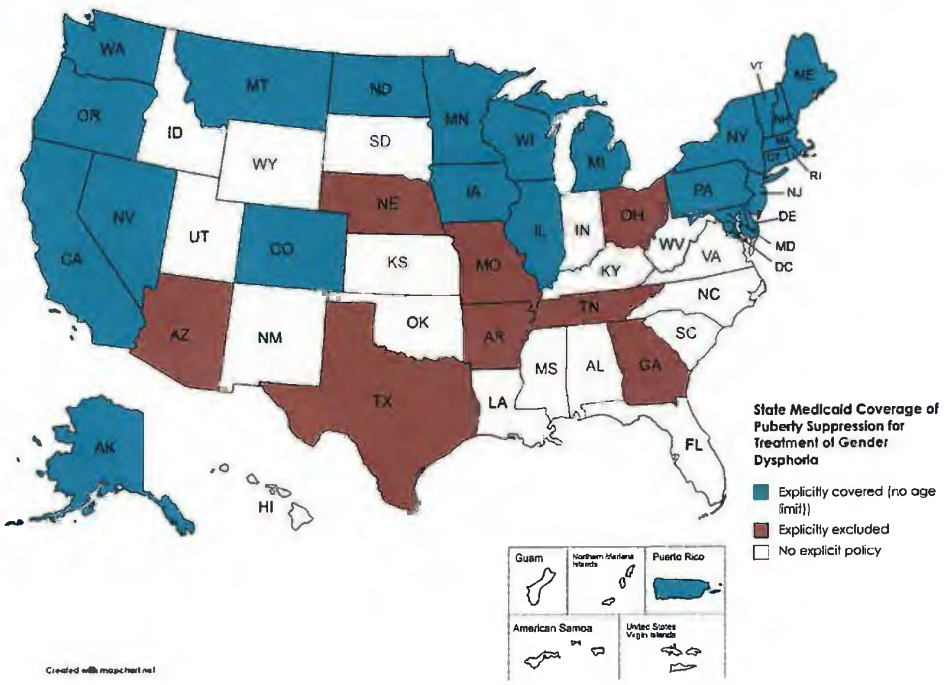
- "Social gender transition should not be a treatment option for children or adolescents."
- "Anyone under 18 should not be prescribed puberty blockers or hormone therapy."
- "Gender reassignment surgery should not be a treatment option for children or adolescents."
- "Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider."

In a separate fact sheet released simultaneously with the guidance, DOH further asserts that the evidence cited by the federal government cannot establish sex reassignment treatment's ability to improve mental health (DOH, 2022).

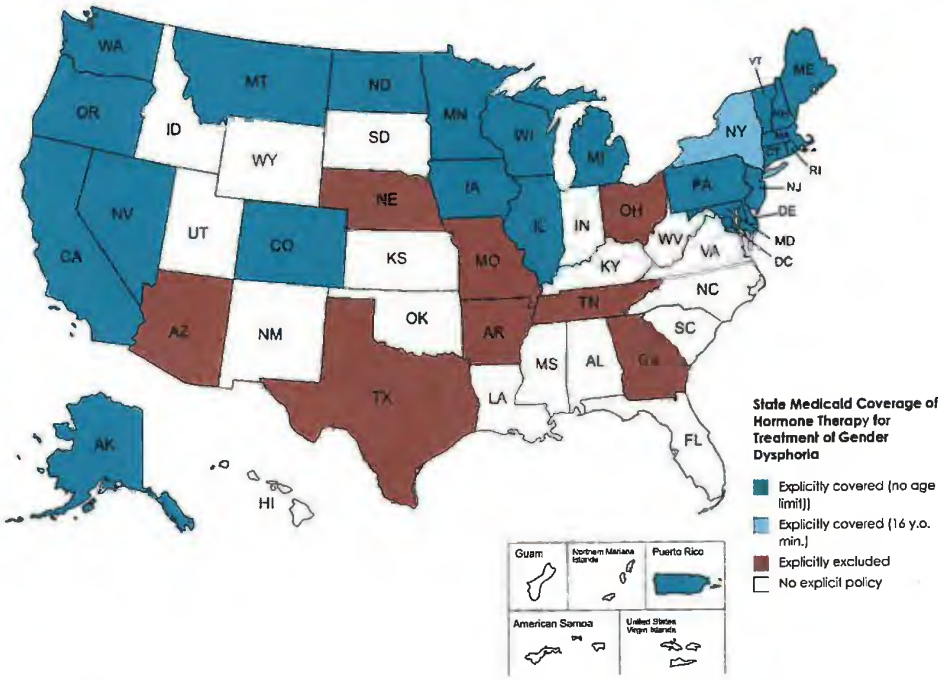
State Medicaid Programs: Because individual states differ in health services offered, Medicaid programs vary in their coverage of sex reassignment treatments. The following maps identify states that cover sex reassignment treatments, states that have no policy, and states that do not cover such treatments.

[13] Unlike the federal government, the State of Florida delegates responsibilities for Medicaid and health care services to five separate agencies (Agency for Health Care Administration, Department of Health, Department of Children and Families, Department of Elder Affairs, and Agency for Persons with Disabilities). Each agency has its own separate head (secretary or surgeon general), which reports directly to the Executive Office of the Governor. As Florida's public health agency, DOH oversees all county health departments, medical professional boards, and numerous health and welfare programs (e.g., Early Steps and Women, Infants, and Children). Because it oversees the boards, DOH has authority to release practice guidelines.

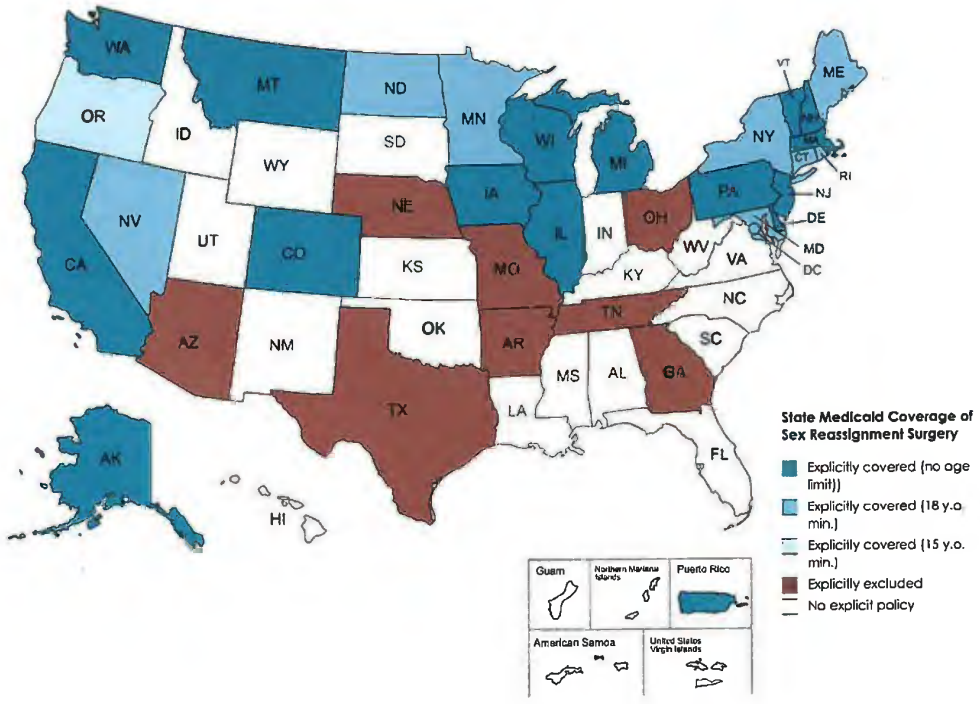
State Medicaid programs with coverage decisions regarding puberty blockers:



State Medicaid programs with coverage decisions regarding cross-sex hormones:



State Medicaid programs with coverage decisions regarding sex reassignment surgery:



Western Europe

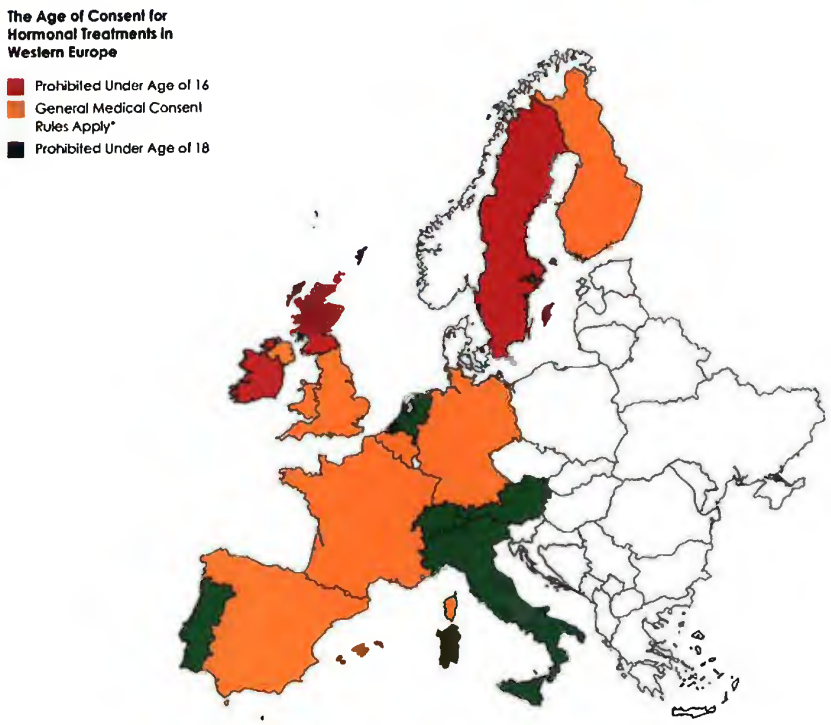
Scandinavian countries such as Sweden and Finland have released new guidelines on sex reassignment treatment for children. In 2022, the Swedish National Board of Health stated that "the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits." With the exception of youths who exhibited "classic" signs of gender identity issues, adolescents who present with the condition will receive behavioral health services and gender-exploratory therapy (Society for Evidence Based Gender Medicine, 2022).

In Finland, the Palveluvalikoima issued guidelines in 2020 stating that sex reassignment in minors "is an experimental practice" and that "no irreversible treatment should be initiated." The guidelines further assert that youths diagnosed with gender dysphoria often have co-occurring psychiatric disorders that must be stabilized prior to prescribing any cross-sex hormones or undergoing sex reassignment surgery (Palveluvalikoima, 2020).

The United Kingdom (U.K.) is also reassessing the use of irreversible treatments for gender dysphoria due the long-term effects on mental and physical health. In 2022, an independent interim report commissioned by the U.K.'s National Health Service (NHS) indicates that additional research and systematic changes are necessary to ensure the safe treatment of gender dysphoric youths. These include reinforcing the diagnosis process to assess all areas of physical and behavioral health, additional training for pediatric endocrinologists, and informing parents about the uncertainties regarding puberty blockers. The interim report is serving as a benchmark until the research is completed for final guidelines (The Cass Report, 2022).

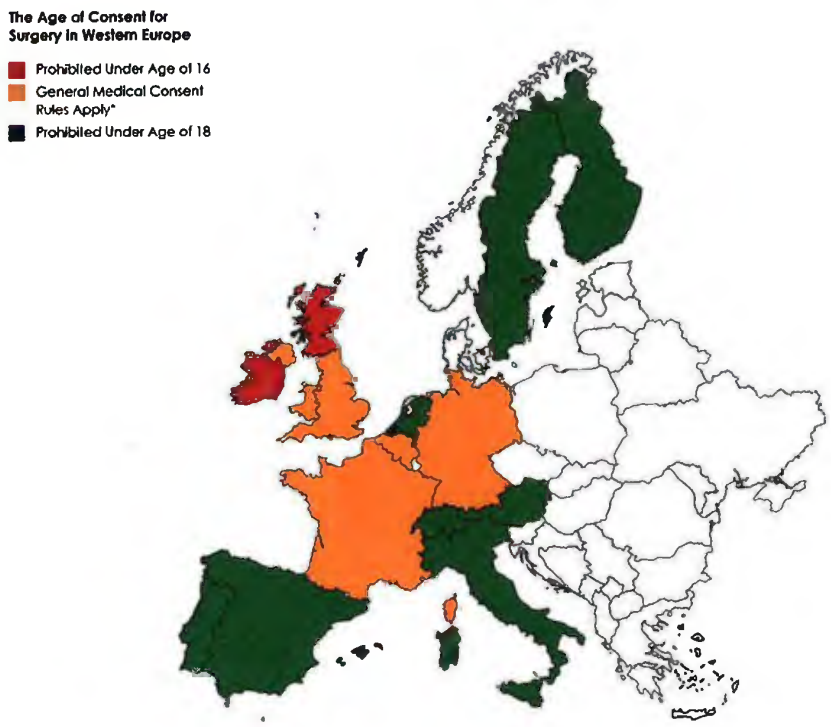
Like state Medicaid programs, health systems across Western Europe also vary in their coverage of sex reassignment treatment.

Western European nations' requirements for cross-sex hormones:



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Western European nations' requirements for sex reassignment surgery:



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Generally Accepted Professional Medical Standards Recommendation

This report does not recommend sex reassignment treatment as a health service that is consistent with generally accepted professional medical standards. Available evidence indicates that the services are not proven safe or effective treatments for gender dysphoria.

Rationale

The available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. As this report demonstrates, the evidence favoring "gender affirming" treatments, including evidence regarding suicidality, is either low or very low quality:

- **Puberty Blockers:** Evidence does not prove that puberty blockers are safe for treatment of gender dysphoria. Evidence that they improve mental health and reduce suicidality is low or very low quality.
- **Cross-Sex Hormones:** Evidence suggesting that cross-sex hormones provide benefits to mental health and prevents suicidality is low or very low quality. Rather, evidence shows that cross-sex hormones cause multiple irreversible physical consequences as well as infertility.
- **Sex Reassignment Surgery:** Evidence of improvement in mental health and reduction in suicidality is low or very low quality. Sex reassignment surgery results in irreversible physical changes, including sterility.

While clinical organizations like the AAP endorse the above treatments, none of those organizations relies on high quality evidence. Their eminence in the medical community alone does not validate their views in the absence of quality, supporting evidence. To the contrary, the evidence shows that the above treatments pose irreversible consequences, exacerbate or fail to alleviate existing mental health conditions, and cause infertility or sterility. Given the current state of the evidence, the above treatments do not conform to GAPMS and are experimental and investigational.

✓ **Concur** ____ **Do not Concur**

Comments:

_____

_____

_____

_____ 6/2/22
Deputy Secretary for Medicaid (or designee) *Date*

Works Cited

Almost Half of LGBTQ Youths 'Seriously Considered' Suicide in Past Year, Survey Says. *NBC News*. 4 May 2022.

American Academy of Pediatrics. Policy Statement: Off-Label Use of Drugs in Children. *Pediatrics*. 2014. 133(3).

American Psychiatric Association. *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders*. 2013.

American Psychiatric Association. *Gender Dysphoria Diagnosis*. 2017.

American Psychiatric Association. *What Is Depression*. 2020.

American Psychological Association. *APA Resolution on Gender Identity Change Efforts*. 2021.

Baker GM, Guzman-Arocho YD, Bret-Mounet VC, Torous VF, Schnitt SJ, Tobias AM, Bartlett RA, Fein-Zachary VJ, Collins LC, Wulf GM, Heng YJ. Testosterone Therapy and Breast Histopathological Features in Transgender Individuals. *Mod Pathol*. 2021. 34(1).

Blake K, Cangelosi S, Johnson-Brooks S, Belcher HME. Reliability of the GAF and CGAS with Children Exposed to Trauma. *Child Abuse and Neglect*. 2007. 31: 909-915.

Bizic MR, Jeftovic M, Pusica S, Stojanovic B, Duisin D, Vujovic S, Rakic V, Djordjevic ML. Gender Dysphoria: Bioethical Aspects of Medical Treatment. *BioMed Research International*. 2018: 9652305.

Bizic M, Kojovic V, Duisin D, Stanojevic D, Vujovic S, Milosevic A, Korac G, Djordjevic ML. An Overview of Neovaginal Reconstruction Options in Male to Female Transsexuals. *The Scientific World Journal*. 2014. 638919.

Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American Journal of Psychiatry*. 2020. 177(8).

Brignardello-Petersen R, Wiercioch W. Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. Unpublished: Commissioned by the Florida Agency for Health Care Administration. 2022.

Bruggeman BS, Dayton K, Diaz A, Evans J, Haller MJ, Hudak ML, Mathews CA, Shapiro M. We 300 Florida Health Care Professionals Say the State Gets Transgender Guidance Wrong. *Tampa Bay Times*. 27 April 2022.

Cantor J. Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *Journal of Sex and Marital Therapy*. 46(4).

Cantor J. *Science of Gender Dysphoria and Transsexualism*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Cass H. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People, Interim Report*. 2022.

The Centers for Medicare and Medicaid Services. Decision Memo: Gender Dysphoria and Gender Reassignment Surgery. 30 August 2016.

The Centers for Medicare and Medicaid Services. Pub 100-03 Medicare National Coverage Determinations. 3 March 2017.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, Steinberg L, Sisk CL, Roth J, Paus T, Mueller SC, McCarthy MM, Micevych PE, Martin CL, Kreukels BPC, Kenworthy L, Herting MM, Herlitz A, Heraldsen RJH, Dahl R, Crone EA, Chelune GJ, Burke SM, Berenbaum SA, Beltz AM, Bakker J, Eliot L, Vilain E, Wallace GL, Nelson EE, Garofalo R. Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth. *Transgender Health*. 2020. 5(4).

Claahsen-van der Grinten H, Verhaak C, Steensma T, Middelberg T, Roeffen J, Klink D. Gender Incongruence and Gender Dysphoria in Childhood and Adolescence – Current Insights in Diagnostics, Management, and Follow-Up. *European Journal of Pediatrics*. 2020. 180: 1349-1357.

Costa R, Colizzi M. The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review. *Neuropsychiatric Disease and Treatment*. 2016. 12: 1953-1966.

Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. 2015. 12(11).

Davy Z, Toze M. What Is Gender Dysphoria? A Critical Systematic Narrative Review. *Transgender Health*. 2018. 3(1).

De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: A Brief Review of Literature. *Acta Biomed*. 2019. 90(3).

De Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment. *Pediatrics*. 2014. 134(4).

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, Landen M. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS One*. 6(2).

Donovan GK. *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Dutra E, Lee J, Torbati T, Garcia M, Merz CNB, Shufelt C. Cardiovascular Implications of Gender-Affirming Hormone Treatment in the Transgender Population. *Maturitas*. 2019. 129: 45-49.

Few Transgender Children Change Their Minds After 5 Years, Study Finds. *New York Times*. 4 May 2022.

Gaetano P. David Reimer and John Money Gender Reassignment Controversy: The John/Joan Case. *The Embryo Project Encyclopedia*. 2017.

Geffen S, Horn T, Smith KJ, Cahill S. Advocacy for Gender Affirming Care: Learning from the Injectable Estrogen Shortage. *Transgender Health*. 2018. 3(1).

Go JJ. Should Gender Reassignment Surgery Be Publicly Funded? *Bioethical Inquiry*. 2018. 15: 527-534.

Gu J, Kanai, R. What contributes to individual differences in brain structure. *Front Hum Neurosci*. 2014. 8:262.

Hariton E, Locascio JJ. Randomised Controlled Trials – The Gold Standard for Effectiveness Research. *BJOG: An International Journal of Obstetrics and Gynecology*. 2018. 125(13).

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinological Metabolism*. 2017. 102(11).

Herman JL, Brown TNT, Haas AP. *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. University of California at Los Angeles School of Law Williams Institute. 2019.

Hess J, Neto RR, Panic L, Rubben H, Senf W. Satisfaction with Male-to-Female Gender Reassignment Surgery. *Deutsches Arzteblatt International*. 2014. 111: 795-801.

Hruz PW. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *Catholic Medical Association*. 2020. 87(1).

James HA, Chang AY, Imhof RL, Sahoo A, Montenegro MM, Imhof NR, Gonzalez CA, Lteif AN, Nippoldt TB, Davidge-Pitts CJ. A Community-Bases Study of Demographics, Medical and Psychiatric Conditions, and Gender Dysphoria/Incongruence Treatment in Transgender/Gender Diverse Individuals. *Biology of Sex Differences*. 2020. 11(55).

Jensen RK, Jensen JK, Simons LK, Chen D, Rosoklija I, Finlayson C. Effect of Concurrent Gonadotropin-Releasing Hormone Against Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. *Transgender Health*. 2019. 4(1).

Joel D., Berman Z., Tavor L. Sex beyond the Genitalia: The Human Brain Mosaic. *Proceedings of the National Academy of Sciences of the United States of America*. 2015. 112(50).

Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals after Gender-Affirming Surgeries: A Comment by the Editor on the Process (Letter). *American Journal of Psychiatry*. 2020. 177:765.

Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*. 2015. 9(9).

Kozlowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR. Attachment Patterns in Children and Adolescents with Gender Dysphoria. *Frontiers in Psychology*. 2021. 11: 582688.

Kuper LE, Mathews S, Lau M. Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy. *Journal of Developmental Behavior Pediatrics*. 2019. 40(8).

Kyriakou A, Nicolaides NC, Skordis N. Current Approach to the Clinical Care of Adolescents with Gender Dysphoria. *Acta Biomed*. 2020. 91(1).

Laidlaw M, Cretella M, Donovan K. The Right to Best Care for Children Does Not Include the Right to Medical Transition. *The American Journal of Bioethics*. 2019. 19(2).

Laidlaw M, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: Endocrine Treatment of Gender-Dsyphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *Journal of Clinical Endocrinological Metabolism*. 2018.

Lappert P. *Surgical Procedures and Gender Dysphoria*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Lee JY, Finlayson C, Olson-Kennedy J, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. *Journal of the Endocrine Society*. 2020. 4(9).

Levine SB. Informed Consent for Transgendered Patients. *Journal of Sex & Marital Therapy*. 2018. 10:1080.

Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*. 2021. 50: 3353-3369.

Littman L. Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports. *PLOS One*. 2018. 13(8).

Mayer L, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *The New Atlantis*. 2016. Fall Edition. 103.

McHugh PR. *The Mind Has Mountains: Reflections on Society and Psychiatry*. The Johns Hopkins University Press. 2006.

Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida. *Fox News*. 8 May 2022.

Merck Pharmaceuticals. *Merck Manual: Professional Version*. 2021.

Monstrey SJ, Ceulemans P, Hoebeke P. Sex Reassignment Surgery in the Female-to-Male Transsexual. *Seminars in Plastic Surgery*. 2011. 25(3).

Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. *Curr Psychiatry Rep*. 2019. 20(12).

Nhi Le HP. *Eminence-Based Medicine vs. Evidence-Based Medicine*. Students 4 Best Evidence. 12 January 2016. https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine,appraisal%20of%20scientific%20evidence%20available

Olson KR, Durwood L, DeMeules M, McLaughlin KL. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*. 2015. 137(3).

Olson KR, Durwood L, Horton R, Gallagher NM, Devor A. Gender Identity 5 Years After Social Transition. *Pediatrics*. 2022; doi: 10.1542/peds.2021-056082.

Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*. 2018. 172(5).

Palveluvalikoima of Finland. Recommendation of the Council for Choices in Health Care in Finland (Palko/Cohere Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020.

Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018. 142(4).

Sadr M, Korashad BS, Talaei A, Fazeli N, Honekopp J. 2D:4D Suggests a Role of Prenatal Testosterone in Gender Dysphoria. *Archives of Sexual Behavior*. 2020. 49: 421-432.

Saleem F, Rizvi SW. Transgender Associations and Possible Etiology: A Literature Review. *Cureus*. 9(12).

Shumer DE, Reisner SL, Edwards-Leeper L, Tishelman A. Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic. *LGBT Health*. 2016. 3(5).

Society for Evidence Based Gender Medicine. Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW). 2022.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2013. 52(6).

Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Open Network*. 2022; 59(2).

Trum H, Hoebeke P, Gooren L. Sex Reassignment of Transsexual People from a Gynecologist's and Urologist's Perspective. *Acta Obstetrica et Gynecologica*. 2016. 94: 563-567.

Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Method Analysis *LGBT Health*. 2021. 8(4).

UF Doctor Says Gender-Affirming Care Works for Kids Who Need It, and Can Even Save Lives. *Health News Florida*. 26 April 2022.

Unger CA. Hormone Therapy for Transgender Patients. *Translational Andrology and Urology*. 2016. 5(6).

University of California at San Francisco Health System. *Overview of Feminizing Hormone Therapy*. 2020.

University of California at San Francisco Health System. *Overview of Masculinizing Hormone Therapy*. 2020.

U.S. Department of Defense, Tricare. *Gender Dysphoria Services*. 2022.

U.S. Department of Health and Human Services: Office for Civil Rights. HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy. 2 March 2022.

U.S. Drug Enforcement Administration. *Drug Fact Sheet: Steroids*. 2020.

A Review of the President's FY 2023 Funding Request and Budget Justification for the National Institutes of Health. U.S. Senate Committee on Appropriations. Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 17 May 2022. https://www.appropriations.senate.gov/hearings/a-review-of-the-presidents-fy-2023-funding-request-and-budget-justification-for-the-national-institutes-of-health

Van Meter QL. Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Van der Miesen AIR, Hurley H, Bal AM, de Vries ALC. Prevalence of the Wish to Be of the Opposite Gender in Adolescents and Adults with Autism Spectrum Disorder. *Archives of Sexual Behavior*. 2018. 47: 2307-2317.

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *American Journal of Psychiatry*. 2020. 177:765.

Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Medical Principles and Practice*. 2021. 30: 17-28.

World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 2012.

Zhao JJ, Marchaim D, Palla MB, Bogan CW, Hayakawa K, Tansek R, Moshos J, Muthusamy A, Kotra H, Lephart PR, Wilson AN, Kaye KS. Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984-2008. *Surgical Infections*. 2014. 15(2).

Zucker K. Debate: Different strokes for different folks. *Child and Adolescent Mental Health*. 2019. doi.org/10.1111/camh.12330.

Attachments

Attachment A: Secretary for the Florida Agency for Health Care Administration's Letter to Deputy Secretary Thomas Wallace. 20 April 2022.

Attachment B: Complete text of Rule 59G-1.035, F.A.C.

Attachment C: Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.

Attachment D: James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.

Attachment E: Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.

Attachment F: Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.

Attachment G: G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

TAB 183-4

From: Cogle, Christopher
Subject: Re: GAPMS process
To: ""English"","" Jeffrey; Jeffrey.English@ahca.myflorida.com
Sent: June 27, 2022 2:52 PM (UTC-04:00)

Thank you.

And thank you for standing up for the true credibility of the GAPMS process.

I will read the SOP attachment you sent and think about it more.

Your dedication and work are appreciated.

Chris

Christopher R. Cogle, M.D.
Chief Medical Officer for Florida Medicaid

2727 Mahan Drive
Bldg 3 Room 2421-A MS8
Tallahassee, FL 32308
Mobile: (850) 228-2868

From: English, Jeffrey <Jeffrey.English@ahca.myflorida.com>
Sent: Monday, June 27, 2022 2:30:05 PM
To: Cogle, Christopher <Christopher.Cogle@ahca.myflorida.com>
Subject: RE: GAPMS process

Good afternoon, Dr. Cogle,

There is a SOP for GAPMS.

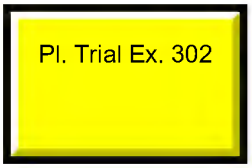
Typically, the requests for consideration of coverage come in either through a health service research email address or from leadership (less often).

The GAPMS process exists to determine whether the service/device requested for coverage is "experimental/investigational" or "medically necessary".

The request gets run through the attached checklist, and once it is determined to be an actual GAPMS (rather than a decision point or "simple" coverage determination) I reach out to the requestor and schedule a time to gently walk them thru the process.

We ask that the requestor(s) send us a host of information, much of which is included on the checklist. They often send us published research about the service/device under consideration, relevant national or local coverage determination information, and as many examples as they have of coverage by other states or major insurers. The amount of information provided by the requestors can vary quite a bit in quality and completeness.

Their request is added to our GAPMS queue to be worked on, typically in the order in which they have been received. We do tend to reward requestors who maintain contact, provide updates, and respond in a timely manner to any inquiries we might have.



Assuming they check off all the boxes on the checklist, so to speak, we begin the process.

- I determine what similar services or alternative treatments we already cover. I verify that the service/device requested has FDA approval and a dedicated billing code.
- I utilize Policy Reporter to determine which states currently include the service/device on their respective fee schedules. I also research and verify any existing coverage among the major insurance companies. I look for any existing national or local coverage determinations.
- The greatest amount of time is spent researching the existing professional literature on the subject, ideally well designed, non-industry sponsored studies, in peer-reviewed journals. Systematic reviews and meta-analyses, when existing, play a big role and can often provide a heads up regarding the quality of the literature as well as any gaps that may exist. The quality can of course vary considerably depending on the item in question and how long it has existed as a treatment option. I also look for any existing clinical guidelines that might exist related to the request, as well as consulting various sites like AHRQ, Cochrane, NICE, etc. What do they have to say about it? Also, are their any ongoing trials identifiable through clinicatrials.gov that might shed more substantial light on the matter at a future date?
- I also pull any relevant articles pertaining to cost analyses that might indicate potential for cost saving for Florida Medicaid.
- Assuming (and for some of these that is a big "If") they check all the right boxes on all of the above, I will submit a request to MPF, along with a minimum of three price examples from other states that currently provide coverage, for a cost analysis. Anything added (with some exceptions) to the fee schedule must be budget neutral. So, we ask, what do we already pay for, can this new service/device offset any existing coverage, and does it lead to healthier outcomes at similar or less cost?

Once everything has been received, researched, and reviewed, I prepare a report that is roughly a template insofar as it is divided into sections ranging from "literature" to "existing coverage among other states" etc. Once the report has been completed, it goes to my immediate supervisor who reviews it for content and then forwards it to the Bureau Chief. Usually there would be a meeting with her, questions asked and answered, and then the report moves on to Tom for his signature, yay or nay, as final approval. Then the requestor is contacted and given a final copy of the report. If it is determined medically necessary and budget neutral, the code is then added to the fee schedule based on the normal fee schedule update timeline.

All of that is the ideal. The reality is that the reviews get done, the reports get written, and then they all bottleneck with leadership because GAPMS are fairly low on the totem pole of priorities, particularly since the pandemic began. It is also extremely common for a request to come in (most of them, really) that are asking for coverage long before the necessary information exists to justify coverage. Manufacturers will have a newfangled device with a tiny evidence base or will make the request before their most significant and enlightening trials/studies have even been completed. I have often said that a lot of what I am asked to look at will likely eventually gain coverage. But it is common for the request to outpace the evidence, and they are often several years away from finalizing their best case.

I believe there are currently about seven completed that are still awaiting review and approval from leadership. Some of them have been written for over two years. I have re-reviewed them and made any necessary updates concerning coverage, research, etc. I typically do that twice a year.

Of course, the requestors are always free to resubmit after a denial, so some of these never really die. But the resubmissions go to the back of the queue and are taken in the order they arrive.

If you will excuse me, I feel obligated to include this information: I was not informed or consulted, did not in any way participate, and did not write the GAPMS concerning gender dysphoria treatment. That particular GAPMS did not come through the traditional channels and was not handled through the traditional GAPMS process. Every report I have written represents my best effort at determining the most timely and accurate information available on the subject under consideration. I do not cherry pick data or studies and would never agree to if I were so asked. All I can say about that report, as I have read it, is that it does not present an honest and accurate assessment of the status of the current evidence and practice guidelines as I understand them to be in the existing literature. I sincerely apologize if I come across as a bit agitated about it, but as the "GAPMS guy" around here, lots of assumptions have been made by those

who do not know me well. I'm a different sort of person than the author of that report. I can't speak for them. I conduct myself and my work with integrity and I do not play favorites, yay or nay. Full stop, period.

Thanks so much for your help Friday. That shaved a few minutes off a tight deadline for me. Please let me know if you have any additional or questions or would like any additional information or clarification.

Take care.

Jeff

From: Cogle, Christopher <Christopher.Cogle@ahca.myflorida.com>
Sent: Saturday, June 25, 2022 9:13 PM
To: English, Jeffrey <Jeffrey.English@ahca.myflorida.com>
Subject: GAPMS process

Hello, Jeff. Good talking with you this past Friday.

Are there standard operating procedures for GAPMS?

If so, can I review them?

If no SOPs, then can I help you develop a SOP for GAPMS?

Thank you,

Chris

Christopher R. Cogle, M.D.
Chief Medical Officer for Florida Medicaid

2727 Mahan Drive
Bldg 3 Room 2421-A MS8
Tallahassee, FL 32308
Mobile: (850) 228-2868

TAB 183-7

HCA Hearing on General Medicaid Policy Rule

July 2022

The purpose of the amendment to Rule 59G-1.050 – General Medicaid Policy – is to update covered Medicaid services for gender dysphoria. The rule specifies covered services and clarifies definitions.

Cabinet

- Cole Gearing – Program Administrator in AHCA Medicaid Policy Bureau
- Jason Weida – Asst. Deputy Secretary for Medicaid Policy Bureau
- Matt Brackett – Program Consultant in AHCA Medicaid Policy Bureau
- Sheena Grant – Chief Counsel and Rules Coordinator in AHCA General Counsel Office
- Mohammad Jazil and Gary Perko of Holtzman and Vogel Law Firm – AHCA Outside Counsel
- Dr. Andre Van Mol – Board-certified family physician
- Dr. Quentin Van Meter – Board-certified pediatric endocrinologist
- Dr. Miriam Grossman – Board-certified child, adolescent, and adult psychiatrist

Key Points:

- April 20, 2022 – FDOH issued guidance on the treatment of gender dysphoria in children and adolescents
- Secretary Simone Marstiller requested the division of Medicaid to determine what treatments are consistent with the process described in Florida Administrative Code 59G-1.035 with generally accepted professional medical standards
- As a result, Subsection 7 would be added to Rule 59G-1.050 to AHCA's general Medicaid policy
    - Subsection 7a provides that the Florida Medicaid program does not cover, and therefore, will not reimburse for the following services for the treatment of gender dysphoria:
        1. Puberty Blockers
        2. Hormones and Hormone Antagonists
        3. Sex Assignment Surgeries
        4. Any other procedures that alter primary or secondary sexual characteristics
    - Subsection 7b provides that for the purposes of determining medical necessity, including the early public screening of diagnosis of treatment, the services listed in Subsection 7a do not meet the definition of medical necessity I accordance with Rule 59G-1.104 Florida Administrative Code
- Rule 59G-1.035 identifies specific factors for determining guidelines that are covered by the Florida Medicaid program including:
    - Evidence-based clinical practice guidelines
    - Published reports and articles in the authoritative medical and scientific literature related to health services

Pl. Trial Ex. 305

Updated July 26, 2022

- Effectiveness of the health service in improving the individual's prognosis or health outcomes
- Utilization trends
- Coverage policies by other credible insurance payor services
- Recommendations or assessments by clinical or technical experts on the subject or field

- Cabinet's determination in the case and its report were published on AHCA's website on June 2, 2022
  - Document explains that the Florida Medicaid program determines that the effectiveness of the services listed above are "low to very low quality" and insufficient to demonstrate that such treatments conform with the guidelines set forth with Rule 59G-1.035
  - Florida Medicaid program determined that the specific services will not be covered

Comments:

Each speaker was allotted two minutes of speaking time. The speakers are listed below in the order in which they spoke. Those individuals whose names were inaudible are represented by "NAME." Those in favor of Rule 59G-1.050 are highlighted in blue while those opposed are highlighted in violet.

- Chloe Cole
  - 17-year-old detransitioner from California
  - Medically transitioned from ages 13-16
  - Was taken to therapist to affirm "male identity"
  - Took puberty blockers and injections
  - Had a double mastectomy at age 14
  - Experiencing many health complications

- Sophia Galvin
  - 22-year-old detransitioner
  - Began transitioning at 18
  - History of mental health
  - Had a double mastectomy at age 19

- NAME
  - Without her consent:
    - 16-year-old daughter was injected with hormones
    - At 17, Medicaid paid surgeons to perform double mastectomy and hysterectomy as an outpatient
    - At 19, Medicaid paid for her to undergo a vaginoplasty
  - Private insurance was bypassed

- Janette Cooper – Partners of Ethical Care
- Hannah Lambert
- Gerald Hustin – Christian Pastor
- Brady Hendricks
- Sabrina Clarksville
- Simone Christ – Director of the Transgender Rights Initiative at Southern Legal Counsel
- Dr. Matthew Benson – Board-certified pediatric endocrinologist
- Karen Schoen – Florida Citizens Alliance
- Bill Snyder
- NAME – Christian Family Coalition
- Richard Carlins
- Amber Hand
- Joan Hazen
- Leonard Lavon

- Pam Olsen
- John Harrison – Public Policy Director for Equality Florida
- Anthony Verdugo – Founder and Executive Director of the Christian Family CoalitioN
- NAME
- Michael Howeler – Professor and Chief of the Pediatric Neurology Division at University of Florida
- Robert Youells
- Keith Law – Florida SIDS Alliance
- Robert Roper
- Karl Charles – Senior Attorney with Atlanta, GA Office of Lambda Legal
- Ed Wilson
- Suzanne Zimmerman
- Judy Hollen
- Ezra Stone – Licensed Clinical Social Worker
- Peggy Joseph

- Jack Walton – Christian Family Coalition and Pastor
- Jose Button – Christian Family Coalition
- Bob Johnson
- Sandy West – Christian Family Coalition
- Gayle Carlin – Christian Family Coalition
- Dorothy Barron – Christian Family Coalition
- Troy Peterson – Christian Family Coalition and President of Warriors of Faith in Florida
- Janet Rath
- Harold Lower
- NAME – Pastor and Director of Protect Our Children Project
- Paul Aarons – Physician
- January Littlejohn – Licensed Mental Health Counselor
- Kendra Parris – Mental Health Attorney
- Nathan Bruemmer – Florida's LGTBQ Consumer Advocate (Appointed by Commissioner of Agriculture Nikki Fried)

- NAME

- Dottie McPherson – Florida Federation of Republican Women

- Maria Calkins

- James Calkins

- NAME

TAB 183-20

Florida Medicaid

Estrogen

Children

FY	Recipient Count	No.of prescriptions
FY2017-18	72	185
FY2018-19	87	212
FY2019-20	89	224
FY2020-21	151	391
Total	399	1,012

Adults

FY	Recipient Count	No.of prescriptions
FY2017-18	148	392
FY2018-19	168	486
FY2019-20	174	484
FY2020-21	223	688
Total	713	2,050

Puberty Blockers

Children

FY	Recipient Count	No.of prescriptions
FY2017-18	15	59
FY2018-19	23	58
FY2019-20	37	108
FY2020-21	55	180
Total	130	405

Testosterone

Children

FY	Recipient Count	No.of prescriptions
FY2017-18	130	330
FY2018-19	191	434
FY2019-20	248	615
FY2020-21	346	925
Total	915	2,304

Adults

FY	Recipient Count	No.of prescriptions
FY2017-18	63	174
FY2018-19	84	190
FY2019-20	87	210
FY2020-21	143	373
Total	377	947

Pl. Trial Ex. 317

Florida Medicaid

Children

Procedure Code	FY1718		FY1819		FY1920		FY2021	
	Recipient Count	Procedure Code count	Recipient Count	Procedure Code count	Recipient Count	Procedure Code count	Recipient Count	Procedure Code count
19303-Mastectomy Simple Complete					2	4	3	6
19325-Breast Augmentation W/IMPLT								
53430-Reconstruction Of Urethra							1	1
54125-Amputation of penis; complete.							1	1
54520-Removal Of Testis	1	2					2	2
55180-Scrotoplasty; complicated.							1	1
55980-Sex Transformation F To M								
56805-Clitoroplasty							1	1
57110-Remove Vagina Wall Complete							1	1
57292-Construction of artificial vagina; with graft.							1	1
57335-Vaginoplasty							1	1
58571-Tlh W/T/O 250 G Or Less								
Total	**1**	**2**			**2**	**4**	**12**	**15**

Adults

Procedure Code	FY1718		FY1819		FY1920		FY2021	
	Recipient Count	Procedure Code count	Recipient Count	Procedure Code count	Recipient Count	Procedure Code count	Recipient Count	Procedure Code count
19303-Mastectomy Simple Complete	1	1	1	1	1	3	6	10
19325-Breast Augmentation W/IMPLT	1	1	1	2				
53430-Reconstruction Of Urethra							1	1
54125-Amputation of penis; complete.	1	1			1	1	1	1
54520-Removal Of Testis	1	1	1	1	5	7	2	3
55180-Scrotoplasty; complicated.								
55980-Sex Transformation F To M					1	1		
56805-Clitoroplasty	1	1					1	1
57110-Remove Vagina Wall Complete			1	1				
57292-Construction of artificial vagina; with graft.			1	1	2	2	1	1
57335-Vaginoplasty	1	1						
58571-Tlh W/T/O 250 G Or Less					1	1	1	2
Total	**6**	**6**	**5**	**6**	**11**	**15**	**13**	**19**

Florida Medicaid

H2019-Ther Behav Svc		
Children		
FY	Recipient Count	No.of prescriptions
FY2017-18	143	1,024
FY2018-19	192	1,467
FY2019-20	183	1,440
FY2020-21	233	1,775
Total	751	5,706

Adults		
FY	Recipient Count	No.of prescriptions
FY2017-18	15	69
FY2018-19	20	128
FY2019-20	19	140
FY2020-21	33	320
Total	87	657

No. 23-12155

In the United States Court of Appeals for the Eleventh Circuit

AUGUST DEKKER, BRIT ROTHSTEIN, SUSAN DOE, by and through her parents and next friends, JANE DOE and JOHN DOE, and K.F., by and through his parent and next friend, JADE LADUE,

Plaintiffs-Appellees,

v.

SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION, *et al.*,

Defendants-Appellants.

On Appeal from the U.S. District Court for the Northern District of Florida, No. 4:22-cv-00325, Honorable Robert L. Hinkle, District Judge

APPELLEES' APPENDIX
VOLUME 7 OF 10 (Tabs 183-26 – 193-6)

Jennifer Altman
Shani Rivaux
PILLSBURY WINTHROP SHAW PITTMAN, LLP
600 Brickell Avenue, Suite 3100
Miami, FL 33131
(786) 913-4900

Catherine McKee
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin Street, Suite 110
Chapel Hill, NC 27514
(919) 968-6308

Simone Chriss
Chelsea Dunn
SOUTHERN LEGAL COUNSEL, INC.
1229 NW 12th Avenue
Gainesville, FL 32601
(352) 271-8890

Abigail Coursolle
NATIONAL HEALTH LAW PROGRAM
3701 Wilshire Boulevard Suite 315
Los Angeles, CA 90010
(310) 736-1652

Omar Gonzalez-Pagan
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, NY 10005
(212) 809-8585

Katy DeBriere
FLORIDA HEALTH JUSTICE PROJECT
3900 Richmond Street
Jacksonville, FL 32205
(352) 278-6059

Counsel for Plaintiffs-Appellees
(Additional counsel listed on inside cover.)

William C. Miller
Gary J. Shaw
PILLSBURY WINTHROP
SHAW PITTMAN, LLP
1200 17th Street, NW
Washington, DC 20036
(202) 663-8000

Karen L. Loewy
LAMBDA LEGAL DEFENSE AND
EDUCATION FUND, INC.
1776 K Street, NW, 8th Floor
Washington, DC 20006
(202) 804-6245

Counsel for Plaintiffs-Appellees

TABLE OF CONTENTS

Tab/Docket No.

VOLUME 1 OF 10

VOLUME 2 OF 10

VOLUME 3 OF 10

VOLUME 4 OF 10

VOLUME 5 OF 10

VOLUME 6 OF 10

VOLUME 7 OF 10

VOLUME 8 OF 10

VOLUME 9 OF 10

TAB 183-26

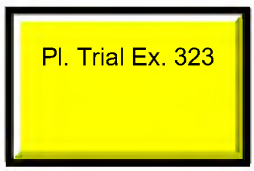
From: FL-Rules@dos.state.fl.us
Sent: Thursday, July 7, 2022 6:05 PM EDT
To: Cole.Giering@ahca.myflorida.com
Subject: One-time User Comment From FLRules.com

FLRules.com one-time comment:

Name: Ms.Mila Becker
Email: mbecker@endocrine.org
Title: 59G-1.050 General Medicaid
Comment: To Whom It May Concern:
The Endocrine Society strongly opposes the proposed rule, which would deny access to gender affirming care to the Florida Medicaid population. The Endocrine Society is the world's oldest and largest organization of scientists devoted to hormone research and physicians who care for people with hormone-related conditions. Many of our 18,000 members are recognized for their expertise in transgender medicine and research.

Our comments below are focused on responding to inaccurate and misleading statements about the Endocrine Society's clinical practice guidelines made in the report Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria (GAPMS) developed by Florida Medicaid in June 2022, which is used to justify the proposed rule.

Quality of Endocrine Society Clinical Practice Guidelines on Endocrine Treatment of Gender Dysphoric/Gender Incongruent Persons and the GRADE System
The Institute of Medicine (IOM) (now known as the National Academy of Medicine) defined clinical practice guidelines as "recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." While guidelines are not standards of care that clinicians are legally bound to follow, they provide a framework for best practices, and deviations must be justified.
Endocrine Society guidelines are developed using a robust and rigorous process that adheres to the highest standards of trustworthiness and transparency as defined by the IOM. The Endocrine Society follows the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology to develop its recommendations. GRADE is the most accepted and internationally recognized standard for guideline development. Of the over 100 international groups that endorse GRADE, other prominent organizations using this methodology include the U.S. Agency for Healthcare Research and Quality, the U.S. Centers for Disease Control and Prevention, England's National Institute for Health and Care Excellence, and the World Health Organization. GRADE is a transparent framework for summarizing evidence and provides a systematic approach for making clinical practice recommendations.
GRADE begins with the formulation of clinical questions followed by a systematic review of the evidence that supports those questions. This evidence is used to develop and support the clinical recommendations that form the basis of the guideline. A certainty of evidence assessment is made for the overall body of evidence for a particular question on a scale from very low, low, moderate, to high. While some of the recommendations in the Endocrine Society's guideline are based on low or very low certainty evidence, strong recommendations can be made for low and very low certainty evidence in the GRADE system in some circumstances (Life threatening situation; uncertain benefit, certain harm; potential equivalence, one option clearly less risky or less costly, high certainty in similar benefits, one option potentially more risky or costly; potential catastrophic harm.) Additionally, the GRADE methodology does not account only for the certainty of the evidence when developing recommendations.
Systematic reviews of the effects of an intervention provide essential, but not sufficient information for making informed decisions. There are other factors that GRADE methodology requires guideline authors to account for including, most importantly, patient values and preferences, in making trade-offs between alternative courses of action.
Additionally, Endocrine Society guidelines are not developed in a vacuum. Guidelines take an average of 2-3 years to be developed through a multi-step drafting, comment, review, and approval process. This includes a public comment period and expert review period, and all comments are addressed by the guideline development panel prior to publication. Expert reviewers are subject to the same conflict of interest rules as panel members. There is ample opportunity for feedback and debate through this years-long development process.



Consequently, the Endocrine Society's guidelines represent a high-quality resource to be used for patient care based on medical evidence, author expertise, rigorous scientific review, and a transparent process. In contrast, GAPMS did not include endocrinologists with expertise in transgender medicine, misunderstands the use of the GRADE methodology and the notion of standard of care, and makes sweeping statements against gender affirming medical care that are not supported by evidence or references provided. Most disturbing, GAPMS does not acknowledge the data showing harm reduction and improvements in behavioral health issues, such as depression and anxiety, with gender affirming care.

Sufficiency of Evidence and Bar for Gender Affirming Care

The Endocrine Society and other medical and mental health organizations representing professionals who treat gender dysphoria/gender incongruence firmly believe there is sufficient evidence to support gender affirming care and to support that harm can occur if these people are not treated. The statement in GAPMS that "low quality" studies provide insufficient evidence for gender affirming care demonstrates a failure to understand medical literature. The medical literature terminology is appropriately conservative. But "low-quality" studies are typical for much of medical care and much better than "expert opinion," also common for medical care.

The Endocrine Society believes Florida is imposing a bar for care that is too high, will result in harm to people with gender dysphoria/incongruence, and is not used for other patients. GAPMS suggests that because puberty blockers are used off-label they are experimental and not safe. The fact is many treatments used in medicine are used off-label. That just means that medication is used for a purpose other than that for which the pharmaceutical company did the paperwork. Such prescribing is common. That is part of the reason states license physicians, to make those prescribing decisions. FDA approval and randomized controlled trials are simply too stringent. Most medical care occurs appropriately without those in place.

Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines

The results of multiple studies indicate that adolescents suffering from gender dysphoria who receive medical interventions as part of their gender-affirming care experience improvements in their overall well-being. Eight studies have been published that investigated the use of puberty blockers in the care of adolescents suffering from gender dysphoria and six studies have been published that investigated the use of hormone therapy to treat adolescents suffering from gender dysphoria. These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.

For example, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not. The study found that those who received puberty blocking hormone treatment had lower likelihood of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support. Approximately nine in ten transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation. Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically significant degree after receiving gender-affirming hormone treatment. As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning. A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety. "Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age matched controls from the general population." As scientists and researchers, the Endocrine Society always welcomes more research, including on this crucial topic. However, the available data indicate that the gender-affirming treatments that would be denied by the proposed rule are effective for the treatment of gender dysphoria. For these reasons, the use of the gender-affirming medical interventions specified in the Endocrine Society's guidelines is supported by all mainstream pediatric organizations, representing thousands of physicians across multiple disciplines.

Statements in GAPMS are Factually Inaccurate and Ignore the Recommendations of the Medical Community

GAPMS asserts that most adolescents who experience gender dysphoria will later overcome it by confirming to their natal sex. This assertion lacks scientific support. While some prepubertal children who experience gender dysphoria may go on to identify with their sex assigned at birth by the time they reach puberty, there are no studies to support the proposition that adolescents with gender dysphoria will come to identify with their sex assigned at birth, whether they receive treatment or not. On the contrary, "[l]ongitudinal studies have indicated that the emergence or

worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult."
Further, GAPMS relies upon controversial research not recognized in the mainstream transgender medicine community. For example, it refers to a paper by Lisa Littman on Rapid Onset Gender Dysphoria (ROGD) – a condition that does not exist -- to justify not supporting gender affirming medical care for adolescents with gender dysphoria without noting the methodological concerns that have been raised regarding this paper, including the fact that only parents (recruited from anti-transgender websites) and none of the youth with gender dysphoria participated in the study, and that parents were not recruited from websites supportive of transgender youth. These methodological concerns prompted publication of a correction by the original author.

The Proposed Rule Would Irreparably Harm Many Adolescents with Gender Dysphoria by Denying Access to the Treatment They Need
The proposed rule would deny Medicaid beneficiaries with gender dysphoria access to medical interventions that alleviate suffering, are grounded in science, and are endorsed by the medical community. The medical treatments prohibited by the proposed rule can be a crucial part of treatment for people with gender dysphoria and necessary to preserve their health. As discussed above, research shows that people with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life. In light of this evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk.
The Endocrine Society is eager to work with Florida to address these concerns and would be happy to connect Florida Medicaid with our transgender medicine experts. If we can be of assistance or provide any additional information, please contact our Chief Policy Officer at mbecker@endocrine.org.

Sincerely,

Ursula Kaiser, MD
President, Endocrine Society

TABLE OF AUTHORITIES
Authorities & Pages

Christal Achille, et al., Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results, 8 Int'l J. Pediatric Endocrinology 1-5 (2020), https://pubmed.ncbi.nlm.nih.gov/32368216.
Page 3

Luke R. Allen, et al., Well-being and suicidality among transgender youth after gender-affirming hormones, 7(3) Clinical Prac. Pediatric Psych. 302 (2019), https://psycnet.apa.org/record/2019-52280-009.
Page 3

Stewart L. Adelson, Practice parameter on gay, lesbian, or bisexual sexual orientation, gender non-conformity, and gender discordance in children and adolescents, 51 J. Am. Acad. of Child & Adolescent Psychiatry 957, 964 (2020), https://pubmed.ncbi.nlm.nih.gov/ 22917211 ("In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood").
Page 3

P Alonso-Coello, HJ Schünemann, J Moberg , et al . GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction. BMJ 2016;353:i2016.doi:10.1136/bmj.i201
Page 2

J Andrews, G Guyatt, AD Oxman, et al . GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. J Clin Epidemiol 2013;66:719–25. doi:10.1016/j.jclinepi.2012.03.013.

Page 2

I Neumann, N Santesso, EA Akl, et al . A guide for health professionals to interpret and use recommendations in guidelines developed with the GRADE approach. J Clin Epidemiol 2016;72:45–55.doi:10.1016/j.jclinepi.2015.11.017
Page 2

Annelou L.C. De Vries, et al., Young adult psychological outcome after puberty suppression and gender reassignment, 134(4) Pediatrics 696-704 (2014).
Page 3

Annelou L.C. de Vries et al., Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study, 8(8) J. Sexual Medicine 2276 (2011), https://pubmed.ncbi.nlm.nih.gov/20646177.
Page 3

R Graham, M Mancher, DM Wolman, S Greenfield, E Steinberg, eds. Clinical Practice Guidelines We Can Trust. Washington, DC: The National Academies Press; 2011.
Page 1, 2

Amy E. Green, et al., Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, J. Adolescent Health (2021), https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext.
Page 3

InformedHealth.org [Internet]. Cologne, Germany: Institute for Quality and Efficiency in Health Care (IQWiG); 2006-. What are clinical practice guidelines? 2016 Jun 15 [Updated 2016 Sep 8]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK390308/
Page 1

Rittakerttu Kaltiala, et al., Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria, 74(3) Nordic J. Psychiatry 213 (2020.
Page 3

Laura E. Kuper, et al., Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy, 145(4) Pediatrics e20193006(2020), https://pubmed.ncbi.nlm.nih.gov/32220906.
Page 3

Diego Lopez de Lara, et al., Psychosocial assessment in transgender adolescents, 93(1) Anales de Pediatria 41-48 (English ed. 2020), https://www.researchgate.net/publication/342652073.
Page 3

Simona Martin et al., Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Case 2:22-cv-00184-LCB-SRW Document 91-1 Filed 05/04/22 Page 8 of 32
Page 3

M. Hassan Murad et al., Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes, 72(2) Clinical Endocrinology 214 (Feb. 2010), https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x; see also Turban et al., Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation, supra note 50.
Page 4

Stephen M. Rosenthal, Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view, 17(10) Nature Rev. Endocrinology 581, 586 (Oct. 2021), https:// pubmed.ncbi.nlm.nih.gov/34376826.
Page 3

Jack L. Turban, et al., Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults, J. Plos One (2022), https://journals.plos.org/plosone/article?id=10.1371/ journal.pone.0261039.
Page 3

Jack L. Turban et al., Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation, 145(2) Pediatrics e20191725 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC7073269.
Page 3

Cases & Pages
Brandt v. Rutledge, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021)
Page 2, 3

TAB 183-27

July 8, 2022

VIA E-MAIL AND WEBSITE

Simone Marstiller, Secretary
Tom Wallace, Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
MedicaidRuleComments@ahca.myflorida.com

Re: Rule No. 59G-1.050: General Medicaid Policy

Dear Secretary Marstiller and Deputy Secretary Wallace:

We are writing to submit a public comment on a proposed amendment to Section 59G-1.050 of the Florida Administrative Code (the "Proposed Rule"), which, if adopted, would deny medical treatment to transgender individuals.[1] The Proposed Rule would apply to Medicaid members of any age and would deny coverage for puberty blockers, hormones, "sex reassignment surgeries," and "any other procedures that alter primary or secondary sexual characteristics."[2]

We are a group of seven scientists and a law professor, and we are deeply dismayed by the content of the Proposed Rule, which will deny long-established, effective, and evidence-based medical care to thousands of Florida Medicaid patients.[3] We are also distressed as scientists and stewards of public health by the shoddy quality of the purported scientific report offered to justify the Proposed Rule. The report, issued by the Florida Agency for Health Care Administration ("AHCA") on June 2, 2022 (hereinafter, "June 2 Report"), disregards well-established clinical practice guidelines and scientific research showing that standard medical treatments for gender dysphoria are "consistent with generally accepted professional medical standards" and are not "experimental or investigational."[4]

As discussed in depth below, we strongly oppose the adoption of the Proposed Rule. The Proposed Rule would violate the sex discrimination protections provided by the U.S. and Florida Constitutions and the federal statute that governs Medicaid by discriminating against transgender people on the basis of their sex, transgender status, and gender identity.[5] We are confident that other comments will focus in depth on the legal authorities that pre-empt the Proposed Rule.

---

[1] 48 Fl. Admin. Reg. 2461 (June 17, 2022). The Notice of Development of Rulemaking was published in 48 Fl. Admin. Reg. 2270 (June 3, 2022) without any specification of the subject of the rulemaking.
[2] The Proposed Rule would add new subsection (7) to Fl. A dmin. Code Section 59G-1.050. See 48 Fl. Admin. Reg. 2461 (June 17, 2022).
[3] Our comments reflect our views and not those of the University of Alabama, the University of Texas, or Yale University.
[4] Division of Florida Medicaid, Agency for Health Care Adm inistration, Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria, June 2022, at https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf ("June 2 Report").
[5] See Bostock v. Clayton County, 590 U.S. __ (2020); Kadel v. Folwell, M.D. N.C., Mem. Op. 6-10-22 (applying Bostock to public health plan coverage); 42 U.S.C. 18116 (requiring nondiscrimination in Medicaid plans).

Pl. Trial Ex. 324

Our comments focus instead on the absence of any persuasive scientific or medical justification for the Proposed Rule. The June 2 Report purports to be a review of the scientific and medical evidence but is, in fact, fundamentally unsound from a scientific perspective. The June 2 Report disregards established scientific knowledge, ignores longstanding clinical practice recommendations developed by authoritative bodies of medical experts, and unaccountably dismisses the medical recommendations of more than 20 medical societies.

As scientists, we are alarmed that Florida's health care agency has adopted a purportedly scientific report that so blatantly violates the basic tenets of scientific inquiry. The report contains glaring errors regarding science, statistical methods, and medicine. Ignoring established science, the report instead relies on biased and discredited sources, stereotyping, and purported "expert" reports that carry no scientific weight.

These fundamental flaws thoroughly discredit the conclusions of the June 2 Report, with two legal consequences. First, the complete absence of scientific foundation for the Proposed Rule renders it an arbitrary and capricious use of rulemaking power. Second, the Florida AHCA cannot characterize the Proposed Rule as a valid interpretation of the existing Florida regulations on generally accepted professional medical standards, because the June 2 Report fails to satisfy Florida's own regulatory requirements for scientific review.[6]

The seven scientists in our group hold academic appointments at the University of Alabama, the University of Texas Southwestern, and Yale University. (The law professor is a tenured professor at the Yale Law School.) We include three Ph.D child and adolescent psychologists and four M.D. physicians with specialties in pediatric endocrinology, child and adolescent psychiatry, and adolescent medicine. All seven are also clinicians who treat transgender youth on a daily basis. Among us, we have accumulated more than 57 years of clinical practice and have treated more than 2,100 transgender youth. We received no funding for our work and have no conflicts of interest to declare.

We are writing to comment on the Proposed Rule because we are concerned that it will harm transgender people in Florida and set a misleading and dangerous national precedent. We are committed to the integrity of science and law, and we strongly oppose legal actions that, like the Proposed Rule and the June 2 Report, claim the authority of science but provide only biased and misleading information. Youth, families, and medical providers in Florida deserve a higher standard of protection and service from their government.

In this comment letter, we focus on the science governing the treatment of gender dysphoria. Our observations are relevant to the treatment of both youth and adults. For example, we show that the June 2 Report falsely claims that the evidence for medical treatment for gender dysphoria does not meet generally accepted professional medical standards and is experimental. We also show that the June 2 report relies on purported "expert" reports that appear to be highly biased and with undisclosed conflicts of interest. To keep our comments focused and manageable in length, the one issue that we do not address is the science of genital surgery used to treat gender dysphoria, which is typically not performed before the age of majority. We are confident that the

[6] See Fl. Admin. Code Section 59G-1.035(1) and (4).

evidence base for surgical procedures is sound, and we are confident that others will address the June 2 Report's erroneous claims regarding surgery.

Throughout our comments, we refer to our companion report, *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria*, which is attached as Appendix A. The report goes into greater detail on many of the points we raise here.

Background

The AHCA appears to have taken a belt-and-suspenders approach to denying Medicaid coverage for standard medical treatment for gender dysphoria: the agency appears to be pursuing two legal strategies simultaneously. The June 2 Report reflects the first strategy, which frames the denial of care as an interpretation of the existing Florida Medicaid coverage regulations.[7] The Florida Medicaid program covers only health services that are "medically necessary" and excludes services that do not meet "generally accepted professional medical standards or are "experimental or investigational." The existing regulations permit the AHCA to determine when health services are consistent with generally accepted professional medical standards (GAPMS).

Specifically, the existing regulations authorize the Florida Deputy Secretary for Medicaid to make a final coverage determination; however, the Deputy Secretary does not have unfettered interpretive authority. The Florida Administrative Code sets out a detailed process, which requires the AHCA to prepare a report that considers scientific evidence including "evidence-based clinical practice guidelines" and "published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations)."[8] The June 2 Report purports to be such a report. It is titled a "Generally Accepted Professional Medical Standards Determination" and concludes that standard medical treatments for gender dysphoria "do not conform to GAPMS and are experimental and investigational."[9]

The AHCA has also pursued, simultaneously, a second legal strategy by publishing the Proposed Rule on June 17. The Proposed Rule makes no reference to the June 2 Report and contains no independent justification for the rule. The Proposed Rule would add a new subsection to Section 59G-1.050 of the Florida Administrative Code, Section (7), which would deny Medicaid coverage in Florida for medical care for gender dysphoria. The Proposed Rule would apply to Medicaid members of any age and would deny coverage for puberty blockers, hormones, "sex reassignment surgeries," and "any other procedures that alter primary or secondary sexual characteristics.[10] According to the Notice of Proposed Rule published in the Florida Administrative Register, a public hearing will be held on July 8, 2022, and public comments on the Proposed Rule may be submitted through that date.[11]

---

[7] See June 2 Report, p. 2 (noting that the Secretary of the Florida Agency for Health Care Administration requested the report from the Florida Division of Medicaid pursuant to Section 59G1.035 of the Florida Administrative Code,
[8] Fl. Admin. Code Section 59G-1.035(4).
[9] The report makes specific reference to these rules.June 2 Report, p. 2.
[10] 48 Fl. Admin. Reg. 2461 (June 17, 2022).
[11] See id. and the instructions at https://www.flrules.org/Gateway/View_notice.asp?id=25979915

Analysis

In our comments below, we show that there is no scientific justification for the Proposed Rule and no scientific justification for the conclusions drawn in the June 2 Report.

1. The Proposed Rule would deny Florida Medicaid coverage for standard medical care for gender dysphoria, which is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.

The conclusion of the June 2 report – that medical treatments for gender dysphoria "do not conform to [generally accepted professional medical standards] and are experimental and investigational" -- is demonstrably false.

Medical care for the treatment of gender dysphoria, which for youth under the age of majority can include gonadotropin releasing hormone agonists ("GnRHa" or puberty blockers) and hormone therapy, has been vetted and approved by international bodies of experts based on the scientific evidence. Two authoritative bodies of scientists, the World Professional Association for Transgender Health (WPATH) and The Endocrine Society, have published extensive clinical practice guidelines for treating gender dysphoria.[13] These clinical guidelines are based on rigorous, structured processes. Each involves the work of a committee of scientific experts and peer review by additional experts. The guidelines are based on careful reviews of the scientific literature and are revised periodically to reflect scientific developments.

These longstanding clinical practice guidelines have been used by clinicians for decades. WPATH issued its initial guidelines in 1979 and updated them in 1980, 1981, 1990, 1998, 2001, and 2012. The eighth version remains in process, and it incorporates systematic literature reviews and ample opportunities for peer review and revision.[14] The original Endocrine Society guidelines were published in 2009 and updated in 2017.[15]

Reflecting this scientific and medical consensus, medical care for gender dysphoria has been confirmed as standard care by every relevant medical organization in the United States, including the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry.[16] In 2022, these organizations united

---

June 2 Report, p. 2.

[13] See Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming Peopd, World Professional Association for Transgender Health (7th version, 2012), at https://www.wpath.org/publications/soc ("WPATH (2012)"); Wylie C. Hembree, et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102(11) J. Clin. Endocrinol. Metab. 38693903 (2017) ("Endocrine Society (2017)").

[14] See World Professional Association for Transgender Health (WPATH), Methodology for the Development of Standards of Care 8 (Soc 8), at https://www.wpath.org/soc8/Methodology

[15] Endocrine Society (2017), supra note 13.

[16] Jason Rafferty, Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, 142(4) Pediatrics E20182162 (2018); American Psychological Association, Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, 70(9) American Psychologist 832-64 (2015); Stewart L. Adelson, Practice Parameter on

with the American Medical Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and other groups to file an amicus brief representing a total of 20 major medical societies. The brief reaffirms that puberty blockers and hormone treatments for gender dysphoria are standard medical care and opposes legal measures that would limit patient access to this standard care.[17]

The weight and volume of these endorsements, across diverse medical specialties, sharply contradicts the June 2 Report's conclusion and undermines any purported scientific justification for the Proposed Regulation.

As further evidence, it is critical to note that the medications used to treat gender dysphoria are used commonly and safely in cisgender patients. Puberty blockers are the main treatment for central precocious puberty. Estrogen is prescribed for patients of all ages to manage fertility and reduce heavy menstrual bleeding (to give just two examples of its many uses). Testosterone is prescribed to address hypogonadism, and spironolactone (androgen blockade) is used to treat hirsutism and acne.

The Florida Medicaid program covers all these uses without question. The program authorizes physicians to tailor treatments to cisgender patients' needs and trusts patients (and, in the case of children, their parents) to make informed decisions. The Proposed Rule would deny coverage only for gender dysphoria, discriminating against transgender patients.

2. The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies on pseudo-science that does not meet Florida's own standards for review. The June 2 Report provides no scientific foundation for the Proposed Rule and fails to meet Florida's own regulatory requirements for Medicaid coverage determinations.

The Florida report dismisses or ignores the WPATH and Endocrine Society clinical practice guidelines and the science that underlies them and instead relies on five attached documents that, the report claims, constitute "clinical and technical expert assessments."[18]

Despite their billing as "expert" reports, the attachments to the June 2 report are unpublished, non-peer-reviewed documents written by authors with questionable claims to expertise and with red flags for undisclosed author bias. These documents should be given no weight in a serious scientific process.

The June 2 Report purports to be a coverage determination pursuant to Fl. Admin. Code Section 59G-1.035, but its reliance on these five documents constitutes a gross violation of the process set out in that regulation. The regulation requires that the AHCA consult actual scientific evidence, including "evidence-based clinical practice guidelines" and "*published* reports and

---

Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 51(9) J. Am. Acad. Child & Adolescent Psychiatry, 957 -974 (2012).

[17] Brief of Amicus Curiae American Academy of Pediatrics and Additi onal National and State Medical and Mental Health Organizations in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction, Eknes-Tucker v. Ivey (later redesignated Eknes-Tucker v. Abbott), May 5, 2022, at https://www.aamc.org/media/60556/download

[18] June 2 Report, p. 2.

articles in the authoritative medical and scientific literature related to the health service (published in *peer-reviewed* scientific literature generally recognized by the relevant medical community or practitioner specialty associations)."[19]

The June 2 Report reads like a roadmap for how to violate these rules. The report disregards the evidence-based clinical practice guidelines published by WPATH and The Endocrine Society and relies entirely on the five attachments, which are not published, are not peer-reviewed, and are written by inexpert and biased authors.

A. The purported "expert" documents attached to the June 2 Report are unpublished and not peer-reviewed, and they are written by authors whose expertise has been successfully challenged in legal proceedings and whose professional histories raise red flags for bias.

None of the documents attached to the June 2 Report meet standard criteria for expert scientific investigations, because none is published or peer reviewed. Publication and peer review are fundamental to science, as they ensure that a scientist's data and conclusions are open to scrutiny from scientific experts.

Florida's own standards for the determination of medical necessity recognize this point when they state that determinations of Medicaid coverage must consult "*published* reports and articles in the authoritative medical and scientific literature related to the health service (*published in peer-reviewed scientific literature* generally recognized by the relevant medical community or practitioner specialty associations)."[20] It is thus both unscientific and a violation of the regulations for the June 2 Report to rely on unpublished documents as its principal evidence base.

Further, the attachments raise red flags for author bias. The June 2 Report does not disclose how these "experts" were identified or by what criteria their expertise was assessed. The opacity of the Florida AHCA process for identifying experts is particularly troubling because at least four of the five experts have strong indications of bias. Further, the qualifications and credibility of two of the experts have been successfully challenged in litigation.[21] The endorsement of these individuals as Florida's banner "experts" raises the appearance of bias – that the AHCA sought a pre-ordained outcome, not a true scientific perspective.

Adding to these red flags for bias, none of the authors of the attachments provide a statement of funding and conflicts of interest. This omission violates a strong norm in scientific writing, which requires authors to declare any professional or financial arrangements that could call into question their independence of judgment.[22] That strong norm also requires authors to disclose

[19] Fl. Admin. Code Section 59G-1.035(4).
[20] Fl. Admin. Code Section 59G-1.035(4).
[21] See Stephen Caruso, A Texas Judge Ruled That This Doctor Was Not an Expert, Pennsylvania Capital-Star, Sept. 15, 2020 (reporting that van Meter was disqualified as an expert in a Texas divorce case, now sealed).
[22] For example, the conflict of interest rules for JAMA, one of the premier medical journals in the United States and the world state that "[a]uthors are expected to provide detailed information about all relevant financial interests, activities, relationships, and affiliations (other than those affiliations listed in the title page of the manuscript) including, but not limited to, employment, affiliation, funding and grants received or pending, consultancies, honoraria or payment, speakers' bureaus, stock ownership or options, expert testimony, royalties, donation of

whether projects have been funded and if so, by whom and whether the authors have engaged in expert testimony. Without these statements, the Florida AHCA and the public cannot detect biases that could affect the integrity of these written products.

These are more than theoretical concerns: *four of the attachments have notable indicators of conflicts of interest and bias*. (Note that these are the only four we examined in detail, and so we do not imply that the other one is free from such bias.)

The author of the document provided as Attachment E is Quentin van Meter, whose history indicates bias and lack of expertise. Although the AHCA presents van Meter as an expert in medical treatment for gender dysphoria, at least one court barred him from providing expert testimony on the issue.[23] Van Meter is the president of the American College of Pediatricians (the "ACP"), which presents itself as a scientific group (and might be confused, by a non-expert, with the authoritative American Academy of Pediatrics). The ACP is, in fact, a political group that opposes same-sex marriage,[24] supports mental health providers practicing conversion therapy,[25] and describes gender dysphoria as "confusion."[26] Troublingly, the van Meter attachment, proffered by the AHCA as a scientific report, contains several passages of uncredited, verbatim language that appears in a "position statement" published by the ACP.[27] The van Meter attachment appears to be a re-use of paid testimony rather than an original product.[28]

James Cantor's document, presented as Attachment D to the June 2 Report, also faces serious questions about bias and lack of expertise. In a 2022 case, a federal court took a skeptical view of Cantor's purported expertise, giving his testimony little weight because Cantor has "no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria.[29] Cantor's document is nearly identical to what

---

medical equipment, or patents planned, pending, or issued." JAMA Network, Instructions for Authors, visited June 22, 2022, at https://jamanetwork.com/journals/jama/pages/instructionsfor-authors#SecConflictsofInterestandFinancialDisclosures

[23] Caruso, supra note 21.

[24] Den Trumbull, Defending Traditional Marriage, American College of Pediatricians (2013), https://acpeds.org/position-statements/defending-traditional-marriage. See Jack Turban, The American College of Pediatricians is an Anti-LGBTQ Group, Psychology Today, May 8, 2017.

[25] Christopher Rosik and Michelle Cretella, Psychotherapy for Unwanted Homosexual Attraction Among Youth, American College of Pediatricians (2 016), https://acpeds.org/position-statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth.

[26] Michelle Cretella, Gender Dysphoria in Children, American College of Pediatricians (2018), https://acpeds.org/position-statements/gender-dysphoria-in-children (site visited June 22, 2022). The author of the ACP position paper is Michelle Cretella, who was publicly rebuked by the Society for Adolescent Health and Medicine, the leading society for adolescent medicine in the United States, for "pushing political and ideological agendas not based on science and facts." https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2017-Activity/Senate-Bill-439-(2).aspx

[27] The similarity was shown by a Word comparison of the van Meter report provided as Attachment E to the June 2 Report with a "position statement" published on the ACP website, with authorship credit given on the website to Michelle Cretella. See Michell e Cretella, Gender Dysphoria in Children, supra note 26.

[28] The van Meter document attached to the June 2 Report is substantially identical to his expert declaration in Adams v. School Board of St. Johns County, Florida. https://files.eqcf.org/wp-content/uploads/2017/12/41-D-AMENDED-Notice-Documents-iso-Response-to-PI.pdf.

[29] Opinion and Order, Eknes-Tucker v. Marshall, 2:22-CV-184-LCB, M.D. Alabama, May 13, 2022.

appears to be paid testimony in another case, where Cantor's declaration was used to support legislation barring transgender athletes from sports teams,[30] Troublingly, Cantor's appearance in that case seems to have been funded by the Alliance Defending Freedom ("ADF"), [31] a religious and political organization that opposes legal protections for transgender people and same-sex marriage[32] and defends the criminalization of gay sex.[33]

Romina Brignardello-Petersen is one of two authors of the document provided as Attachment C to the June 2 Report. Although Brignardello-Petersen claims to have no research interests in medical care for transgender youth,[34] she has conducted research for the Society for Evidence-Based Gender Medicine ("SEGM").[35] Although SEGM claims to be an international medical society, it is, in fact, an advocacy group that opposes standard medical care for gender dysphoria. The SEGM has no publications or conferences and seems to consist solely of a website. The group appears to be run by a small group of people with limited or no scientific credentials and the website presents a cherry-picked collection of studies and narrative content that is full of scientific errors.[36]

Patrick Lappert, whose document is attached to the June 2 Report as Attachment F, has been disqualified as an expert in a recent federal court decision in North Carolina. [37] The judge found that the evidence "calls Lappert's bias and reliability into serious question" and noted that Lappert has worked closely with ADF and has actively lobbied for legal bans on medical care for

---

[30] The case is BPJ v. West Virginia State Board of Education, and the Alliance Defending Freedom takes credit for it here: https://adfmedia.org/case/bpj-v-west-virginia-state-board-education. Cantor's declaration appears here: https://adfmedialegalfiles.blob.core.windows.net/files/BPJCantorDeclaration.pdf

[31] The ADF seems to take credit for the case in this press conference notice: https://adfmedia.org/case/bpj-v-west-virginia-state-board-education

[32] Marriage is the Future, American College of Pediatricians, https://adflegal.org/issues/marriage/overview (site visited July 2, 2022. Content on the page includes this statement: "Marriage is about equality and diversity. It's about joining the two equally important and diverse halves of humanity represented in men and women."

[33] Southern Poverty Law Center, Dangerous Liaisons, July 10, 2013, https://www.splcenter.org/20130709/dangerous liaisons [visited July 2, 2022].

[34] Like the van Meter and Cantor attachments, the BPW document provides no express statement of conflicts of interest. The BPW document does offer a statement of "credentials and expertise," in which she declares that "her research interests are not in this area," meaning apparently research on medical care for gender dysphoria. BPW Document, p. 1.

[35] BPW document, p. 1. For one example of the purported research that Brignardello-Petersen apparently assisted in, see Alison Clayton et al., Commentary: the Signal and the Noise– Questioning the Benefits of Puberty Blockers for Youth with Gender Dysphoria – A Commentary on Rew et al. (2021), Child and Adolescent Mental Health, Dec. 22, 2021, at https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12533 In the "Acknowledgements" section, the authors state, "We would also like to thank the Society for Evidence-based Gender Medicine (SEGM) for providing access to several experts who helped shape this commentary and ensure its accuracy. Specifically, we would like to thank Dr. Romina Brignardello Petersen [sic] for contributing her methodological expertise."

[36] Susan Boulware et al., Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims (April 28, 2022), at 28-29 (Appendix A) available at https://medicine.yale.edu/childstudy/policy-and-social-innovation/lgbtq-youth/.

[37] Kadel v. Folwell, 1:19CV272, M.D. N.C. June 10, 2022. The judge ruled that Lappert was not qualified to "render opinions about the diagnosis of gender dysphoria, its possible causes, the efficacy of the DSM, the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on the non-surgical treatments." Lappert was also disqualified from opining on "the efficacy of randomized clinical trials, cohort studies, or other longitudinal, epidemiological, or statistical studies of gender dysphoria." Id.

transgender youth.[38] The judge gave no weight to Lappert's testimony about informed consent, finding that it was unsupported by scientific evidence.[39] The judge also found that "Lappert has provided the Court with no data or methodology used to draw his conclusion that surgical treatment for gender dysphoria has "never been generally accepted by the relevant scientific community."[40]

B. The linchpin of the June 2 Report is the analysis by Brignardello-Petersen and Wiercioch (the "BPW document"), provided as Attachment C, which purports to be a comprehensive review of the scientific literature but, in fact, is extremely narrow in scope and so flawed in its analysis that it merits no scientific weight at all.

The BPW document, like the other attachments to the June 2 Report, is an unpublished, non-peer-reviewed document. It is written by inexpert authors who construct an arbitrarily truncated sample and adopt a method that violates scientific guidelines and produces a biased result. The authors describe their findings in deceptive language and jargon predictably mislead the reader. Our review shows that *nothing in the BPW document calls into question the scientific foundations of the WPATH and the Endocrine Society clinical practice guidelines.*

The BPW document seems scientific on its face, because it uses technical jargon and includes numerous tables and charts. But a closer examination shows that it violates established standards for medical research and shows signs of being engineered to produce a pre-ordained and inaccurate result.

The bottom line is that, contrary to the BPW document's claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria.

(1) The BPW document lacks scientific credibility due to the authors' lack of relevant qualifications and their ties to an activist group.

The BPW document purports to be a systematic review of the scientific literature on medical treatment for gender dysphoria, but it is full of errors and omissions, resulting in a biased and misleading result. Here, we describe just three of the notable defects that undercut entirely the document's claim to objectivity and sound method. We provide additional detail on these errors in the Appendix to these comments.

First, *neither of the BPW authors are experts* in medical care for gender dysphoria, either as researchers or clinicians. One author (Brignardello-Petersen) has not previously studied the subject, except in her work for the ideological organization SEGM.org, noted just above. Her only clinical experience appears to be in dentistry.[41] The other author (Wiercioch) is a junior researcher (a postdoctoral fellow) with no prior research or clinical experience in this field.[42]

---

[38] Id.
[39] Id., pp. 29-30.
[40] Id., p. 31.
[41] Romina Brignardello bio, at https://experts.mcmaster.ca/display/brignarr[visited July 2, 2022]
[42] Google Scholar, Wojtek Wiercioch, visited June 22, 2022, https://scholar.google.com/citations?user=vdi3r_AAAAAJ&hl=en

The authors' lack of interest and experience renders the BPW work inexpert rather than objective, and it violates the National Academy of Medicine standards for systematic reviews.[43] By analogy, one would not rely on, say, two dermatologists to conduct a review of the scientific literature on neurosurgery and to make recommendations for clinical practice.

Second, not only is the study not formally peer-reviewed, the BPW authors violate scientific norms and standards by *failing to engage at all with their peers or with actual experts* in the subject matter.[44] The BPW authors appear not to have published their protocol in advance or otherwise to have submitted their protocol for peer review.

Third, the BPW document raises red flags for opinion bias. Buried in the methodology pages of the BPW document is the fact that the authors include the fringe website SEGM.org.[45] As noted above, the group's website posts are not peer-reviewed or published, and its cherry-picked content is assembled by activists and is often full of errors.[46] Troublingly, this is the group to which one of the authors, Brignardello-Petersen, has ties, as noted above.

(2) The BPW document violates scientific standards for evaluating medical evidence. The picture that emerges is of a rushed and inexpert report with indications of bias.

The BPW document has a patina of scientific expertise. It invokes the respected GRADE standards for rating the quality of studies, and it occupies many pages with tables and technical specifications. When a reader looks past the jargon, however, the BPW authors adopt a method that violates scientific standards and appears to be jury-rigged to reach a foregone conclusion. The authors convey their conclusions in misleading language. *Contrary to the BPW authors' claims, their study does not call into question the scientific and clinical importance of the established science that supports medical care for gender dysphoria.*

The BPW analysis incorporates numerous decisions that bias the results, and the authors describe their findings in grossly misleading terms. To begin, the BPW document reviewed only a small sample of the relevant scientific literature. In the introduction, the BPW authors initially claim to have reviewed 61 systematic reviews of medical treatment for gender dysphoria.[47] But buried in

---

[43] Committee on Standards for Systematic Reviews of Comparati ve Effectiveness Research, Institute of Medicine, Finding What Works in Health Care: Standards for Systematic Reviews, National Academies (Jill Eden et al., eds 2011), p. 48 (Standard 2.1.1 states that teams for systematic reviews should include expertise in pertinent clinical content areas). Background: The Institute of Medicine, now called the National Academy of Medicine, is one of three branches of the National Academies of Science, Engineering, and Medicine. The National Academy of Science dates to 1963 and was established by Congress; the Institute of Medicine was established as a separate entity in 1970 and serves as the nation's leading authority on scientific research and knowledge. National Academy of Medicine, About the National Academy of Medicine, website visited June 22, 2022, https://nam.edu/about-the-nam/ The standards for systematic reviews were published in 2011, responding to a Congressional request to set benchmarks for high-quality systematic reviews that could reliably guide physicians and healthcare providers in making informed, scientific judgments about health care.

[44] For additional detail, see the Appendix.

[45] BPW document, Methods section, p. 2.

[46] See Boulware et al., supra note 36, pp. 28-29 (Appendix A).

[47] BPW document, Introduction Section, p. 2.

the middle of the document is the admission that the analysis is based on a sample of 27 systematic reviews, not 61 as claimed.[48]

Troublingly, the authors also embed in the middle of their technical document an unjustified decision to limit their analysis to studies published from 2020 to the present. The authors disclose that they "prioritized" studies from the last 30 months (two full years plus four months in 2022), but they do not defend that priority. The reader is left to wonder whether this truncation served only to help the authors produce their analysis in a very short time frame.

Further, the BPW authors mechanically apply a series of rating systems (AMSTAR and GRADE) for assessing the quality of scientific evidence, but their use violates key principles for using these systems. Based on this mechanical review of truncated sources, the BPW analysis reaches the conclusion that there is little or no evidence for the benefits of medical care for gender dysphoria.[49]

But the BPW analysis is deceptive, because it dismisses nearly all existing studies of medical treatment for gender dysphoria as "low quality," without explaining that this is a highly technical term and not a natural-language condemnation of the studies. By contrast, the GRADE system, which the authors purport to use, is quite clear about its quality rating systems and its limitations.[50] We provide additional detail on the authors' misuse and deceptive statements in the Appendix.

The key point is that "low quality" in this context is a technical term and not a condemnation of the evidence, because "low quality" studies regularly guide important aspects of clinical practice. Indeed, the GRADE system, which the BPW document claims to use, specifically notes that GRADE should *not* be used to dismiss observational studies or to give absolute priority to RCTs:

> Although higher quality evidence is more likely to be associated with strong recommendations than lower quality evidence, a particular level of quality does not imply a particular strength of recommendation. *Sometimes, low or very low quality evidence can lead to a strong recommendation*.[51]

The methodology adopted by the BPW document will thus, predictably, conclude that any body of scientific literature that does not contain RCTs is "low" in quality. The 30 pages that it takes the authors to lay out their methodology is thus extremely misleading: a knowledgeable reader

---

[48] BPW document, Results Section, p. 1.

[49] For example, the BPW document states that there is *evidence* about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. BPW document, Results section, p. 4.

[50] See Howard Balshem et al., GRADE Guideline: 3. Rating the Quality, 64 J. Clinical Epidemiology P401-406 (2011), Table 3, p. 404

[51] Balshem et al., supra note 50, at 402 (emphasis added).

would know that if there are few or no RCTs in the literature, then the BPW technical conclusion is foregone, and, as importantly, is not a sound guide for clinical recommendations.

Put in simpler terms, if we coded apples as "high quality fruit" and bananas as "low quality fruit," then any fruit bowl that has only bananas would predictably be technically coded as "low quality." But that technical conclusion conveys very little information without context. For example, if no apples exist, then bananas may be a nutritious choice.

The drafters of the GRADE system emphasize that technically "low quality" evidence can support a strong clinical treatment recommendation. For example, pediatricians now agree – and every parent has been told -- that children should not be given aspirin for fevers. This recommendation is based on observational studies that showed an association between aspirin treatment during viral illnesses and the development of Reyes syndrome (a rapid and progressive disease of neurological dysfunction that can be fatal). Based on those studies, it would be unethical to conduct an RCT giving some children aspirin, and so the strong, consensus treatment recommendation is based entirely on "low quality" studies.[52]

The critical fact is that RCTs are not, and cannot be, the gold standard for medical research on gender dysphoria, due to strong ethical constraints. Medical care has long been shown, by reliable scientific methods, to address gender dysphoria and improve mental health: as we have repeatedly noted, these treatments have been recommended by rigorous clinical practice guidelines issued by WPATH and the Endocrine Society and endorsed by every major medical organization. Given this medical consensus, which is based on solid scientific evidence, it would be unethical to conduct an RCT that involved denying standard medical care to a control group of individuals.

It is thus simply a mistake – and a mischaracterization of medical research – to conclude that the absence of RCTs means that there is "no evidence" for the efficacy of medical treatment for gender dysphoria.

3. The June 2 Report reflects a faulty understanding of statistics, medical regulation, and scientific research, and it repeats discredited claims and engages in speculation and stereotyping without scientific evidence. The report therefore provides no scientific support for the Proposed Rule or for an interpretation of existing Florida Medicaid standards.

The June 2 Report provides no credible scientific support for the Proposed Rule, because its analysis is full of errors and misstatements. In this section, we offer seven examples, all of which are documented in more detail in the Appendix to these comments.

> A. The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

[52] Balshem et al., supra note 50, at 402.

In its opening words, the June 2 Report makes an error that is repeated throughout the document: "Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased."

As we document in Section 2.B., above, it is an outright mistake to conclude that a study in the technical category of "low quality" is unreliable or poor evidence for clinical practice.[53] We provide additional analysis of the misuse of this language in the June 2 Report in the Appendix.

It is quite common for consensus medical practices to be supported only by technically "low quality" but respected observational studies – without RCTs. For example, the famous Framingham Heart Study provided the framework for clinical practice guidelines that support the use of statins, a cholesterol-lowering drug that is effective in preventing cardiovascular death.[54]

The statins example shows that the June 2 Report rests on a fundamental misunderstanding of medical research and clinical practice. If the Florida Medicaid program actually adopted the standard of evidence urged by the June 2 report, the program would not cover statins, which are prescribed to 28% of adults over the age of 40.[55] Other common practices that would have to be reconsidered under this logic include post-menopausal hormone replacement therapy (which reduces lifetime risk of heart attacks and stroke) and mammography screening for breast cancer.

The same point is true of the technically "low quality" evidence base for many surgical procedures, including minimally invasive gall bladder surgery, which has a solid evidence base in observational studies. We think it unlikely that Florida's Medicaid program will begin to refuse to pay for statins, mammograms, and routine surgeries. If not, then the June 2 Report and the Proposed Rule reflect an untenable and discriminatory double standard.

> B. The June 2 Report disregards robust clinical research studies and instead relies on sources with no scientific credibility. The report's analysis fails to satisfy Florida's own regulatory standards for Medicaid coverage decisions and provides no scientific foundation for the Proposed Rule.

The June 2 Report repeatedly cites sources with little or no scientific credibility – including journalism, a student blog, a website, and letters to the editor – rather than peer-reviewed empirical research, in violation of Florida's own regulatory standards.[56] At the same time, the

---

[53] Balshem et al., supra note 50, at 404 ("Well-conducted studies may be part of a body of evidence rated low quality because they only provide indirect or imprecise evidence for the question of interest.")

[54] Neil J. Stone, et al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Red uce Atherosclerotic Cardiovascular Risk in Adults, 129(25) Circulation S1 -S45 (2014).

[55] Joseph A. Salami et al., National Trends in Statin Use and Expenditures in the U.S. Adult Population From 2002 to 2013, 2(1) JAMA Cardiology 56-65 (2017).

[56] Sources from journalism include Jon Brown, Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida, Fox News, May 8, 2022, at 8 https://www.foxnews.com/politics/textbook-strips-gender-dysphoria-definition-cited-florida [visited July 3, 2022; Lawrence S. Mayer and Paul McHugh, Sexuality and Gender: Finding from the Biological,Psychological, and Social Science, The New Atlantis (Fall 2016), https://www.thenewatlantis.com/wp-content/uploads/legacy-pdfs/20160819_TNA50SexualityandGender.pdf [visited July 3, 2022]. The citation to the student blog is Hong Phuong Nhi Le, Eminence-Based Medicine vs. Evidence-Based Medicine, Students 4 Best Evidence

report makes baseless or exaggerated criticisms of solid studies. Here, we offer only brief examples, with additional illustrations in the Appendix showing how selective and ungrounded criticism permeates the June 2 Report and further undermines its scientific credibility.

For example, the June 2 report attacks a 2015 study by Costa et al., claiming that the study design is flawed because it did not include a control group of adolescents without gender dysphoria.[57] This point is incorrect: as the Appendix to this report explains, the Costa et al. study did include an appropriate control group.

In addition to glaring technical errors, the June 2 Report's criticism of Costa makes an even more fundamental error: the June 2 report levels baseless criticisms at a single study *and fails to acknowledge that the weight of the literature as a whole strongly supports the same results Costa et al. report*. Scientific knowledge is, importantly, cumulative. It is thus entirely misleading – and unscientific – to dismiss the effectiveness of puberty blockers by criticizing studies in isolation. Put simply, the June 2 Report fails to acknowledge the number of solid studies that all find that puberty blockers are effective.[58] Indeed, at least 16 studies show that puberty blockers and hormones benefit patients with gender dysphoria, and the benefits have been documented across study designs, including retrospective report, cross sectional, longitudinal, and qualitative.[59]

The June 2 Report also grossly misleads the reader in its discussion of a study by Chen et al. in 2020[60] and a study by DeSanctis et al. in 2019.[61] The Appendix discusses these examples at

---

[blog], https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine [visited July 3, 2022]. The website is SEGM.org, which we discuss in the text in Section 2. Citations to letters and opinion pieces include, inter alia, Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765-766 (2020); Michael Laidlaw, et al., The Right to Best Care for Children Does Not Include the Right to Medical Transition, 19(2) Am. J. Bioethics 75-77 (2019); Michael Laidlaw, et al., Letter to the Editor: "Endocrine Treatment of Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Prace Guideline," 104(3) J. Clinical Endocrinology and Metabolism 686687 (2018); Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765 -766 (2020).

[57] June 2 Report, p. 15 ("Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control"). The Costa study is Rosalia Costa et al., Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria, 12 (11) J. Sexual Medicine P2206-2214 (2015) (hereinafter, "Costa et al. (2015)."

[58] See Luke R. Allen, et al., Well-Being and Suicidality Among Transgender Youth after Gender -Affirming Hormones, 7(3) Clinical Practice in Pediatric Psychology 302 -11 (2019); Amy E. Green, et al., Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, 70(4) J. Adolescent Health 643-649 (2022); Jack L. Turban, et al., Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation, 145(2) Pediatrics e20191725 (2020); Maureen D. Connolly, et al., The Mental Health of Transgender Youth: Advances in Understanding59(5) J. Adolescent Health 489-95 (2016); Gemma L. Witcomb et al., Levels of Depression in Transgender People and its Predictors: Results of a Large Matched Control Study with Transgender People Accessing Clinical Services, J. Affective Disorders (2018)..

[59] For citations, see Boulware et al., supra note 36, at n. 43.

[60] Diane Chen, et al., Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth, Transgender Health 246257 (2020).

[61] Vincenzo De Sanctis, et al., Long-Term Effects and Significant Adverse Drug Reactions (ADRs)Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: a Brief Review of Literature, 90(3) Acta Biomed. 345-359 (2019).

length. As a final example, the June 2 Report criticizes a 2019 preliminary study by Kuper et al. without acknowledging the existence of a more extensive 2020 study by Kuper et al.[62] The earlier study presented data on the mental health of adolescents when initially presenting for care; only the later study presented full data that demonstrated the benefit of treatment.

> C. The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used "off-label" and not approved by the FDA. In fact, off-label use, when supported by scientific evidence, as here, is extremely common in medical practice and especially in pediatrics.

The June 2 Report repeatedly notes that the FDA has not approved the use of puberty blockers and hormones for the treatment of gender dysphoria in minors.[63] The report infers that lack of FDA approval renders a treatment unauthorized and experimental, but this is false. Once again, the June 2 Report (mis)uses technical language to confuse readers.

The term "off-label" has a very specific meaning: a drug is off-label if the FDA has not approved a particular medication for a particular use in a specific population. The off-label use of medications for children is common and often necessary, because an "overwhelming number of drugs" have no FDA-approved instructions for use in pediatric patients.[64]

The lack of FDA approval does not imply that the use of medications should be restricted. There is a consensus in the medical community that off-label use is necessary because of limits imposed by burdensome and expensive regulatory processes. Pharmaceutical companies often lack financial incentives to support research required for FDA approval for specific use in children.[65]

The American Academy of Pediatrics, recognizing these facts, specifically authorizes the off-label use of drugs:

> The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, *the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use.* Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.[66]

---

[62] June 2 Report, p. 16. The earlier Kuper et al. study is Laura E. Kuper et al., Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy, 40(8) J. Dev. Behav. Pediatr. 589-596 (2019). The later study is Laura E. Kuper et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) Pediatrics e20193006 (2020).

[63] June 2 Report, pp. 8, 14, 15, 19.

[64] Boulware et al, supra note 36, quoting Kathleen A. Neville, et al., American Academy of Pediatrics Committee on Drugs, Off-label use of drugs in children, 133(3) Pediatrics 563-7 (2014) ("AAP Committee on Drugs")

[65] AAP Committee on Drugs (2014), supra note 64.

[66] AAP Committee on Drugs (2014), supra note 64 (emphasis added). See also Lenneke Schrier, et al., Off-label Use of Medicines in Neonates, Infants, Children, and Adolescents: a Joint Policy Statement by the European Academy of Paediatrics and the European Society for Developmental Perinatal and Pediatric Pharmacology, 179(5) Eur. J. Pediatr 839-845 (2020).

Off-label use is so common in pediatrics that off-label drugs are prescribed in 20% of patient visits.[67] We discuss numerous examples in the Appendix, but a few familiar examples provide illustrations of day-to-day, off-label use in pediatrics.[68]

As many parents know, the use of steroids for croup is a life-saving treatment that is off-label. The medication helps toddlers get through severe, potentially airway-obstructing illnesses safely. Ondansetron (Zofran) is used off-label for nausea and vomiting to prevent dehydration.

In psychiatry, some of the most commonly-prescribed medications for youth are off label. For example, selective serotonin reuptake inhibitors (SSRIs) are used to treat major depressive disorder in adolescents and have been shown to be effective, even though several are off-label.[69] Another common example is clonidine, which is FDA-approved for attention deficit hyperactivity disorder (ADHD) but is used off-label for anxiety, insomnia, and post-traumatic stress disorder (PTSD).[70]

Finally, the June 2 Report notes that testosterone is a controlled substance and is subject to risk of abuse, but, once again, this is misleading. The inclusion of testosterone on the schedule of controlled substances reflects the misuse of the drug by some individuals and communities (e.g., weightlifters and athletes who may use the drug to build muscle). The classification does not in any way imply that physicians should not dispense the drug if medically necessary. No special license is necessary for prescribing the medication, which is routinely prescribed to cisgender men with testosterone deficiency.

> D. The June 2 Report falsely claims that medical care for gender dysphoria is provided to a large percentage of children who will come to regret their treatment. In fact, patients with gender dysphoria have vanishingly low rates of regret regarding their medical treatment.

The June 2 Report attempts to cast doubt on medical treatment for gender dysphoria by repeating the debunked claim that most transgender teens ultimately reject their transgender identity. Below, we analyze two related claims made in the report and show why both are refuted by sound evidence. We provide additional detail in the Appendix.

First, the report claims that "the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex."[71] This is false. We have refuted this claim in detail in prior work. The key point is that *adolescents with gender dysphoria rarely find*

---

[67] Diya Hoon, et al., Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015, 144(4) Pediatrics 1-10 (2019) (emphasis added).
[68] These examples are drawn from the list of off-label uses in AAP Committee on Drugs (2014) and reflect our clinical experience in major hospitals and clinics.
[69] For AACAP guidelines, see Boris Birmaher and David Brent, Practice Parameter for the Assessment and treatment of Children and Adolescents with Depressive Disorders, 46(11) J. Am. Acad. Child and Adolescent Psychiatry P1503-1526 (2007).
[70] Rama Yasaei and abdolreza Saadabadi, Clonidine, National Library of Medicine (2022), at https://www.ncbi.nlm.nih.gov/books/NBK459124/[visited July 4, 2022].
[71] June 2 Report, p. 14.

that their dysphoria resolves without treatment.[72] Because medical treatment for gender dysphoria begins only in adolescence, and only if medically necessary, medical treatment is thus provided only to a group known to be quite stable in their gender identity.

Second, the June 2 report claims that many transgender people regret their medical treatment. This is false. We provide a detailed discussion in the Appendix, but the scientific evidence is clear: solid studies show very low percentages of regret (typically under 1%) among transgender people who receive medical treatment for gender dysphoria. For example, Bustos et al. (2021) found regret expressed by one percent or fewer of transgender patients who underwent gender-affirming surgery, and Danker et al. (2018) report a rate of far less than 1%, as do Wiepjes et al. (2015).[73]

> E. The June 2 Report repeats discredited claims that "social contagion" is leading teens to become transgender. Scientific evidence refutes this claim, which is based on a single, discredited study whose results have not been replicated by more rigorous studies.

The June 2 Report claims that "social factors (e.g., peer influences and media) may be contributing factors to gender dysphoria,"[74] citing as evidence a single, discredited study by Littman. We have addressed this claim at length in other work and note that the study incorporated such serious methodological errors that the journal of publication required an extensive correction because of the article's misstatements. [75]

Littman's sensationalist hypothesis has been widely covered in the press, but no clinical studies have found that rapid-onset gender dysphoria exists. Further, no professional organization has recognized "rapid-onset gender dysphoria" as a distinct clinical condition or diagnosis.

Most recently, an April 2022 study of 173 youth presenting at Canadian gender clinics *found no evidence of rapid-onset dysphoria or social contagion.* The researchers posited that if "rapid onset" gender dysphoria were a real phenomenon, then teens who had more recently begun identifying as transgender would (per the Littman hypothesis) also be more likely to report online support and engagement in their gender identity. They might also (per Littman's hypothesis) be more likely to struggle with mental health concerns.

An April 2022 study of 173 youth found no such correlations, strongly undercutting the "rapid-onset" hypothesis endorsed by the June 2 report. The researchers controlled for age and sex assigned at birth and looked for correlations with recent gender knowledge (defined as less than one to two years having passed since "you realized your gender was different from what other people called you"). Recent gender knowledge was *not* significantly associated with depressive symptoms, psychological distress, past diagnoses with comorbid mental health issues or neurodevelopmental disorders, or self-harm. Nor was it associated with having gender-

[72] Boulware et al., supra note 36, at 17-19.
[73] Id.
[74] June 2 Report, p. 12.
[75] Boulware et al., supra note 36, at 20-21 (internal citations omitted).

supportive online friends, general support from online friends or transgender friends, or gender support from parents.[76]

Data do substantiate that younger people today are more likely to identify as transgender than are older people, but this does not substantiate the idea of social contagion. The increase may be due to a cohort effect associated with the increasing social acceptance of gender diversity (i.e., older people grew up in a much more restrictive and transphobic social environment). In fact, adolescent presentation of transgender identity is often observed and should not be pathologized.[77]

Further, the data do not show a massive wave of transgender identity even among teens. A 2022 study by the Williams Institute found that, using an expansive definition of "transgender," about 0.5% of adults now identify as transgender, while 1.4% of youth aged 13-17 do, or about 300,000 young people.[78] This is not a large percentage or a large absolute number.

The June 2 Report's social contagion claim also disregards the enormous social pressure on teenagers to adopt a cisgender identity; transgender teens face significant discrimination and violence by asserting their gender identity and report very high rates of bullying at school.[79] Further, the evidence shows that teens (like adults) tend to use social media for emotional support and to access a helpful peer group that may not be available in person.[80]

Ultimately, however, the social contagion hypothesis is irrelevant to the question whether medical care for gender dysphoria is effective. As we have noted, medical treatments are not offered to all gender-questioning youth. Instead, the WPATH and Endocrine Society standards recommend drug therapies for transgender adolescents whose interdisciplinary medical team has determined that they have lasting and intense gender dysphoria and that treatment is medically necessary.

> F. The June 2 Report claims that inappropriate medical care is provided to adolescents with gender dysphoria who also have anxiety, depression, and other mental health conditions. These assertions are unsupported by evidence and disregard evidence-based clinical practice guidelines that provide sound guidance for treating complex cases.

The June 2 Report speculates that because "a high proportion" of youth receiving medical care for gender dysphoria also have a behavioral health disorder, "available research raises

---

[76] Greta R. Bauer, et al., 243 J. Ped iatrics 224-227 (2022).

[77] In the largest U.S. sample of transgender adults, over half reported first starting to realize that they were transgender in adolescence (57% ages 11-20) and roughly half (47%) started to disclose their identity during this time frame. Sandy E. James, et al., The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2015).

[78] Jody L. Herman, et al., How Many Adults and Youth Identify as Transgender in the United States?, U.C.L.A. School of Law, Williams Institute (2022).

[79] See, Joseph G. Kosciw, et al., The 2019 National School Climate Survey, GLSEN (2019), https://www.glsen.org/sites/default/files/2021-04/NSCS19-FullReport-032421-Web_0.pdf [visited July 3, 2020].

[80] Ashley Austin, et al., It's My Safe Space: The Life -Saving Role of the Internet in the Lives of Transgender and Gender Diverse Youth 21(1) Int'l J. Transgender Health 33-44 (2020); Ellen Selkie, et al., Transgender Adolescents' Uses of Social Media for Social Support, 66(3) J. Adolescent Health 275280 (2020).

questions as to whether the [individuals'] distress is secondary to pre-existing behavioral health disorders and not gender dysphoria."[81] In simpler terms, the June 2 Report speculates that perhaps gender dysphoria is not real but is, rather, an imagined by-product of underlying mental illness.

A close examination shows that this claim has no foundation in science; it rests on unexamined and harmful stereotypes and unaccountably dismisses the scientific knowledge and clinical skill of child and adolescent psychologists and psychiatrists. Here, we briefly explain why the June 2 Report's speculations are scientifically unfounded. We provide further detail on these points in the Appendix.

The June 2 Report implicitly posits that behavioral health disorders cause gender dysphoria, but this hypothesis is completely unsupported by scientific evidence, which strongly suggests that the direction of causation runs the other way. It is well-established that being transgender leads to mental health concerns because of the social stress and discrimination of being transgender in our society.[82] Although the effects of gender minority stress are well-known, the June 2 Report makes no mention of the literature.

Further, the co-occurrence of psychological distress among individuals with gender dysphoria provides no reason for denying care. Any population of individuals – cisgender or transgender -- will include some with mental health concerns. In response, the WPATH and Endocrine Society guidelines include a careful psychological assessment of each adolescent as part of the process for determining whether medical treatment for gender dysphoria is appropriate.

Importantly, experts in child and adolescent psychiatry, child psychology, and adolescent medicine have established that youth – including youth with mental health conditions -- can make complex medical decisions. The scientific literature specifically demonstrates that transgender youth with co-occurring mental health conditions can competently participate in medical decision-making.[83]

> G. The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies.

The June 2 Report argues, without scientific evidence, that youth with gender dysphoria should not be offered medical treatment but instead should only receive psychotherapy, an approach that

---

[81] June 2 Report, p. 6.
[82] Rylan J. Testa, et al., Development of the Gender Minority Stress and Resilience Measure, 2(1) Psychology of Sexual Orientation and Gender Diversity 65-77 (2015); Rylan J. Testa, et al., Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors, 126(1) J. Abnormal Psychology 125-36 (2017); Alexandrai M. Delozier, et al., Health Disparities in Transgender and Gender Expansive Adolescents: A Topical Review from a Minority Stress Framework, 45(8) J. Pediatric Psychology 842-847 (2020); Jessica Hunter, et al., Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People, 26(4) Clinical Child Psychology and Psychiatry 1182-1195 (2021).
[83] Lieke J. Vrouenraets, et al., Assessing Medical Decision-Making Competence in Transgender Youth, 148(6) Pediatrics e2020049643 (2021).

it mistakenly terms "watchful waiting."[84] This statement is false. Here we provide an overview of the actual science, with more detail in the Appendix.

Several solid, recent studies have demonstrated that medical care for gender dysphoria has positive effects on mental health that are not associated with psychotherapy alone. Costa et al. in 2015 found that puberty blockers improve psychosocial functioning in teens with gender dysphoria, compared to teens who receive psychotherapy but not blockers.[85] In a 2022 study, Tordoff et al. clearly found that youth with gender dysphoria reported better outcomes if they received puberty blockers, even after controlling for the effects of psychotherapy.[86] A 2020 study by Laura Kuper et al. also shows that hormone treatment for gender dysphoria is effective above and beyond the benefits of psychotherapy and psychiatric medications. [87]

Conclusion

Our analysis demonstrates that the June 2 Report carries no scientific weight. The report disregards established clinical guidelines and peer-reviewed studies and instead relies on purported "expert" reports that raise major red flags for lack of expertise, close ties to advocacy groups, and financial conflicts of interest. The report makes repeated errors about scientific research and medical regulation, and it engages in ungrounded speculation and stereotyping.

Accordingly, the Proposed Rule is ungrounded in scientific research and is arbitrary and capricious. Further, because the June 2 report violates Florida's own standards for scientific review, it cannot support the Proposed Rule as an interpretation of the existing Florida regulatory scheme.

We respectfully submit this letter of comment for your consideration.

Very truly yours,

Anne L. Alstott

Anne L. Alstott
Jacquin D. Bierman Professor, Yale Law School
Professor, Yale Child Study Center

---

[84] For example, at p. 12, the June 2 Report asks, "[S] hould conventional behavioral health services be utilized without proposing treatments that pose irreversible effects [i.e., drug therapies]? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects {i.e., the watchful waiting approach)?" At p. 20, t he June 2 Report misuses the term "watchful waiting" to describe the denial of medical care to adolescents with gender dysphoria, and the report miscites its own purported expert report. The Cantor document discusses "watchful waiting" meaning the denial of social transition to prepubertal children, not the denial of medical treatment to adolescents. Cantor document, p. 10-11.

[85] Costa et al., supra note 57.

[86] Diana M. Tordoff et al., Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care, 5(2) JAMA Network Open e220978 (2022).

[87] Laura E. Kuper, et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) Pediatrics e20193006 (2020).

With co-authors:

Hussein Abdul-Latif, M.D., Professor of Pediatrics and Pediatric Endocrinology, University of Alabama at Birmingham

Susan D. Boulware, M.D., Associate Professor of Clinical Pediatrics (Endocrinology), Yale School of Medicine; Director Clinical Operations, Section of Pediatric Endocrinology; Medical Director, Yale Pediatric Gender Program

Rebecca Kamody, PhD (Clinical Psychology), Assistant Professor, Yale School of Medicine: Child Study Center, Pediatrics, and Psychiatry

Laura Kuper PhD (Clinical Psychology), ABPP, Assistant Professor in Psychiatry, University of Texas Southwestern; Child and Adolescent Psychologist, Children's Medical Center Dallas

Meredithe McNamara, M.D., M.S., FAAP, Assistant Professor of Pediatrics (Adolescent Medicine), Yale School of Medicine

Christy Olezeski, PhD (Clinical Psychology), Associate Professor of Psychiatry, Yale Child Study Center and Pediatrics, Yale School of Medicine; Director, Yale Pediatric Gender Program

Nathalie Szilagyi, M.D., Instructor, Yale Child Study Center, Yale Pediatric Gender Program; Director, Greenwich Child and Adolescent Psychiatry, Greenwich Center for Gender & Sexuality

Appendix

July 8, 2022

A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria

Meredithe McNamara, M.D., M.S. (Clinical Research), FAAP, Assistant Professor of Pediatrics (Adolescent Medicine), Yale School of Medicine

Hussein Abdul-Latif, M.D., Professor of Pediatrics and Pediatric Endocrinology, University of Alabama at Birmingham

Susan D. Boulware, M.D., Associate Professor of Clinical Pediatrics (Endocrinology), Yale School of Medicine; Director Clinical Operations, Section of Pediatric Endocrinology; Medical Director, Yale Pediatric Gender Program

Rebecca Kamody, PhD (Clinical Psychology), Assistant Professor, Yale School of Medicine: Child Study Center, Pediatrics, and Psychiatry

Laura Kuper PhD (Clinical Psychology), ABPP, Assistant Professor in Psychiatry, University of Texas Southwestern; Child and Adolescent Psychologist, Children's Medical Center Dallas

Christy Olezeski, PhD (Clinical Psychology), Associate Professor of Psychiatry, Yale Child Study Center and Pediatrics, Yale School of Medicine; Director, Yale Pediatric Gender Program

Nathalie Szilagyi, M.D., Instructor, Yale Child Study Center, Yale Pediatric Gender Program; Director, Greenwich Child and Adolescent Psychiatry, Greenwich Center for Gender & Sexuality

Anne L. Alstott, J.D., Jacquin D. Bierman Professor, Yale Law School; Professor, Yale Child Study Center*

Introduction

On June 2, 2022, the Florida Agency for Health Care Administration ("AHCA") issued a purported scientific report (hereinafter, "June 2 Report") concluding that standard medical care

* The authors have received no funding for this report or for our public comments on Florida's proposed Medicaid rule. We have no conflicts of interest to declare. Dr. Olezeski prepared paid expert testimony in a case for the Federal Public Defender for the District of Connecticut. We thank Melisa Olgun for excellent research assistance.

for gender dysphoria does not meet generally accepted medical standards and is experimental and investigational.[88]

We are a group of seven scientists and a law professor, and we have concluded, after a careful examination of the June 2 Report, that its conclusions are incorrect and scientifically unfounded. The June 2 Report purports to be a review of the scientific and medical evidence but is, in fact, fundamentally unscientific.

We are alarmed that Florida's health care agency has adopted a purportedly scientific report that so blatantly violates the basic tenets of scientific inquiry. The report makes false statements and contains glaring errors regarding science, statistical methods, and medicine. Ignoring established science and longstanding, authoritative clinical guidance, the report instead relies on biased and discredited sources, including purported "expert" reports that carry no scientific weight due to lack of expertise and bias.

So repeated and fundamental are the errors in the June 2 Report that it seems clear that the report is not a serious scientific analysis but, rather, a document crafted to serve a political agenda.

The AHCA has offered the June 2 Report as justification for a proposed rule that would deny Florida Medicaid coverage for gender dysphoria to people of all ages (the "Proposed Rule").[89] We strongly oppose the Proposed Rule and have documented our reasons in public comments submitted to the AHCA on July 8, 2022. This report provides our detailed reasons for concluding that the June 2 Report provides no scientific support for Florida's proposed action.

Executive Summary

As we note in our comments on the Proposed Rule, we strongly oppose Florida's proposal to deny Medicaid coverage to standard medical care for gender dysphoria. In this report, we show that the June 2 Report is so thoroughly flawed and biased that it deserves no scientific weight. Although our focus is on the science, we also note that the Proposed Rule would violate the sex discrimination protections provided by the U.S. and Florida Constitutions and the federal statute that governs Medicaid by discriminating against transgender people on the basis of their sex, transgender status, and gender identity.[90]

In this report, we examine closely the "scientific" claims made in the June 2 Report, and we show that its basic conclusion is incorrect. Medical treatment for gender dysphoria does meet generally accepted professional medical standards and is not experimental or investigational. We also show that the June 2 report reflects a faulty understanding of statistics, medical regulation, and scientific research. The report ignores solid scientific evidence and instead

---

[88] Division of Florida Medicaid, Agency for Health Care Administration, Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria, June 2022, at https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf("June 2 Report").
[89] 48 Fl. Admin. Reg. 2461 (June 17, 2022).
[90] See Bostock v. Clayton County, 590 U.S. __ (2020); Kadel v. Folwell, M.D. N.C., Mem. Op. 6-10-22 (applying Bostock to public health plan coverage); 42 U.S.C. 18116 (requiring nondiscrimination in Medicaid plans).

repeats discredited claims, cites to sources with no scientific merit, and engages in unfounded speculation based on stereotypes rather than science.

Specifically, we show that:

- Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.
- The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science, particularly purported "expert" reports that are biased, inexpert, and full of errors. The claimed "expert" reports are written by authors whose testimony has been disqualified in court and who have known ties to anti-LGBTQ advocacy groups.
- Nothing in the June 2 Report calls into question the scientific foundations of standard medical care for gender dysphoria. The June 2 Report makes unfounded criticisms of robust and well-regarded clinical research and instead cites sources with little or no scientific merit, including journalism, a blog entry, letters to the editor, and opinion pieces.
- The linchpin of the June 2 Report is an analysis by two epidemiologists that claims to undermine the scientific evidence supporting medical care for gender dysphoria. Their analysis is extremely narrow in scope, inexpert, and so flawed that it merits no scientific weight at all.
- The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cardioprotective cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

I. Contrary to the June 2 Report's repeated claims, medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational.

The conclusion of the June 2 report – that medical treatments for gender dysphoria "do not conform to [generally accepted professional medical standards] and are experimental and investigational"[91] – is demonstrably false.

Medical care for the treatment of gender dysphoria, which for youth under the age of majority can include gonadotropin releasing hormone agonists ("GnRHa" or puberty blockers) and hormone therapy, has been vetted and approved by international bodies of experts based on the scientific evidence. Two authoritative bodies of scientists, the World Professional Association for Transgender Health (WPATH) and The Endocrine Society, have published extensive clinical practice guidelines for treating gender dysphoria.[92] These clinical guidelines are based on

[91] June 2 Report, p. 2.

[92] See Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Professional Association for Transgender Health (7th version, 2012), at https://www.wpath.org/publications/soc ("WPATH (2012)"); Wylie C. Hembree, et al., Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent

rigorous, structured processes that include a committee of scientific experts and peer review by additional experts. The guidelines are based on careful reviews of the scientific literature and are revised periodically to reflect scientific developments.

These longstanding clinical practice guidelines have been used by clinicians for decades. WPATH issued its initial guidelines in 1979 and updated them in 1980, 1981, 1990, 1998, 2001, and 2012. The eighth version remains in process, and it incorporates systematic literature reviews and ample opportunities for peer review and revision.[93] The original Endocrine Society guidelines were published in 2009 and updated in 2017.[94]

Reflecting this scientific and medical consensus, medical care for gender dysphoria has been confirmed as standard care by every relevant medical organization in the United States, including the American Academy of Pediatrics, the American Psychological Association, and the American Academy of Child and Adolescent Psychiatry.[95] In 2022, these organizations united with the American Medical Association, the American College of Obstetricians and Gynecologists, and other groups to file an amicus brief representing a total of 20 major medical societies. The brief reaffirms that puberty blockers and hormone treatments for gender dysphoria are standard medical care and opposes legal measures that would limit patient access to this standard care.[96]

The weight and volume of these endorsements, across diverse medical specialties, sharply contradicts the June 2 Report's conclusions.

II. The June 2 Report appears to be a scientific report, but its veneer hides a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science. The report heavily relies on five purported "expert" documents that are biased, inexpert, and full of errors.

The Florida report dismisses or ignores the WPATH and Endocrine Society clinical practice guidelines and the science that underlies them and instead relies on five attached documents that, the report claims, constitute "clinical and technical expert assessments."[97]

Persons: An Endocrine Society Clinical Practice Guideline, 102(11) J. Clin. Endocrinol. Metab. 3869-3903 (2017) ("Endocrine Society (2017)").

[93] See World Professional Association for Transgender Health (WPATH), Methodology for the Development of Standards of Care 8 (Soc 8), at https://www.wpath.org/soc8/Methodology

[94] Endocrine Society (2017), supra note 5.

[95] Jason Rafferty, Committee on Psychosocial Aspects of Child and Family Health; Committee on Adolescence; Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, 142(4) Pediatrics E20182162 (2018); American Psychological Association, Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, 70(9) American Psychologist 832-64 (2015); Stewart L. Adelson, Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 51(9) J. Am. Acad. Child & Adolescent Psychiatry, 957 -974 (2012).

[96] Brief of Amicus Curiae American Academy of Pediatrics and Additi onal National and State Medical and Mental Health Organizations in Support of Plaintiffs' Motion for Temporary Restraining Order and Preliminary Injunction, Eknes-Tucker v. Ivey (later redesignated Eknes-Tucker v. Abbott), May 5, 2022, at https://www.aamc.org/media/60556/download

[97] June 2 Report, p. 2.

Despite their billing as "expert" reports, the attachments to the June 2 report are unpublished, non-peer-reviewed documents written by authors with questionable claims to expertise and with red flags for undisclosed author bias. These documents should be given no weight in a serious scientific process.

> A. The purported "expert" documents attached to the June 2 Report carry no scientific weight. They are unpublished and not peer-reviewed, and they are written by authors whose expertise has been successfully challenged in legal proceedings and whose backgrounds raise red flags for bias.

None of the documents attached to the June 2 Report meet standard criteria for expert scientific investigations, because none is published or peer reviewed. Publication and peer review are fundamental to science, as they ensure that a scientist's data and conclusions are open to scrutiny from scientific experts.

Florida's own standards for the determination of medical necessity recognize this point when they state that determinations of Medicaid coverage must consult "*published* reports and articles in the authoritative medical and scientific literature related to the health service (*published in peer-reviewed scientific literature* generally recognized by the relevant medical community or practitioner specialty associations)."[98] It is thus both unscientific and a violation of the regulations for the June 2 Report to rely on the unpublished documents as its principal evidence base.

Further, the attachments all raise red flags for author bias. The June 2 Report does not disclose how these "experts" were identified or by what criteria their expertise was assessed. The opacity of the Florida AHCA process for identifying experts is particularly troubling because at least four of the experts have strong indications of bias. Further, the qualifications and credibility of two of the experts have been successfully challenged in litigation.[99] Two of the expert reports duplicate, word-for-word (or with very slight edits) testimony that was offered, apparently for pay, in litigation. Both have connections to advocacy organizations that oppose LGBTQ rights across the board. The endorsement of these individuals as Florida's banner "experts" raises the appearance of bias – that the AHCA sought a pre-ordained outcome, not a true scientific perspective.

Adding to these red flags for bias, none of the authors of the attachments provide a statement of funding and conflicts of interest. This omission violates a strong norm in scientific writing, which requires authors to declare any conflicts of interest; these include any professional or financial arrangements that could call into question their independence of judgment.[100] That

---

[98] Fl. Admin. Code Section 59G-1.035(4).

[99] See Stephen Caruso, A Texas Judge Ruled That This Doctor Was Not an Expert, Pennsylvania Capital-Star, Sept. 15, 2020 (reporting that van Meter was disqualified as an expert in a Texas divorce case, now sealed).

[100] For example, the conflict of interest rules for JAMA, one of the premier medical journals in the United States and the world state that "[a]uthors are expected to provide detailed information about all relevant financial interests, activities, relationships, and affiliations (other than those affiliations listed in the title page of the manuscript) including, but not limited to, employment, affiliation, funding and grants received or pending, consultancies, honoraria or payment, speakers' bureaus, stock ownership or options, expert testimony, royalties, donation of medical equipment, or patents planned, pending, or issued." JAMA Network, Instructions for Authors, visited June

strong norm also requires authors to disclose whether projects have been funded and if so, by whom and whether the authors have engaged in expert testimony. Without these statements, the Florida AHCA and the public cannot detect biases that could affect the integrity of these written products.

These are more than theoretical concerns: at least four of the attachments have notable indicators of conflicts of interest and bias. (Note that these are the only four we examined in detail, and so we do not imply that the other one is free from such bias.)

The author of the document provided as Attachment E is Quentin van Meter, whose history indicates bias and lack of expertise. Although the AHCA presents van Meter as an expert in medical treatment for gender dysphoria, at least one court barred him from providing expert testimony on the issue.[101] Van Meter is the president of the American College of Pediatricians (the "ACP"), which presents itself as a scientific group (and might be confused, by a non-expert, with the authoritative American Academy of Pediatrics). The ACP is, in fact, a political group that opposes same-sex marriage,[102] supports mental health providers practicing conversion therapy,[103] and describes childhood gender dysphoria as "confusion."[104] Troublingly, the van Meter attachment, proffered by the AHCA as a scientific report, contains several passages of uncredited, verbatim language that appears in a "position statement" published by the ACP.[105] The van Meter attachment appears to be a re-use of paid testimony rather than an original product.[106]

James Cantor's document, presented as Attachment D to the June 2 Report, also faces serious questions about bias and lack of expertise. In a 2022 case, a federal court took a skeptical view of Cantor's purported expertise, noting that "the Court gave [Cantor's] testimony little weight because he admitted, inter alia, to having no clinical experience in treating gender dysphoria in minors and no experience monitoring patients receiving drug treatments for gender dysphoria.[107]

22, 2022, at https://jamanetwork.com/journals/jama/pages/instructions-for-authors#SecConflictsofInterestandFinancialDisclosures

[101] Caruso, supra note 12.

[102] Den Trumbull, Defending Traditional Marriage, American College of Pediatricians (2013), https://acpeds.org/position-statements/defending-traditional-marriage. See Jack Turban, The American College of Pediatricians is an Anti-LGBTQ Group, Psychology Today, May 8, 2017.

[103] Christopher Rosik and Michelle Cretella, Psychotherapy for Unwanted Homosexual Attraction Among Youth, American College of Pediatricians (2016), https://acpeds.org/position -statements/psychotherapy-for-unwanted-homosexual-attraction-among-youth.

[104] Michelle Cretella, Gender Dysphoria in Children, American College of Pediatricians (2018), https://acpeds.org/position-statements/gender-dysphoria-in-children (site visited June 22, 2022). The author of the ACP position paper is Michelle Cretella, who was publicly rebuked by the Society for Adolescent Health and Medicine, the leading society for adolescent medicine in the United States, for "pushing political and ideological agendas not based on science and facts." https://www.adolescenthealth.org/Advocacy/Advocacy-Activities/2017-Activity/Senate-Bill-439-(2).aspx

[105] The similarity was shown by a Word comparison of the van Meter report provided as Attachment E to the June 2 Report with a "position statement" published on the ACP website, with authorship credit given on the website to Michelle Cretella. See Michelle Cretella, Gender Dysphoria in Children, supra note 17.

[106] The van Meter document attached to the June 2 Report is substantially identical to his expert declaration in Adams v. School Board of St. Johns County, Florida. https://files.eqcf.org/wp-content/uploads/2017/12/41-D-AMENDED-Notice-Documents-iso-Response-to-PI.pdf.

[107] Opinion and Order, Eknes-Tucker v. Marshall, 2:22-CV-184-LCB, M.D. Alabama, May 13, 2022.

Cantor's document is nearly identical to what appears to be paid testimony in another case, where Cantor's declaration was used to support legislation barring transgender athletes from sports teams,[108] Troublingly, Cantor's appearance in that case seems to have been funded by the Alliance Defending Freedom ("ADF"), [109] a religious and political organization that opposes legal protections for transgender people and same-sex marriage[110] and defends the criminalization of sexual activity between partners of the same sex.[111] Because Cantor provides no conflicts of interest disclosure, readers cannot ascertain whether Florida AHCA also paid for Cantor's report and whether Florida officials were aware that the Cantor report reused his work for (apparently) the ADF.

Romina Brignardello-Petersen is one of two authors of the document provided as Attachment C to the June 2 Report. Although Brignardello-Petersen claims to have no research interests in medical care for transgender youth,[112] she has conducted research for the Society for Evidence-Based Gender Medicine ("SEGM").[113] Although SEGM claims to be an international medical society, it is actually an activist group that opposes standard medical care for gender dysphoria. The SEGM has no publications or conferences and seems to consist solely of a website created by a small group of people with limited or no scientific credentials or clinical experience. The site presents a cherry-picked collection of studies and narrative content that is full of scientific errors.[114]

Patrick Lappert, whose document is attached to the June 2 Report as Attachment F, has been disqualified as an expert in a recent federal court decision in North Carolina. [115] The judge found

---

[108] The case is BPJ v. West Virginia State Board of Education, and the Alliance Defending Freedom takes credit for it here: https://adfmedia.org/case/bpj-v-west-virginia-state-board-education. Cantor's declaration appears here: https://adfmedialegalfiles.blob.core.windows.net/files/BPJCantorDeclaration.pdf

[109] The ADF seems to take credit for the case in this press conference notice: https://adfmedia.org/case/bpj-v-west-virginia-state-board-education

[110] Marriage is the Future, American College of Pediatricians, https://adflegal.org/issues/marriage/overview(site visited July 2, 2022. Content on the page includes this statement:"Marriage is about equality and diversity. It's about joining the two equally important and diverse halves of humanity represented in men and women."

[111] Southern Poverty Law Center, Dangerous Liaisons, July 10, 2013, https://www.splcenter.org/20130709/dangerousliaisons [visited July 2, 2022].

[112] Like the van Meter and Cantor attachments, the BPW document provides no express statement of conflicts of interest. The BPW document does offer a statement of "credentials and expertise," in which she declares that "her research interests are not in this area," meaning apparently research on medical care for gender dysphoria. BPW Document, p. 1.

[113] BPW document, p. 1. For one example of the purported research that Brignardello -Petersen apparently assisted in, see Alison Clayton et al., Commentary: the Signal and the Noise– Questioning the Benefits of Puberty Blockers for Youth with Gender Dysphoria– A Commentary on Rew et al. (2021), Child and Adolescent Mental Health, Dec. 22, 2021, at https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12533 In the "Acknowledgements" section, the authors state, "We would also like to thank the Society for Evidence -based Gender Medicine (SEGM) for providing access to several experts who helped shape this commentary and ensure its accuracy. Specifically, we would like to thank Dr. Romina Brignardello Petersen [sic] for contributing her methodological expertise."

[114] Susan Boulware et al., Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims (April 28, 2022), at 28-29 (Appendix A) available at https://medicine.yale.edu/childstudy/policy-and-social-innovation/lgbtq-youth/.

[115] Kadel v. Folwell, 1:19CV272, M.D. N.C. June 10, 2022. The judge ruled that Lappert was not qualified to "render opinions about the diagnosis of gender dysphoria, its possible causes, the efficacy of the DSM, the efficacy of puberty blocking medication or hormone treatments, the appropriate standard of informed consent for mental health professionals or endocrinologists, or any opinion on the non-surgical treatments." Lappert was also

that evidence "calls Lappert's bias and reliability into serious question" and noted that Lappert has worked closely with ADF and has actively lobbied for legal bans on medical care for transgender youth.[116] The judge gave no weight to Lappert's testimony about informed consent in that case, finding that it was unsupported by scientific evidence.[117] The judge also found that "Lappert has provided the Court with no data or methodology used to draw his conclusion that surgical treatment for gender dysphoria has "never been generally accepted by the relevant scientific community."[118]

B. The linchpin of the June 2 Report is the analysis by Brignardello-Petersen and Wiercioch (the "BPW document"), provided as Attachment C, which purports to be a comprehensive review of the scientific literature on medical treatment for gender dysphoria but, in fact, is extremely narrow in scope and so flawed in its analysis that it merits no scientific weight.

The BPW document, like the other attachments to the June 2 Report, is an unpublished, non-peer-reviewed document. It claims to conduct a systematic review of the relevant scientific literature, but in fact, it is written by inexpert authors who construct an arbitrarily truncated sample and adopt a method that violates scientific guidelines and produces a biased result. The authors describe their findings in deceptive language and jargon predictably mislead the reader. Our review shows that *nothing in the BPW document calls into question the scientific foundations of the WPATH and the Endocrine Society clinical practice guidelines.*

The BPW document seems scientific on its face, and it may be impressive to non-experts, because it uses technical jargon and includes numerous tables and charts. But a closer examination shows that it violates established standards for medical research and shows signs of being engineered to produce a pre-ordained and inaccurate result: the false claim that there is no scientific evidence base for medical treatment for gender dysphoria. Contrary to the authors' claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria and spans decades.

The bottom line is that, contrary to the BPW document's claims, there is a large body of reliable scientific literature that supports standard medical treatment for gender dysphoria.

(1) The BPW document lacks scientific credibility due to the authors' lack of relevant qualifications and their ties to an activist group.

The BPW document purports to be a systematic review of the scientific literature on medical treatment for gender dysphoria. But the document, like the other attachments to the June 2 Report, is not published or peer-reviewed, and its design and execution raise numerous red flags for bias. Here, we describe just four of the notable defects that undercut entirely the document's claim to objectivity and sound method.

---

disqualified from opining on "the efficacy of randomized clinical trials, cohort studies, or other longitudinal, epidemiological, or statistical studies of gender dysphoria." Id.

[116] Id.

[117] Id., pp. 29-30.

[118] Id., p. 31.

First, neither of the BPW authors are experts in medical care for gender dysphoria, either as researchers or clinicians. One author (Brignardello-Petersen) has not previously studied the subject, except in her work for the ideological organization SEGM.org, noted just above. Her only clinical experience appears to be in dentistry.[119] The other author (Wiercioch) is a junior researcher (a postdoctoral fellow) with no prior research or clinical experience in this field.

The authors' lack of interest and experience renders the BPW work inexpert rather than objective, and it violates the National Academy of Medicine (formerly, Institute of Medicine) standards for systematic reviews. By analogy, one would not rely on, say, two dermatologists to conduct a review of the scientific literature on neurosurgery and to make recommendations for clinical practice.

Second, not only is the study not formally peer-reviewed, the BPW authors violate scientific norms and standards by *failing to engage at all with their peers or with actual experts in the subject matter*. As experts in research methodology should know, any sound systematic review should propose explicit and reproducible methods to methodically summarize the existing literature; the protocol (i.e., the research design) is then published to solicit input and criticisms from potential users of the review and experts in the field. Peer review of the literature review and publication of the protocol are not optional or merely window-dressing; they reflect bedrock commitments of the scientific method. These processes help ensure that the authors of any review understand the existing research and craft a research design that will usefully build on and add to prior work.

The BPW document violates these standards, raising questions about whether this was a rushed study designed to serve a political agenda – rather than a considered, comprehensive, scientific enterprise. The BPW document does not contain a review of the existing literature, and it does not acknowledge the WPATH and Endocrine clinical practice guidelines, which are themselves based on careful systematic reviews. The BPW authors appear not to have published their protocol in advance or otherwise to have submitted their protocol for peer review. That is, there is no indication that they vetted their research design in consultation with subject-matter experts.

---

[119] Romina Brignardello bio, at https://experts.mcmaster.ca/display/brignarr [visited July 2, 2022]
Google Scholar, Wojtek Wiercioch, visited June 22, 2022, https://scholar.google.com/citations?user=vdi3r_AAAAAJ&hl=en
Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institute of Medicine, Finding What Works in Health Care: Standards for Systematic Reviews, National Academies (Jill Eden et al., eds 2011), p. 48 (Standard 2.1.1 states that teams for systematic reviews should include expertise in pertinent clinical content areas). Background: The Institute of Medicine, now called the National Academy of Medicine, is one of three branches of the National Academies of Science, Engineering, and Medicine. The National Academy of Science dates to 1963 and was established by Congress; the Institute of Medicine was established as a separate entity in 1970 and serves as the nation's leading authority on scientific research and knowledge. National Academy of Medicine, About the National Academy of Medicine, website visited June 22, 2022 https://nam.edu/about-the-nam/ The standards for systematic reviews were published in 2011, responding to a Congressional request to set benchmarks for high-quality systematic reviews that could reliably guide physicians and healthcare providers in making informed, scientific judgments about health care.
Committee on Standards for Systematic Reviews of Comparative Effectiveness Research, Institute of Medicine, supra note 34, at pp. 72-75.

Third, the BPW document raises red flags for opinion bias. Buried in the methodology pages of the BPW document is the fact that the authors uncritically include politically biased "grey literature" sources, giving them equal weight to peer-reviewed, published literature. Specifically, the authors include in their search the fringe website SEGM.org. As noted above, the group's website posts are not peer-reviewed or published, and its content is assembled by a small group of activists with few or no expert credentials and is often full of errors. Troublingly, this is the group to which one of the authors, Brignardello-Petersen, has ties, as noted above.

> *(2) The BPW document examines a truncated sample of the literature and adopts a methodology that violates scientific standards for evaluating medical evidence. The authors compound this bias by describing their results using overstated and deceptive language. The picture that emerges is of a rushed and inexpert report with indications of bias.*

The BPW document has a patina of scientific expertise. It invokes the respected GRADE standards for rating the quality of studies, and it occupies many pages with tables and technical specifications. When a reader looks past the jargon, however, the BPW authors adopt a method that actually violates GRADE standards and appears to be jury-rigged to reach a foregone conclusion. The authors then convey their conclusions in misleading language. *Contrary to the BPW authors' claims, their study does not call into question the scientific and clinical importance of the established science that supports medical care for gender dysphoria.*

The BPW analysis incorporates numerous decisions that bias their results, and they make numerous misleading statements. First, the BPW document reviewed only a small sample of the relevant scientific literature. In the introduction, the BPW authors initially claim to have reviewed 61 systematic reviews of medical treatment for gender dysphoria. But buried in the middle of the document is the admission that the analysis is based on a sample of 27 systematic reviews, not 61 as claimed. The result is that the BPW analysis excludes a great deal of relevant evidence, and the authors provide no rationale for this "prioritization," as they call it. Troublingly, although the BPW document claims to be conducting a review of the literature that analyzes existing systematic reviews, the 27 studies they analyze are not all systematic reviews. Three of the 27 are mislabeled as systematic reviews but are actually practice bulletins, unpublished protocols or unlocatable.

Troublingly, the authors also embed in the middle of their document a*n unjustified decision to limit their analysis to studies published from 2020 to the present, and their project has strong indications that it was rushed work.* The authors disclose that they "prioritized" studies from the last 30 months (two full years plus four months in 2022), but they do not defend that priority.

BPW document, Methods section, p. 2.
See Boulware et al., supra note 27 pp. 28-29 (Appendix A).
BPW document, Introduction Section, p. 2.
BPW document, Results Section, p. 1.

The reader is left to wonder whether this truncation served only to help the authors produce their analysis in what was apparently a very short time frame.

The truncation of the literature sample to the period from 2020 to early 2022 is worrisome because that period coincides with the worst global public health emergency in generations. The pandemic disrupted many institutions, straining the health care system and putting immense pressure on clinicians. It is likely that the pandemic stalled the production and publication of non-COVID research during this period, calling into sharp question the BPW authors' sampling strategy.

The BPW sample is also questionable because the authors choose, without justification, a small subsection of databases to search and have likely missed important literature as a result. Specifically, they chose not to source from other important databases such as Embase, PsycInfo, Web of Science, Scopus, or Cochrane. They also limited their scope to works published in English only, an exclusion that can introduce bias.

Second, the BPW authors misused and mechanically applied a well-regarded rating system known as AMSTAR, which is intended to evaluate the methodological strength of systematic reviews. They misused this rating system because their so-called group of systematic reviews included documents that cannot correctly be included (practice bulletins, unpublished protocols, and unlocatable documents) and thus led to a negative bias. The BPW error is further amplified because the authors used the flawed results of the AMSTAR phase to inform their next level of analysis, the GRADE system (which assesses the quality of medical evidence of pooled systematic reviews). Based on this flawed and purely mechanical review of truncated sources, the BPW analysis reaches the conclusion that there is little or no evidence for the benefits of medical care for gender dysphoria.

The BPW analysis is highly deceptive, because it dismisses nearly all existing studies of medical treatment for gender dysphoria as "low quality," without explaining that this is a highly technical term and not a natural-language condemnation of the studies. By contrast, the GRADE system, which the authors purport to use, is quite clear about its quality rating systems and its limitations. In general, only randomized controlled trials (RCTs) are coded as "high" quality evidence in the GRADE system. A randomized controlled trial is a study that divides patients randomly into a control group (no treatment) and a treatment group. In contrast, an observational study records information about patients in a real-world setting that is more reliably generalizable, e.g., a cohort of patients seen at a clinic. Under the GRADE guidelines, observational studies are coded as "low" in quality.

The authors disclose that they conducted their initial literature searches– the first step in the review process – at the end of April 2022. BPW document, Methods section, p. 2.

For example, the BPW document states that there is *evidence* about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. BPW document, Results section, p. 4.

See Howard Balshem et al., GRADE Guideline: 3. Rating the Quality, 64 J. Clinical Epidemiology P401 -406 (2011), Table 3, p. 404

The key point is that "low quality" in this context is a technical term and not a condemnation of the evidence, because "low quality" studies regularly guide important aspects of clinical practice. Indeed, the GRADE system, which the BPW document claims to use, specifically notes that GRADE should *not* be used to dismiss observational studies or to give absolute priority to RCTs:

> Although higher quality evidence is more likely to be associated with strong recommendations than lower quality evidence, a particular level of quality does not imply a particular strength of recommendation. *Sometimes, low or very low quality evidence can lead to a strong recommendation.*[130]

The methodology adopted by the BPW document will thus, predictably, conclude that any body of scientific literature that does not contain RCTs is "low" in quality. Had BPW begun, as they should have, with a literature review of the evidence on puberty blockers and hormones, they would have seen that the evidence consists primarily of observational studies (for the good reasons discussed below). Thus, the 30 pages that it takes the authors to lay out their methodology is misleading: a knowledgeable reader would know that if there are few or no RCTs in the literature, then the BPW technical conclusion is foregone and, as importantly, is not a sound guide for clinical recommendations.

Put in simpler terms, if we coded apples as "high quality fruit" and bananas as "low quality fruit," then any fruit bowl that has only bananas would predictably be technically coded as "low quality." But that technical conclusion conveys very little information without context. For example, if no apples exist, then bananas may be a nutritious choice.

The drafters of the GRADE system emphasize that technically "low quality" evidence can support a strong clinical treatment recommendation. For example, pediatricians now agree that children should not be given aspirin for fevers. This recommendation is based on observational studies that showed an association between aspirin treatment during viral illnesses and the development of Reyes syndrome (a rapid and progressive disease of neurological dysfunction that can be fatal). Based on those studies, it would be unethical to conduct an RCT giving some children aspirin, and so the strong, consensus treatment recommendation is based entirely on "low quality" studies.[131]

The critical fact is that RCTs are not, and cannot be, the gold standard for medical research on gender dysphoria. In the context of treatments for gender dysphoria, randomized controlled trials would often be inappropriate for ethical reasons. Medical care has long been shown, by reliable scientific methods, to address gender dysphoria and improve mental health: as we have repeatedly noted, these treatments have been recommended by rigorous clinical practice guidelines issued by WPATH and the Endocrine Society and endorsed by every major medical organization. Given this medical consensus, which is based on solid scientific evidence, it would be unethical to conduct an RCT that involved denying standard medical care to a control group of individuals.

---

[130] Balshem et al., supra note 42, at 402 (emphasis added).
[131] Id.

Similar ethical issues, along with practical barriers, leave many areas of consensus medicine supported by observational studies and not RCTs. Many surgical procedures, for example, are not supported by RCTs.[132] Nor are standard protocols for lowering cholesterol using statins, one of the most widely-prescribed drugs in the United States. (See Section III.A of this report.)

It is thus simply a mistake – and a mischaracterization of medical research across fields of medicine – to conclude that the absence of RCTs means that there is "no evidence" for the efficacy of medical treatment for gender dysphoria. Medical research requires, instead, that researchers evaluate the design and conduct of specific observational studies and do so with an awareness of clinical context.[133]

In sharp contrast to BPW, this is precisely what the authors of the Endocrine Society did in their 2017 clinical guidelines, which use the GRADE system but, in addition, carefully discuss the characteristics of the studies supporting each treatment guideline.[134] The Endocrine Society discloses the GRADE rankings for each treatment recommendation in order to be transparent about the evidence base for each of its recommendations. Then, following National Academy of Medicine (formerly, Institute of Medicine) standards for clinical practice guidelines, they proceed to a qualitative review of the evidence, place the evidence in clinical context, and discuss openly the values at stake in making a clinical practice recommendation.[135]

III. The June 2 Report reflects a faulty understanding of statistics, medical regulation, and scientific research, and it repeats discredited claims and engages in speculation and stereotyping without scientific evidence.

The June 2 Report is full of errors and misstatements. Disregarding solid scientific evidence, the report relies on debunked studies and sheer speculation, and it levels criticisms at solid evidence that betray a poor understanding of medical research and statistics.

A. The June 2 Report repeatedly and erroneously dismisses solid studies as "low quality." If Florida's Medicaid program applied the June 2 Report's approach to all medical procedures equally, it would have to deny coverage for widely-used medications like statins (cholesterol-lowering drugs taken by millions of older Americans) and common medical procedures like mammograms and routine surgeries.

---

[132] See, e.g., Peter McCulloch, et al., Randomised Trials in Surgery: Problems and Possible Solutions, 324 (7351) BMJ 1448-1451 (2002).

[133] See Balshem et al., supra note 42 at 405 ("[W] e caution against a mechanistic approach toward the application of the criteria for rating the quality of the evidence up or down…. Fundamentally, the assessment of evidence quality is a subjective process, and GRADE should not be seen as obviating the need for or minimizing the importance of judgment or as suggesting that quality can be objectively determined"). See also the National Institute of Medicine (Institute of Medicine) Standards, supra note 34, at 176: ("We are disappointed when a systematic review simply lists the characteristics and findings of a series of singlestudies without attempting, in a sophisticated and clinically meaningful manner, to discover the pattern in a body of evidence. Although we greatly value meta -analyses, we look askance if they seem to be mechanistically produced without careful consideration of the appropriateness of pooling results or little attempt to integrate the finds into the contextual background.")

[134] Endocrine Society (2017), supra note 5.

[135] Id.

In its opening words, the June 2 Report makes an error that is repeated throughout the document: "Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased."

As we document in Section II.B., above, it is an outright mistake to conclude that a study in the technical category of "low quality" is unreliable or poor evidence for clinical practice.[136] Thus, it is frank error for the June 2 Report to dismiss well-done, scientifically important studies because they rank as "low quality" using specialized, technical terms.

Like the BPW document, the June 2 Report thus relies on a deceptive use of technical terminology that is at odds with the standards used in medical research. It simply is not – and cannot be – the case that all clinical recommendations must be based on RCTs. Many areas of medicine do not lend themselves to ethical and practical RCTs. It is unethical to conduct an RCT when randomizing a patient to a control group would cause harm by denying treatments of known efficacy. For example, it would be unethical to conduct an RCT on the treatment of juvenile diabetes by randomizing some participants to receive insulin and others to receive no treatment.[137]

It is quite common for the medical community to adopt important, consensus clinical practices supported by observational studies alone. For example, observational studies, notably the famous Framingham Heart Study, provided the framework for clinical practice guidelines in prevention and treatment of cardiovascular disease. In 2013, the American College of Cardiology and the American Heart Association issued updated clinical practice guidelines on the treatment of cholesterol to reduce heart disease risk in adults (the "Cholesterol Guidelines").[138] These authoritative guidelines have been widely used in clinical practice but are based not only on RCTs but on a great deal of observational evidence, including studies technically ranked as "low quality."[139] Concretely, many of the original treatment recommendations regarding statins are based on observational studies, not RCTs.[140] The authors of the Cholesterol Guidelines, very much like the Endocrine Society authors, are quite careful to grade their evidence. But they do not rest their treatment guidelines on a mechanical assessment of technical quality. Instead, they (like the Endocrine Society) carefully explain why particular bodies of evidence should be given weight in clinical decisionmaking.

The cholesterol example shows that the June 2 Report rests on a fundamental misunderstanding of medical research and clinical practice. If the Florida Medicaid program actually adopted the standard of evidence urged by the June 2 report, the program would not cover statins (drugs to

---

[136] Balshem et al., supra note 42, at 404 ("Well-conducted studies may be part of a body of evidence rated low quality because they only provide indirect or imprecise evidence for the question of interest.")
[137] RCTs have other limitations as well. For example, RCTs often have strict exclusionary criteria that recruit healthier and more homogenous study populations than observational studies. Thus, this can lead to results that are not easily generalizable in real-world settings.
[138] Neil J. Stone, et al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, 129(25) Circulation S1 -S45 (2014).
[139] Id., Tables 3 and 4.
[140] Syed S. Mahmood, et al., The Framingham Heart Study and the Epidemiology of Cardiovascular Disease: a Historical Perspective, 383 Lancet 999-1008 (2014).

lower cholesterol) for many patients, which are prescribed to 28% of adults over the age of 40 and are one of the most effective ways to prevent cardiovascular death.[141] Other common practices that would have to be reconsidered under this logic include: post-menopausal hormone replacement therapy (which reduces lifetime risk of heart attacks and stroke) and mammography screening for breast cancer.

The same point is true of the technically "low quality" evidence base for many surgical procedures, including minimally invasive gall bladder surgery, which have long since had a foundational grounding in observational studies. We think it unlikely that Florida's Medicaid program will begin to refuse to pay for statins, mammograms, and routine surgeries. If not, then the June 2 Report reflects an untenable and discriminatory double standard.

Thus, the June 2 Report not only relies on the biased and methodologically flawed evidence in the BPW document, as documented in Section II above; it also misuses scientific terminology in an effort to mislead readers and to support the unwarranted conclusion that medical treatment for gender dysphoria is "experimental."

> B. The June 2 Report disregards robust clinical research studies and instead relies on letters to the editor and opinion pieces. The report's analysis fails to satisfy Florida's own regulatory standards for Medicaid coverage decisions and does not undermine the scientific research that supports medical treatment for gender dysphoria.

The June 2 Report repeatedly cites sources with little or no scientific credibility – including journalism, a student blog, a website, and letters to the editor – rather than peer-reviewed empirical research.[142] At the same time, the report makes baseless or exaggerated criticisms of solid studies. The report's objections to these studies incorporate mistakes about basic statistics and often misrepresent the aims and findings of studies. Here, we offer several examples, but the problem of selective and ungrounded criticism permeates the June 2 Report and further undermines its scientific credibility.

---

[141] Joseph A. Salami et al., National Trends in Statin Use and Expenditures in the U.S. Adult Population From 2002 to 2013, 2(1) JAMA Cardiology 56-65 (2017).

[142] Sources from journalism include Jon Brown, Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida, Fox News, May 8, 2022, at 8 https://www.foxnews.com/politics/textbook-strips-gender-dysphoria-definition-cited-florida [visited July 3, 2022; Lawrence S. Mayer and Paul McHugh, Sexuality and Gender: Finding from the Biological, Psychological, and Social Science, The New Atlantis (Fall 2016), https://www.thenewatlantis.com/wp-content/uploads/legacy-pdfs/20160819_TNA50SexualityandGender.pdf[visited July 3, 2022]. The citation to the student blog is Hong Phuong Nhi Le, Eminence-Based Medicine vs. Evidence-Based Medicine, Students 4 Best Evidence [blog], https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine [visited July 3, 2022]. The website is SEGM.org, which we discuss in the text in SectionII.B and Section III.A. Citations to letters and opinion pieces include, inter alia, Andre van Mol, et al.,Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765-766 (2020); Michael Laidlaw, et al., The Right to Best Care for ChildrenDoes Not Include the Right to Medical Transition, 19(2) Am. J. Bioethics 75 -77 (2019); Michael Laidlaw, et al., Letter to the Editor: "Endocrine Treatment of Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Prace Guideline," 104(3) J. C linical Endocrinology and Metabolism 686-687 (2018); Andre van Mol, et al., Gender-Affirmation Surgery Conclusion Lacks Evidence, 177(8) Am. J. Psychiatry 765 -766 (2020).

For example, the June 2 report attacks a 2015 study by Costa et al., claiming that the study design is flawed because it did not include a control group of adolescents without gender dysphoria.[143] This point is simply incorrect. The Costa study was designed to measure the impact of puberty blockers on gender dysphoria. To do so, the authors validly compared outcomes in teens with dysphoria who received treatment with blockers and those who did not. They were able to do this ethically because the control group of teens (who received psychotherapy but not puberty blockers) were not yet eligible for blockers or were eligible but chose to delay or forgo blockers. The study found that puberty suppression was associated with improvements in psychosocial functioning.

The Costa study is, despite the June 2 Report's claims, a solid methodology. In the context of this study, adding a third "control group" of teens without gender dysphoria would serve no scientific purpose. Further, the June 2 Report also criticizes Costa for "rel[ying] heavily on self-assessments."[144] But this is a wildly off-base criticism. Costa et al. measure psychosocial functioning using a widely-used and accepted instrument, the Children's Global Assessment Scale. Psychological research typically relies on such assessments, which are carefully constructed and psychometrically validated. This is one example of the June 2 Report's poor understanding of research in psychology and medicine.

In addition to these glaring errors, the June 2 Report's criticism of Costa makes an even more fundamental error: the June 2 report levels baseless criticisms at a single study *and fails to acknowledge that the weight of the literature as a whole strongly supports the same results that Costa et al. report*. Scientific knowledge is, importantly, cumulative. It is thus entirely misleading – and unscientific – to dismiss the effectiveness of puberty blockers by criticizing studies in isolation. Put simply, the June 2 Report fails to acknowledge the number of solid studies that all find that puberty blockers are effective.[145] Indeed, at least 16 studies show that puberty blockers and hormones benefit patients with gender dysphoria, and the benefits have been documented across study designs, including retrospective report, cross sectional, longitudinal, and qualitative studies.[146]

To take another example, the June 2 Report grossly misleads the reader in its discussion of a study by Chen et al. in 2020.[147] The report cherry-picks quotes from Chen et al. to the effect

---

[143] June 2 Report, p. 15 ("Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control"). The Costa study is Rosalia Costa et al., Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria, 12 (11) J. Sexual Medicine P2206-2214 (2015) (hereinafter, "Costa et al. (2015)").
[144] Id.
[145] See Luke R. Allen, et al., Well-Being and Suicidality Among Transgender Youth after Gender -Affirming Hormones, 7(3) Clinical Practice in Pediatric Psychology 302 -11 (2019); Amy E. Green, et al., Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth, 70(4) J. Adolescent Health 643-649 (2022); Jack L. Turban, et al., Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation, 145(2) Pediatrics e20191725 (2020); Maureen D. Connolly, et al., The Mental Health of Transgender Youth: Advances in Understanding, 59(5) J. Adolescent Health 489-95 (2016); Gemma L. Witcomb et al., Levels of Depression in Transgender People and its Predictors: Results of a Large Matched Control Study with Transgender People Accessing Clinical Services, J. Affective Disorders (2018).
[146] For citations, see Boulware et al., supra note 27, at n. 43.
[147] Diane Chen, et al., Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Puberty Suppression in Transgender Youth, Transgender Health 246-257 (2020).

that "the effects of pubertal suppression warrant further study" and the "full consequences of suppressing endogenous puberty are not yet understood."[148]

These criticisms are misapplied, because the Chen article is not a substantive study of the effects of puberty blockers. It is, instead, a consensus parameter, which is an article that uses a structured methodology to consult experts to develop a research agenda for future studies. It is expected that the Chen piece would focus on what is not yet known, or what is not completely known, because it is attempting to identify research topics and approaches. Notably, and contrary to the June 2 Report's claims, Chen et al. recognize that existing evidence suggests that puberty blockers improve mental health functioning.

More generally, the June 2 Report's misleading characterization of Chen et al. reflects a basic lack of knowledge about scientific research. All research is flawed, including all RCTs: there simply is no perfect study in any area of medicine. The task of the scientist is to be rigorous in assessing what we know and to work to improve knowledge, incrementally, by conducting additional studies that build on earlier work. Thus, it is commonplace for authors to conclude medical research studies by calling for further research. Chen et al's statements are not indictments of puberty blockers – they are conventional acknowledgments of the value of further study that drives scientific inquiry and innovation.

The June 2 Report also contains a misleading account of the study by DeSanctis et al. The DeSanctis article reviews the literature on the use of puberty blockers (GnRHa's) for children diagnosed with central precocious puberty. De Sanctis finds that blockers are generally "safe and well-tolerated in children and adolescents" and that most drug reactions were mild.[149] The June 2 Report misleadingly and without foundation cites the De Sanctis piece as "[raising] questions about whether off-label use to treat a psychological condition [gender dysphoria] is worth the risks."[150] This attribution is bizarre, because De Sanctis et al. actually *support* the use of puberty blockers (by finding them safe and with only rare side effects) and do not offer any evidence at all to suggest that the risks are higher in the treatment of gender dysphoria.

As a final example, the June 2 Report criticizes a 2019 preliminary study by Kuper et al. without acknowledging the existence of a 2020 study by Kuper et al.[151] The earlier study presented data on the mental health of adolescents when initially presenting for care; only the later study presented full data that demonstrated the benefit of treatment.

C. The June 2 Report mistakenly claims that puberty blockers and hormones are experimental because they are used "off-label" and not approved by the FDA. In fact,

---

[148] June 2 Report, p. 15.
[149] Vincenzo De Sanctis, et al., Long-Term Effects and Significant Adverse Drug Reactions (ADRs)Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: a Brief Review of Literature, 90(3) Acta Biomed. 345-359 (2019).
[150] June 2 Report, p. 16.
[151] June 2 Report, p. 16. The earlier Kuper et al. study is Laura E. Kuper et al., Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy, 40(8) J. Dev. Behav. Pediatr. 589-596 (2019). The later study is Laura E. Kuper et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) Pediatrics e20193006 (2020).

> off-label use, when supported by scientific evidence, as is the case here, is extremely common in medical practice and especially in pediatrics.

The June 2 Report repeatedly notes that the FDA has not approved the use of puberty blockers and hormones for the treatment of gender dysphoria in minors.[152] The report infers that lack of FDA approval renders a treatment unauthorized and experimental, but this is false.

Once again, the June 2 Report is (mis)using technical language in a way that is likely confusing to non-experts. The term "off-label" has a very specific meaning: a drug is off-label if the FDA has not specifically approved a particular medication for a particular use in a specific population. The off-label use of medications for children is quite common and often necessary, because an "overwhelming number of drugs" have no FDA-approved instructions for use in pediatric patients.[153]

The lack of FDA approval does not imply that the use of medications should be restricted. There is a consensus in the medical community that off-label use reflects a product of burdensome and expensive regulatory processes. Pharmaceutical companies often lack financial incentives to support research required for FDA approval for specific use in children.[154]

The American Academy of Pediatrics, recognizing these facts, specifically authorizes the off-label use of drugs:

> The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, *the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use.* Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient.[155]

Off-label use is so common in pediatrics that off-label drugs are prescribed in 20% of patient visits.[156] Combined hormonal contraceptives or progesterone-only contraceptive methods, which are approved on-label for contraception, are also used off-label to treat heavy menstrual bleeding, which could be due to a bleeding disorder, a delay in normal pubertal maturity or variety of other conditions; they are also used off-label for premenstrual dysphoria disorder and polycystic ovarian syndrome.

---

[152] June 2 Report, pp. 8, 14, 15, 19.
[153] Boulware et al, supra note 27, quoting Kathleen A. Neville, et al., American Academy of Pediatrics Committee on Drugs, Off-label use of drugs in children, 133(3) Pediatrics 563-7 (2014) ("AAP Committee on Drugs")
[154] AAP Committee on Drugs (2014), supra note 66.
[155] Id. (emphasis added). See also Lenneke Schrier, et al., Off-label Use of Medicines in Neonates, Infants, Children, and Adolescents: a Joint Policy Statement by the European Academy of Paediatrics and the EuropeanSociety for Developmental Perinatal and Pediatric Pharmacology , 179(5) Eur. J. Pediatr 839-845 (2020).
[156] Diya Hoon, et al., Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015, 144(4) Pediatrics 1-10 (2019) (emphasis added).

A host of familiar examples provide illustrations of day-to-day, off-label use in pediatrics.[157] The use of steroids for croup is a life-saving treatment that is off-label. The medication helps toddlers get through severe, potentially airway-obstructing illnesses safely. Ondansetron (Zofran) is used off-label for nausea and vomiting to prevent fluid loss, as children are particularly vulnerable to severe dehydration.

Off-label use is also common in pediatric compassionate care, and frequently the on-label use is very different from the off-label use. Gabapentin, for example, is used on-label for the treatment of seizures but used off-label for neuropathic or mixed pain. Ketamine and fentanyl are used on-label in anesthesia but off-label for pain relief, for example, to manage chronic pain in palliative care and in patients with cancer.

In neonatal medicine, off-label medications are routinely used to treat the smallest and most fragile babies. Caffeine is used off-label to treat apnea (i.e., idiopathic respiratory arrest) of prematurity and phenobarbital is used off-label to treat neonatal seizures. More routinely, in general pediatric care, pantoprazole is a proton pump inhibitor (PPI) used to treat acid reflux. It is used off-label in neonates with gastroesophageal reflux disease who do not respond to traditional first-line treatments. It is used successfully to help infants gain adequate weight in the first four to six months of life if they do not respond to using different types of bottles, slow flow nipples, or more frequent and lower volume feedings.

In addiction medicine, routine medications like supplemental nicotine patches are off-label; they are not approved for use in those younger than 18 but are used successfully in vaping/smoking cessation, so much so that the AAP has issued guidelines on how to use and dose them. Buproprion is used on-label as an antidepressant and off-label for smoking cessation. Buprenorphine (suboxone) is used on-label in those 16 or older with opioid use disorder but used off-label in those who are younger; this medication prevents overdose death and allows those struggling with addiction to safely recover.

In psychiatry, some of the most commonly-prescribed medications for youth are off label. For example, selective serotonin reuptake inhibitors (SSRIs) are used to treat major depressive disorder and generalized anxiety in adolescents and have been shown to be effective, even though several of these ncluding sertraline and escitalopram) are off-label.[158] Other common examples include clonidine, which is FDA-approved for attention deficit hyperactivity disorder (ADHD) but is also used off-label for anxiety, insomnia, and post-traumatic stress disorder (PTSD).[159]

Finally, the June 2 Report also notes that testosterone is a controlled substance and is subject to risk of abuse, but, once again, this is misleading. The inclusion of testosterone on the schedule of controlled substances reflects the misuse of the drug by some individuals and

---

[157] These examples are drawn from the list of off-label uses in AAP Committee on Drugs (2014) and reflect our clinical experience in major hospitals and clinics.
[158] For AACAP guidelines, see Boris Birmaher and David Brent, Practice Parameter for the Assessment and treatment of Children and Adolescents with Depressive Disorders, 46(110 J. Am. Acad. Child and Adolescent Psychiatry P1503-1526 (2007).
[159] Rama Yasaei and abdolreza Saadabadi, Clonidine, National L ibrary of Medicine (2022), at https://www.ncbi.nlm.nih.gov/books/NBK459124/[visited July 4, 2022].

communities (e.g., weight lifters and athletes who may use the drug to build muscle). The classification does not in any way imply that physicians should not dispense the drug if medically necessary. No special license is necessary for prescribing the medication, which is routinely prescribed to cisgender men with testosterone deficiency as well as to transgender men.

D. The June 2 Report falsely claims that medical care for gender dysphoria is provided to a large percentage of children who will come to regret their treatment. In fact, patients with gender dysphoria have vanishingly low rates of regret regarding their medical treatment.

The June 2 Report attempts to cast doubt on medical treatment for gender dysphoria by repeating the debunked claim that most transgender teens ultimately reject their transgender identity. Below, we analyze two related claims made in the report and show why both are refuted by sound evidence.

First, the report claims that "the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex."[160] This is false. We have refuted this claim in detail in prior work (addressing similar claims made to support medical treatment bans in Texas and Alabama). The key point is that *adolescents with gender dysphoria rarely find that their dysphoria resolves without treatment.*[161] Because medical treatment for gender dysphoria begins only in adolescence, and only if medically necessary for gender dysphoria, medical treatment is thus provided only to a group known to be quite stable in their gender identity.

The authoritative WPATH and Endocrine Society clinical practice guidelines contain measures to ensure that medical treatment is administered only when medically necessary.[162] As part of the process of diagnosis and treatment, clinicians take care to explain to the youth and their parents the risks and the benefits of medical treatment as well as the risks and benefits of no medical interventions.

Second, the June 2 report claims, without citation, that "roughly 8% [of transgender people] decide to return to their natal sex" for reasons ranging "from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria.[163] The 8% figure is not large, but it is nevertheless an overstatement of the percentages found in the scientific literature: solid studies show very low percentages of regret (typically under 1%) among transgender people who receive medical treatment for gender dysphoria.

The June 2 report offers as general evidence for its claims about regret only a 2021 study by Littman.[164] But the Littman study cannot establish how prevalent it is for transgender individuals to reject their transgender identity. Indeed, the Littman study does not even purport

---

[160] June 2 Report, p. 14.
[161] Boulware et al., supra note 27, at 17-19.
[162] WPATH (2012) and Endocrine Society (2017), supra note 5.
[163] Id.
[164] Lisa Littman, Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners, 50 Archives of Sexual Behavior 3353-3369 (2021).

to show the percentage of transgender people who "detransition." Instead, it simply asked 100 people who self-identified as "detransitioners" about their reasons. Using Littman's study as evidence of widespread regret is akin to saying that giant pandas (an endangered species) are common because, if we search, we can find 100 of them.

Furthermore, the Littman study used a biased sampling and survey methodology: survey was anonymous; its participants were solicited from (among other venues) anti-transgender social media groups.

Finally, the June 2 Report makes a flagrant error in conflating "detransition" with "regret."[165] In addition, the Littman study is unscientific in describing a likely very diverse group of people as "detransitioners." She defines detransition as "discontinuing medications, having surgery to reverse the effects of transition, or both." Littman's definition is highly misleading, because transgender people may have many reasons to discontinue medication. One might continue to live socially in a gender role that is not the one assigned at birth and yet, by Littman's criteria, be counted as a "detransitioner." In our clinical practice, we have seen youth who discontinued hormone therapy because the effects had addressed their dysphoria; these patients were nonbinary, but Littman's method would mistakenly count them as "detransitioners."

By contrast, the June 2 report disregards a very large and far more nuanced and important 2021 study by Turban et al., which shows that transgender people who do return to live as the sex assigned at birth may not permanently do so and are, by their own report, influenced largely by "external factors, such as pressure from family, nonaffirming school environments, and sexual assault."[166] The study found that only a minority of survey participants "reported that detransition was due to internal factors, including psychological reasons, uncertainty about gender identity, and fluctuations in gender identity." Indeed, as the authors note, these psychological experiences "*did not necessarily reflect regret* regarding past gender affirmation, and were presumably temporary, as all of these respondents subsequently identified as transgender/gender diverse, an eligibility requirement for study participation."[167]

The June 2 Report also ignores a recent study, Olson et al. (2022), who find that after an average of 5 years of social transition, only 2.5% of youth identified as cisgender.[168]

Studies that actually focus on regret consistently find that transgender people only rarely regret their medical treatments.[169] For example, Bustos et al. (2021) found regret expressed by one

---

[165] See generally Jack L. Turban, et al., Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis, 8(4) LGBT Health 273-280 (2021) (noting that "the term 'detransition' has at times been conflated with regret, particularly with regard to medical and surgical affirmation").
[166] Id.
[167] Id.
[168] Kristina R. Olson, et al., Gender Identity Five Years After Social Transition, Pediatrics (preprint, May 2022) .
[169] Valeria P. Bustos, et al., Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence, 9(3) Plastic and Reconstructive Surgery- Global Open e3477 (2021); Sara Danker, et al., Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries, 6(9 Supp.) Plastic and Reconstructive Surgery 189 (2018); Chantal M. Wiepjes, et al., The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets, 15(4) J. Sex Med.582-590 (2018); see also Yolanda L.S. Smith, et al., Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals, 35(1) Psychological Medicine 89-99 (2005).

percent or fewer of transgender patients who underwent gender-affirming surgery, and Danker et al. (2018) report a rate of far less than 1%, as do Wiepjes et al. (2015).[170]

> E. The June 2 Report repeats discredited claims that "social contagion" is leading teens to become transgender. The issue, although sensationalized in the June 2 Report, is ultimately irrelevant to medical treatment, which is provided only after a multidisciplinary assessment and after a finding that gender dysphoria is persistent and medical treatment is warranted.

The June 2 Report claims that "social factors (e.g., peer influences and media) may be contributing factors to gender dysphoria,"[171] citing as evidence a single, discredited study by Littman. We have addressed this study at length in other work and note that

> WPATH, among other authorities, has taken a skeptical view of Littman's claim, and the study has been criticized for serious methodological errors, including the use of parent reports instead of clinical data and the recruitment of its sample of parents from anti-transgender websites. The journal of publication required an extensive correction of the original Littman article because of its misstatements. Such a correction in reputable, peer-reviewed academic journals is taken only when a panel of experts, in retrospect, came to recognize the methodological flaws of the original study and concluded that it would be unscientific to allow the originally published findings to stand."[172]

Littman's sensationalist hypothesis has been widely covered in the press, but no clinical studies have found that rapid-onset gender dysphoria exists. Further, no professional organization has recognized "rapid-onset gender dysphoria" as a distinct clinical condition or diagnosis.

Most recently, an April 2022 study of 173 youth presenting at Canadian gender clinics *found no evidence of rapid-onset dysphoria or social contagion.* The researchers posited that if "rapid onset" gender dysphoria were a real phenomenon, then teens who had more recently begun identifying as transgender would (per the Littman hypothesis) also be more likely to report online support and engagement in their gender identity. They might also (per Littman's hypothesis) be more likely to struggle with mental health concerns.

An April 2022 study of 173 youth found no such correlations, strongly undercutting the "rapid-onset" hypothesis endorsed by the June 2 report. The researchers controlled for age and sex assigned at birth and looked for correlations with recent gender knowledge (defined as less than one to two years having passed since "you realized your gender was different from what other people called you"). Recent gender knowledge was *not* significantly associated with depressive symptoms, psychological distress, past diagnoses with mental health issues or neurodevelopmental disorders, or self-harm. Nor was it associated with having gender-supportive online friends, general support from online friends or transgender friends, or gender support from parents.[173]

---

[170] Id.
[171] June 2 Report, p. 12.
[172] Boulware et al., supra note 27, at 20-21 (internal citations omitted).
[173] Greta R. Bauer, et al., 243 J. Pediatrics 224 -227 (2022).

Data do substantiate that younger people today are more likely to identify as transgender than are older people, but this does not substantiate the idea of social contagion. The increase may be due to the increasing social acceptance of gender diversity (i.e., older people grew up in a more transphobic social environment). In fact, adolescent presentation of transgender identity is often observed and should not be pathologized. In the largest U.S. sample of transgender adults, over half reported first starting to realize that they were transgender in adolescence (57% ages 11-20) and roughly half (47%) started to disclose their identity during this time frame.[174]

Further, the data do not show a massive wave of transgender identity even among teens. A 2022 study by the Williams Institute found that, using an expansive definition of "transgender," about 0.5% of adults now identify as transgender, while 1.4% of youth aged 13-17 do, or about 300,000 young people.[175] This is not a large percentage or a large absolute number.

Underlying the June 2 Report's claim about social contagion is a set of imagined stereotypes – that teenagers do not known their own gender identity and readily change their gender identity based on peer influence and social media. But these stereotypes contradict the scientific understanding of gender identity formation. Studies of so-called "conversion" or "reparative" therapy, for example, finds that transgender identity is highly resistant to change even in the face of concerted efforts by medical authorities versed in psychological methods. Studies find that conversion therapy is ineffective in altering gender identity and is psychologically damaging.[176]

> F. The June 2 Report claims that inappropriate medical care is provided to adolescents with gender dysphoria who also have anxiety, depression, and other mental health conditions. These assertions are unsupported by scientific evidence and disregard evidence-based clinical practice guidelines that provide sound guidance for treating complex cases.

The June 2 Report speculates that because "a high proportion" of youth receiving medical care for gender dysphoria also have a behavioral health disorder, "available research raises questions as to whether the [individuals'] distress is secondary to pre-existing behavioral health disorders and not gender dysphoria."[177] In simpler terms, *the June 2 Report speculates that perhaps gender dysphoria is not real but is, rather, an imagined by-product of underlying mental illness.* A close examination shows that this claim has no foundation in science; it rests on unexamined and harmful stereotypes and unaccountably dismisses the scientific knowledge and clinical skill of child and adolescent psychologists and psychiatrists.

---

[174] Sandy E. James, et al., The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (2015).
[175] Jody L. Herman, et al., How Many Adults and Youth Identify as Transgender in the United States?, U.C.L.A. School of Law, Williams Institute (2022).
[176] A survey of the scientific literature by the U.S. Department of Health and Human Services finds that "no ne of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation." Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth, U.S. Department of Health and Human Services, HHS Publication No. (SMA) 15-4928 (2015), p. 1.
[177] June 2 Report, p. 6.

First, the June 2 Report implicitly posits a causal hypothesis that behavioral health disorders cause gender dysphoria. This hypothesis is entirely devoid of scientific evidence. Indeed, the scientific evidence strongly suggests that the direction of causation runs the other way. It is well-established that being transgender leads to mental health concerns because of the social stress and discrimination of being transgender in a society that is strongly oriented to cisgender identity and disapproving of transgender identity.[178] In our society, transgender individuals experience a great deal of discrimination, hostility, and physical violence. Quite simply, it is unsafe to be transgender in this current hostile climate.[179] Accumulation of existential fear and threatening experiences can manifest as physical and mental conditions. Thus, one would expect – and studies confirm – that transgender people, on average, have worse physical and mental health than cisgender people.

Although the effects of gender minority stress are well-known, the June 2 Report makes no mention of the literature. Instead, it indulges in speculation based, apparently, on the stereotyping of transgender people as confused and dysfunctional. The June 2 Report posits that individuals with mental health concerns cannot be trusted to understand their own gender identity. This is a highly prejudicial stance and one that disregards the key role of psychologists and psychiatrists, who have developed sensitive and effective approaches to treating adolescents with gender dysphoria and mental health concerns.[180]

Second, the co-occurrence of psychological distress among individuals with gender dysphoria provides no reason for denying care. Any population of individuals – cisgender or transgender – will include some with mental health concerns, and the WPATH and Endocrine Society guidelines recognize that there is a higher prevalence of anxiety, depression and post-traumatic stress disorder among transgender youth than among cisgender youth. In response, the guidelines set out practices that include a careful psychological assessment of each adolescent as part of the process for determining whether medical treatment for gender dysphoria is appropriate and likely to have benefits that outweigh risks.

The Endocrine Society guidelines specifically recommend that mental health professionals should be able to diagnose gender dysphoria and distinguish it from other "conditions that have similar features (*e.g.*, body dysmorphic disorder)." In addition, the mental health provider should be prepared to diagnose psychiatric conditions, provide or refer for treatment, and to "psychosocially assess the person's understanding, mental health, and social conditions that can

---

[178] Rylan J. Testa, et al., Development of the Gender Minority Stress and Resilience Measure, 2(1) Psychology of Sexual Orientation and Gender Diversity 65-77 (2015); Rylan J. Testa, et al., Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors, 126(1) J. Abnormal Psychology 125-36 (2017); Alexandrai M. Delozier, et al., Health Disparities in Transgender and Gender Expansive Adolescents: A Topical Review from a Minority Stress Framework, 45(8) J. Pediatric Psychology 842-847 (2020); Jessica Hunter, et al., Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People, 26(4) Clinical Child Psychology and Psychiatry 1182-1195 (2021).

[179] See, e.g., Rebecca L. Stotzer, Violence Against Transgender People: A Review of United States Data, 14(3) Aggression and Violent Behavior 170-179 (2009).

[180] See John F. Strang, et al., Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents, 47(1) J. Clinical Child & Adolescent Psychology 105-115 (2016).

impact gender-affirming hormone therapy."[181] In our clinical practice, we also ensure that youth and their caregivers have the information and support necessary to fully understand the risks, benefits, and outcomes of treatment. That is, we not only provide assessment but also fill in any gaps in understanding and support the decision-making process.

Our experience in clinical practice reflects these guidelines. Any consultation for medical treatment for gender dysphoria includes a mental health assessment. Further, the treatment plan for each adolescent is then individualized to reflect the risks and benefits of treatment and the risks and benefits of no treatment. Consistent with the WPATH guidelines, as clinicians, we ensure that the mental health concerns are not interfering with our ability to assess gender dysphoria and youth assent to treatment.

Third, the June 2 Report implicitly claims that any mental health disorder impairs a minor's ability to provide informed assent and, somehow, also invalidates the informed consent of their guardian. Experts in child and adolescent psychiatry, child psychology, and adolescent medicine have established that youth can make complex medical decisions. Further, the literature specifically demonstrates that transgender youth with co-occurring mental health conditions can competently participate in decision-making.[182] With guidance from mental health providers, parents, and physicians, teens can be part of a decision process that helps them explore their identity and make nuanced decisions about the benefits and risks of medical treatment.[183] Indeed, these processes of exploration and decision-making are central goals of, and central tasks for, trained mental health providers who work with teens.

> G. The June 2 Report speculates, without evidence, that psychotherapy alone is as effective as medical treatment for gender dysphoria. This claim contradicts the findings of solid scientific studies, which show that medical care is more effective than psychotherapy alone.

The June 2 Report argues, without scientific evidence, that youth with gender dysphoria should not be offered medical treatment but instead should only receive psychotherapy, an approach that it mistakenly terms "watchful waiting."[184]

---

[181] Endocrine Society (2017), supra note 5.
[182] Lieke J. Vrouenraets, et al., Assessing Medical Decision-Making Competence in Transgender Youth, 148(6) Pediatrics e2020049643 (2021).
[183] Beth A. Clark and Alice Virani, "This wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy, 18 J. Bioethical Inquiry 151-164(2021); Vrouenrats, et al., supra note 95; Megan S. O'Brien, Critical Issues for Psychiatric Medication Shared Decision Making with Youth and Families, 92(3) Families in Society 310-316 (2011); Mary Ann McCabe, Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations 21(4) J. Pediatric Psychology 505-516 (1996).
[184] For example, at p. 12, the June 2 Report asks, "[S]hould conventional behavioral health services be utilized without proposing treatments that pose irreversible effects [i.e., drug therapies]? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects {i.e., the watchful waiting approach)?" At p. 20, the June 2 Report misuses the term "watchful waiting" to describe the denial of medical care to adolescents with gender dysphoria, and the report miscites its own purported expert report. The Cantor document discusses "watchful waiting" meaning the denial of social transition to prepubertal children, not the denial of medical treatment to adolescents. Cantor document, p. 10-11.

The report offers no actual evidence for this denial of standard medical care. Its recommendation rests, instead, on an unfounded and mistaken criticism of the existing literature. The Cantor document, attached to the AHCA report as Appendix C, states that several studies "successfully identified evidence of [mental health] improvement [due to medical treatment for gender dysphoria], *but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.*"[185]

This statement is false. Medical treatment for gender dysphoria has been shown to lead to positive effects on mental health that are not associated with psychotherapy alone. Costa et al. in 2015 found that puberty blockers improve psychosocial functioning in teens with gender dysphoria, compared to teens who receive psychotherapy but not blockers.[186] Costa's study ewas designed to include a control group of teens with gender dysphoria who did not receive blockers.

In a 2022 study, Tordoff et al find that puberty blockers and hormone therapy are associated with significant improvements in depression and suicidality in a population of transgender and nonbinary youths aged 13 to 20.[187] The authors showed the independent effects of medications such as puberty blockers and hormones on depression, anxiety, and gender dysphoria. They controlled for temporal trends and other confounding factors, expressly including whether the teen received "ongoing mental health therapy other than for the purpose of a mental health assessment to receive a gender dysphoria diagnosis."[188] Put simply, Tordoff et al. clearly found that youth with gender dysphoria reported better outcomes if they received puberty blockers, even after controlling for the effects of psychotherapy.

Similarly, in a 2020 study, Laura Kuper et al. found that gender-affirming hormone therapy made a large improvement in adolescents' body-related distress and led to small to moderate improvement in symptoms of depression and anxiety.[189] Kuper et al. specifically collected data on psychotherapy and the use of psychiatric medications and expressly controlled for both. Thus, Kuper et al.'s study shows that hormone treatment for gender dysphoria is effective above and beyond the benefits of psychotherapy and psychiatric medications.

---

[185] Cantor document, p. 13.
[186] Costa et al., supra note 56.
[187] Diana M. Tordoff et al., Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care, 5(2) JAMA Network Open e220978 (2022).
[188] Id.
[189] Laura E. Kuper, et al., Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy, 145(4) Pediatrics e20193006 (2020).

TAB 183-28

From: FL-Rules@dos.state.fl.us
Sent: Thursday, July 7, 2022 1:43 PM EDT
To: Cole.Giering@ahca.myflorida.com
Subject: One-time User Comment From FLRules.com

FLRules.com one-time comment:

Name: Scott VanDeman
Email: svandeman@fcaap.org
Title: Comments from American Academy of Pediatrics and Florida Chapter, American Academy of Pediatrics
Comment: July 7, 2022

Tom Wallace
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive
Mail Stop #8
Tallahassee, FL 32308

Dear Director Wallace,

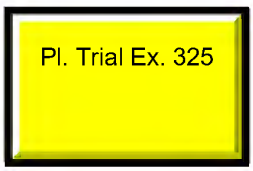
The American Academy of Pediatrics (AAP), a nonprofit organization representing 67,000 pediatricians dedicated to the health, safety and well-being of all children and the Florida Chapter of American Academy of Pediatrics, Inc (FCAAP), a nonprofit organization representing more than 2,600 pediatricians committed to serving all children across the state, thank you for the opportunity to provide comments on the Florida Agency for Health Care Administration's proposed rule to prohibit gender-affirming care in the state's Medicaid program.

We write to express our grave concerns with the proposed rule. Denying evidence-based, medically necessary standards of care to transgender adolescents constitutes a broad and sweeping discriminatory action by the State of Florida and its Medicaid program.

Gender-affirming care is the widely accepted standard of care for treating transgender adolescents with gender dysphoria. Gender-affirming care is endorsed and recommended by the American Academy of Pediatrics; the Florida Chapter of the American Academy of Pediatrics, Inc; the American Medical Association; the American College of Obstetricians and Gynecologists; the American College of Physicians; the American Psychiatric Association; the American Psychological Association; the American Academy of Family Physicians; the American Academy of Child and Adolescent Psychiatry; the Endocrine Society; the Society for Adolescent Health and Medicine; the Pediatric Endocrine Society; the World Professional Association for Transgender Health (WPATH); and many more members of the medical community.

Gender-Affirming Care is the Standard of Care
Gender-affirming care is developmentally appropriate care that seeks to understand and appreciate a child's or adolescent's gender identity and experience through a safe and nonjudgmental partnership that includes general pediatricians, pediatric specialists, mental health providers, children and adolescents and their families. While gender-affirming care is irrefutably the standard of care, it must, like all other areas of medicine, be individualized to meet the needs of each and every unique patient.

WPATH and the Endocrine Society have developed well-researched and evidence-based standards of care and clinical guidelines for the care of children and adolescents with gender dysphoria. WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7 and the Endocrine Society's Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (both are herein referenced as "standards of care") are in fact the gold standard, contrary to the State of



Florida's assertion, among the medical community for caring for children and adolescents with gender dysphoria.

For a model of care to be considered the standard of care for a specific diagnosis, the care must be "treatment that is accepted by medical experts as a proper treatment for a certain type of disease and that is widely used by healthcare professionals." The State of Florida's attempt to argue that gender-affirming care is not the standard of care, as referenced in its Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria report and its "Florida Fact-Checked" version of the HHS Office of Population Affairs Guidance on gender-affirming care, is entirely inconsistent with the well-recognized and established definition of standard of care, and represents a purposeful mischaracterization of available evidence as well as the position of the medical community.

Instead of supporting the standard of care for transgender adolescents, the state is seeking to rely only on "watchful waiting." This outdated model is based on long-refuted binary notions of gender and assumes without evidence that gender identity becomes fixed at a certain age and will result in direct harm to gender dysphoric children and adolescents who are denied access to well-evidenced multidisciplinary care. Notably, "watchful waiting" is based on studies with flawed methodology, validity concerns, and limited follow-up of transgender adolescents. Thus, "watchful waiting" is not recommended by any major medical association in the United States.

Gender Dysphoria
Gender dysphoria is a formal diagnosis under The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in which there is a pronounced incongruence between someone's gender identity or expression and sex assigned at birth. For the diagnosis, the patient must exhibit 2 of the following for at least 6 months:
? A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
? A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
? A strong desire for the primary and/or secondary sex characteristics of the other gender
? A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
? A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
? A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
In an apparent attempt to undermine the validity of the diagnosis of gender dysphoria, the state, under "Etiology of Gender Dysphoria," implies that mental and physical health conditions are the primary cause of gender dysphoria and that psychological support is all that is needed to provide care for gender dysphoric youth. However, the preponderance of the evidence indicates that gender dysphoria is indeed a primary diagnosis in which mental health issues are often exacerbated by lack of access to appropriate gender affirming care. The state disqualifies its own arguments by stating: "At the moment, none of these studies provides a definitive cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative." To be clear, there is no evidence that mental or physical health conditions cause gender dysphoria. As such, mischaracterizing the diagnosis in an effort to prohibit gender-affirming care is disingenuous at best and would result in direct harm to transgender children and adolescents.

Included in the state's document is the suggestion that mental health care should be the first line of care for youth diagnosed with gender dysphoria. On this, we agree. In fact, the evidence-based standards of care for gender-dysphoria, as referenced above, recommend mental health evaluation and care as the first step for affected children and adolescents. Indeed, research demonstrates that transgender children and adolescents experience stigma and discrimination, which adversely affects their mental health. Children and adolescents diagnosed with gender dysphoria often have to hide their gender identities to avoid bullying and harassment and face greater risks of homelessness, physical violence in the home and in the community, and substance use. However, the state conflates the association of mental health diagnoses, trauma, and attachment issues with causality for gender dysphoria in an effort to discredit the primary diagnosis. In reality, the mental health issues faced by those with gender dysphoria are often the direct result of a lack of access to care or not being supported in their gender identity.

In further attempting to undermine the well-established diagnosis of gender dysphoria, the state seeks to incorporate

the concept of "rapid onset gender dysphoria." The manuscript from which the term "rapid onset gender dysphoria" originates has been widely criticized. An expert review emphasized the following issues:

? "This study of parent observations and interpretations serves to develop the hypotheses that rapid-onset gender dysphoria is a phenomenon and that social influences, parent-child conflict, and maladaptive coping mechanisms may be contributing factors for some individuals. Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon. Additional research that includes AYAs, along with consensus among experts in the field, will be needed to determine if what is described here as rapid-onset gender dysphoria (ROGD) will become a formal diagnosis. Furthermore, the use of the term, rapid-onset gender dysphoria should be used cautiously by clinicians and parents to describe youth who appear to fall into this category. The term should not be used in a way to imply that it explains the experiences of all gender dysphoric youth nor should it be used to stigmatize vulnerable individuals."
? "…the study design of this research falls under descriptive research: as such, it did not assign an exposure, there were no comparison groups, and the study's output was hypothesis-generating rather than hypothesis-testing."

The Coalition for the Advancement & Application of Psychological Science, which includes the American Psychiatric Association, the American Psychological Association, the Society for a Science of Clinical Psychology, the Society of Clinical Child and Adolescent Psychology, the Society of Pediatric Psychology, and many more international, national, and state psychological and psychiatric associations, published a position statement on the concept of rapid onset gender dysphoria, stating:

? …it has not been subjected to rigorous peer-review processes that are standard for clinical science. Further, there is no evidence that ROGD aligns with the lived experiences of transgender children and adolescents.
? Research on gender identity development in children and adolescents continues to evolve and these advances will likely influence diagnosis and empirically-based standards of care, as well as the legislative landscape impacting trans people's access to care and legal protections. The available research is clear that transgender people are subjected to marginalization, stigmatization, and minority stress, which have significant detrimental effects on health and well-being. Terms, such as ROGD, that further stigmatize and limit access to gender-affirming and evidence-based care violate the principles upon which CAAPS was founded and public trust in clinical science.

Mental Health Care
Under the evidence-based standards of care, mental health care is indeed the first step in the care of children and adolescents diagnosed with gender dysphoria. The evidence-based standards of care recommend that a child or adolescent diagnosed with gender dysphoria be seen and evaluated by a qualified mental health professional trained in child and adolescent developmental psychopathology, competent in diagnosing and treating the ordinary problems of children and adolescents and meeting the same competency requirements as mental health professionals working with adults. Under the evidence-based standards of care, a qualified mental health professional has a responsibility to:

? Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).
? Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.
? Assess and treat any coexisting mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.
? Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.
? Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006 Grossman, D'Augelli, Howell, & Hubbard, 2006); Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

? Provide children, youth, and their families with information and referral for peer support such as support groups for parents of gender-nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

The evidence-based standards of care clearly recommend that mental health providers who care for children and adolescents with gender dysphoria diagnose and treat any other mental health conditions the child or adolescent is experiencing. Thus, the state's implication that mental health providers are not addressing existing mental health concerns prior to beginning gender-affirming medical care is wholly inaccurate. Prior to puberty, mental health professionals, pediatricians, and other health care providers "work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender" without medical interventions.

Medical Care

The state begins its literature review on gender dysphoria and puberty suppression by attempting to argue that a majority of children and adolescents will cease showing signs of gender dysphoria and conform to their sex assigned at birth. Herein lies a distinction between prepubertal children and adolescents that the state fails to consider, or outright ignores.

In its "Florida Fact-Checked" version of the HHS Gender Affirming Care document, the state notes that "most children identifying as transgender will detransition following the onset of puberty." Additionally, in the ACHA GAPMS report, the state makes a similar argument, including "neither organization explains that a majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that puberty suppression can have side effects." By definition, a child is defined as "a young person especially between infancy and puberty," while adolescence is defined as "the period of life when a child develops into an adult: the period from puberty to maturity terminating legally at the age of majority." The key difference between children and adolescents being the onset of puberty. By referencing "children" it is "Florida Fact- Checked" document and "young adolescents" in the ACHA GAPMS report, the state erroneously conflates the 2 terms. However, the definitions of these terms are different and cannot be used interchangeably.

Furthermore, the state relies on a study that "offers data on the percentage of children who opt not to transition after experiencing gender dysphoria." Similar claims made in other states that have attempted to ban gender-affirming care have been thoroughly debunked by a recent expert review from faculty from Yale University and the University of Texas Southwestern. The report from Yale examined in detail the misrepresentation of the Steensma et al study, explaining that:

? "...the Steensma study was not designed to (and the lead author has acknowledged) does not provide a basis for calculating what percentage of prepubertal children diagnosed with gender dysphoria persist with that diagnosis into adolescence. Rather, the Steensma study was designed only to study the characteristics of those who persisted.60 Among other limitations, in Steensma (2013), former patients who opted to not participate in the study (either refused to participate or did not respond to an offer to participate) were categorized as "desisters," i.e., patients whose gender dysphoria resolved without transition or treatment. Patients can fail to respond to a study request for many reasons, including having moved away, receiving treatment elsewhere, or being uninterested in participating in a study. Thus, SEGM misuses the Steensma data by counting nonresponding patients as having "desisted" in experiencing gender dysphoria.61 Indeed, in published correspondence, Steensma emphasizes that the 2013 study should not be used to calculate the percentages of "persisters" and "desisters."62 The misrepresentation of Steensma on the SEGM website constitutes a major violation of the scientific method and the accepted conventions of research."

Some prepubertal children's diagnosis of gender dysphoria will indeed not continue in adolescence, and as such, there are no recommended medical interventions for prepubertal children. For prepubertal children, gender exploration is a natural part of child development. However, for children diagnosed with gender dysphoria persisting at the onset of puberty (adolescence), research demonstrates that gender dysphoria will continue. ; Under gender-affirming care, adolescents diagnosed with gender dysphoria, after careful and exhaustive mental health evaluation and care , may progress to gender-affirming medical care under the evidence-based standards of care.

Pubertal Blockers

Under the evidence-based standards of care, gender-affirming medical care is a highly individualized model of care. Prior to beginning gonadotrophin-releasing hormone agonists (GnRH, herein referred to as puberty blockers) as a component of a multidisciplinary approach to caring for adolescents diagnosed with gender dysphoria, adolescents must meet stringent criteria under the evidence-based standards of care from WPATH, including:

? The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
? Gender dysphoria emerged or worsened with the onset of puberty;
? Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment.
? The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment."

The Endocrine Society lays out additional criteria that must be met prior to undergoing puberty blockers as a component of gender-affirming medical care:

? (the adolescent) has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
? (the adolescent) has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
? And a pediatric endocrinologist or other clinician experienced in pubertal assessment
o agrees with the indication for GnRH agonist treatment,
o has confirmed that puberty has started in the adolescent (Tanner stage =G2/B2),
o has confirmed that there are no medical contraindications to GnRH agonist treatment.

In the ACHA GAPMS report and the "Florida Fact- Checked" document, the state asserts that there is no credible evidence demonstrating puberty blockers benefit adolescents diagnosed with gender dysphoria. However, the state either unknowingly or willingly ignores the body of evidence that supports this practice. Medication to suppress puberty has been used to treat precocious puberty for decades. The identical therapeutics are also used in adolescents diagnosed with gender-dysphoria and perhaps more importantly represent a very reasonable balance of risk and benefit when considering the totality of the available data and clinical experience. The pubertal blocker phase of gender-affirming care importantly allows the patient to delay the development of secondary sex characteristics. By pausing the progression of secondary sex characteristics, adolescents are provided time to explore their gender identity, access and/or continue mental health support, and assess and define their treatment goals, in conjunction with their families.

Contrary to the state's assertion that the evidence supporting use of puberty blockers is "weak," a large body of evidence supports their use in adolescents diagnosed with gender dysphoria. For example, recent research examined 272 adolescents who were referred to a gender clinic, but had not yet began undergoing gender-affirming medical care, including puberty blockers, and 178 adolescents who had already began receiving gender-affirming care using puberty blockers with 651 cisgender adolescents. The researchers found that adolescents with gender dysphoria had worse psychological health compared with their cisgender adolescent peers and that after receiving puberty blockers as part of gender-affirming care, the adolescents with gender dysphoria had similar or better psychological health than their cisgender peers. Another recent study found that transgender adults who wanted and were able to access puberty blockers as adolescents were less likely to have lifetime suicidal ideation compared to transgender adults who were not able to access puberty suppression medication as adolescents. In a 2-year follow-up study, researchers found that the use of puberty blockers led to improvements in overall functioning and decreased instances of depression.

The state further asserts that "puberty suppression causes side effects, some of which have the potential to be permanent." However, experts point out that "recent studies suggest that puberty-blocking medication has

negligible or small effects on bone development in adolescents, and any negative effects are temporary and reversible. The most recent studies show that puberty-blocking drug therapy either has no effect on bone mineral density (BMD), a proxy measure of bone strength, or is associated with a very small decrease." Overall, the studies that have examined the use of puberty blockers, as a component of gender-affirming care, demonstrate that the use of these medications is evidence-based and provides for an appropriate risk/benefit ratio for adolescents diagnosed with gender dysphoria.

In addition, the state fixates on the argument that puberty blockers are used off-label, not approved by the Federal Drug Administration (FDA), and that no randomized clinical trials (RCT) have been completed on the use of puberty blockers to treat gender dysphoria. These arguments lack any basis. First, in pediatric medicine, "the purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. As such, the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient." The use of off-label medication in pediatric medicine is supported by clinical evidence and data. In suggesting that puberty blockers cannot be used to treat gender dysphoria simply because they have not been approved by the FDA for such purposes, the state fails to understand the relationship between the FDA and the practice of medicine:

? Good medical practice and the best interests of the patient require that physicians use legally available drugs, biologics and devices according to their best knowledge and judgment. If physicians use a product for an indication not in the approved labeling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects. Use of a marketed product in this manner when the intent is the "practice of medicine" does not require the submission of an Investigational New Drug Application (IND), Investigational Device Exemption (IDE) or review by an Institutional Review Board (IRB). However, the institution at which the product will be used may, under its own authority, require IRB review or other institutional oversight.

The use of off-label medication in pediatric medicine is not experimental, nor does it constitute anything other than the practice of evidence-based medicine. Off-label medication use for pediatric patients is commonplace and there is no basis to prohibit puberty blockers because of their off-label use in pediatrics.

The state's argument that puberty blockers have not undergone RCTs and therefore should be disqualified for use treating adolescents diagnosed with gender dysphoria is also severely flawed. As explained by Armand H. Antommaria, MD, PhD, FAAP, HEC-C, Director of the Ethics Center, the Lee Ault Carter Chair of Pediatric Ethics, and an Attending Physician in the Division of Hospital Medicine at Cincinnati Children's Hospital Medical Center:

? …it may, at times, be unethical to conduct randomized trials. For randomized trials to be ethical, clinical equipoise must exist; there must be uncertainty about whether the efficacy of the intervention or the control is greater. Otherwise, it would be unethical to knowingly expose trial participants to an inferior intervention or control. Trials must also be feasible; it would also be unethical to expose individuals to the risks of trial participation without the benefit of the trial generating generalizable knowledge. A randomized trial that is unlikely to find enough people to participate because they believe they might be randomized to an inferior intervention would be unethical because it could not produce generalizable knowledge due to an inadequate sample size.

Furthermore, a group of leading bioethicists echo Dr Antommaria's explanation: "Randomized control trials also are only ethical when there is clinical "equipoise," which means they are only appropriate when there is genuine uncertainty about whether the intervention will be more effective than the control." There is no uncertainty about the use of puberty blockers to treat adolescents diagnosed with gender dysphoria -- the evidence fully supports this intervention as a component of gender-affirming care. Studies other than RCTs are, in fact, utilized regularly in the practice of medicine and are preferable in some instances.

Gender-Affirming Hormone Therapy
As a component of gender-affirming care, adolescents who have received extensive mental health care and puberty blockers may progress to hormone therapy. As with every component of gender-affirming care, the use of hormone therapy is a highly individualized decision, and any decisions are made in concert with the adolescent, their family, and mental health and medical care providers. Under the evidence-based standards of care for receiving hormone

therapy, the following criteria must be met:

? A qualified MHP (mental health professional) has confirmed:
o the persistence of gender dysphoria,
o any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
o the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
? And the adolescent:
o has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
o has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
? And a pediatric endocrinologist or other clinician experienced in pubertal induction:
o agrees with the indication for sex hormone treatment,
o has confirmed that there are no medical contraindications to sex hormone treatment.

The state remarks in its Fact-Checked document that it is "misleading" to state that hormone therapy is partially reversible. This is purposefully misleading. The evidence-based standards of care acknowledge that some forms of hormone therapy are reversible and that some are not reversible. Initiating hormone therapy is not a decision that is made lightly and there are stringent criteria that must be met, as referenced above. Furthermore, experts at Yale University explain that hormone therapy has a wide range of uses in adolescents:

? Estrogen and testosterone are often used off-label to treat adolescents with intersex conditions. Common hormonal medications used off-label include norethindrone, a progesterone analogue used off-label for the treatment of heavy menstrual bleeding in those with polycystic ovarian syndrome, bleeding disorder, and anovulatory bleeding of early puberty. It is also used to treat endometriosis, which is a painful inflammatory condition. Many forms of combined hormonal contraception, as well as a testosterone-blocking medication (spironolactone), are used off-label to treat acne. Other examples include clonidine, a blood pressure medication used off-label for the treatment of ADHD, migraine headaches, disorders of behavioral regulation, and insomnia; and propranolol, a blood pressure medication used off-label for the treatment of performance anxiety.

As referenced in the preceding paragraph, the off-label use of hormone therapy for adolescents diagnosed with gender dysphoria "does not imply an improper, illegal, contraindicated, or investigational use. Therapeutic decision-making must always rely on the best available evidence and the importance of the benefit for the individual patient." Decision-making to initiate this form of gender-affirming care takes place at the clinical level, using the evidence-based standards of care and the best available evidence. By attempting to argue that hormone therapy is somehow more dangerous to adolescents with gender dysphoria than to cisgender adolescents undergoing to same treatment for a different medical condition, the state makes it abundantly clear that this is not about the health and well-being of adolescents; it is rather a misguided attempt to discriminate against adolescents with gender dysphoria.

In the GAPMS report, the state cites a study by Dutra et al that "examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that the use of estrogen or testosterone can increase risks for cardiovascular disease." To use this as a basis for the state's argument to prohibit gender-affirming care for adolescents diagnosed with gender dysphoria would mean that the state would need to prohibit the use of hormone therapy in Florida's population at large. Additionally, in making this argument the state fails to consider the intent of hormone therapy -- to align one's body with one's gender identity. The experts at Yale University also clarify this misrepresentation or misunderstanding:

? The medical result is that transgender individuals move toward the typical medical profile of their identified gender. And so transgender women, like cisgender women, have lower risks of cardiovascular disease than

cisgender men.111 Transgender women, like cisgender women, have a slightly higher risk of venous thromboembolism than cisgender men. In fact, transgender women have a lower risk of venous thromboembolism than cisgender women, and the overall risk is extremely low (less than 1%) for all transgender individuals, both women and men.112 The risk of venous thromboembolism in transgender women and non-pregnant cisgender women is less than the risk in pregnancy, which is the highest estrogenic physiologic state known.

? It is also critical to note that the medical impact of gender-affirming treatment is generally the same in transgender people as in cisgender people who take the same hormone medications. For example, physicians commonly prescribe hormonal contraceptives containing ethinyl estradiol (a synthetic estrogen) to adolescents for reasons including birth control, management of irregular or painful menstrual periods, and acne. In other words, similar doses of exogenous sex hormones are commonly administered to cisgender individuals for a host of reasons and are well tolerated.

Research shows that hormone therapy, as a component of gender-affirming care, is beneficial to caring for adolescents diagnosed with gender dysphoria. A recent study in the Journal of Adolescent Health examined data from transgender or nonbinary adolescents and young adults between 13-24 and found that the provision of hormone therapy in those under 18 resulted in lower levels of depression and suicide attempts compared to adolescents who were unable to access hormone therapy. Another recent study demonstrated that the provision of puberty blockers and hormone therapy reduced depression and suicidality over the course of 1 year.

Additionally, the evidence cited in the evidence-based standards of care reinforces the sound basis for the provision of hormone therapy in adolescents diagnosed with gender dysphoria. Under the evidence-based standards of care, there are specific criteria for gender-affirming surgical interventions. The state's focus on gender-affirming surgery and its attempt to classify it as common is a blatant misrepresentation intended to politicize the issue and cast doubt on the evidence-based standards of care.

Risks

Unlike the state's assertion on its "Florida Fact-Checked" document that "no reliable evidence shows that gender dysphoria significantly increases the risk of suicide," there is in fact evidence to support this. In a study of more than 1,000 transgender adolescents, transgender adolescents had higher odds of all suicide outcomes compared to cisgender adolescents, and were at greater risk for suicidal ideations and attempts compared to their cisgender peers. Additionally, in the first large scale (N = 120,670) study examining the relationship between transgender adolescents and suicide, the authors found that between 30-51% of transgender adolescents reported engaging in suicidal behavior, compared to between 10-18% of their cisgender peers.

As noted in the earlier section on mental health, adolescents with gender dysphoria face increased bullying, discrimination, harassment, and a lack of social acceptance. To add to these daily, ongoing issues, adolescents with gender dysphoria are at greater risk for suicide and other mental health conditions. Curiously, the State of Florida appears to agree that transgender adolescents (and other LGBTQ adolescents) face more serious mental health concerns than their cisgender peers, as it maintains a web site, Youth Suicide Prevention under the FL Department of Health, explaining the protective factors and risks associated with suicide in adolescents (the state refers to this population as teens). In identifying these protective factors and risks associated with suicide in adolescents, the state readily admits that "It is important to know that some youths experience an increased amount of risk. Youths are those who identify as LGBTQ, American Indian/Alaska Native, youth in the child welfare and juvenile justice systems or military service members can have higher incidence of suicidal behavior." The state cannot have it both ways; it cannot argue that gender dysphoria doesn't increase the risk of suicide, as noted it its "Florida Fact-Checked" document (ignoring the evidence that patently refutes this argument), and then readily acknowledge via its youth suicide prevention web site that transgender adolescents are at increased risk of suicide.

As referenced in an earlier section of this comment letter, access to and the provision of puberty blockers and hormone therapy as part of gender-affirming care works and is the gold standard according to the medical community to alleviate mental health conditions and risks associated with gender dysphoria in adolescents.

Medicaid is a Critical Source of Health Care for Children, including Transgender Adolescents

Medicaid is a vital source of health insurance for children (for data reporting purposes below, the term "children" is inclusive of "adolescents") in Florida and across the United States. Nationally, children make up the single largest group of enrollees in Medicaid and the Children's Health Insurance Program (CHIP); more than 40 million—or 53%

of all US children—rely on Medicaid and CHIP coverage, including with special health care needs and those from low-income families. In Florida, over 2.8 million children were enrolled in Medicaid or CHIP as of February 2022. Medicaid also provides comprehensive prenatal care, enabling millions of healthy pregnancies and births, thereby helping millions of children obtain a healthy start. In states that have expanded Medicaid coverage to low-income adults, this coverage not only provides many documented benefits to those adults, but also has added benefits for children and adolescents, including an increased likelihood that they are covered, improved access to needed care, improved financial security for the family, higher preventive care use, and other benefits. ;

The direct benefits of Medicaid coverage for children and adolescents are many. In addition to improved access to care and health outcomes, those with Medicaid coverage miss less school, do better in school, are more likely to graduate and attend college, become healthier adults, earn higher wages, and pay more in taxes. Together with CHIP, Medicaid has been instrumental in driving down the rate of uninsurance among children, which stands at 5.7% nationally and 7.6% in Florida (2019).
Medicaid is not a benefit exclusive to cisgendered individuals. Indeed, Medicaid is of vital importance to transgender individuals, as it is estimated that almost 1/3 of all transgender persons will fall below the poverty line, more than twice the rate of the general population. Both cisgender and transgender individuals enrolled in Medicaid rely on the program to cover their necessary medical care. However, the State of Florida, in promulgating this rule, is discriminating against Medicaid's transgender enrollees by seeking to arbitrarily ban a whole category of treatments which is exclusively utilized by transgender individuals.

Unlike many private health insurance plans, Medicaid guarantees that benefits for children are designed specifically for them. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provision of federal Medicaid law is a cornerstone Medicaid protection and the definitive gold standard of pediatric health care benefits. EPSDT guarantees that all Medicaid-eligible children are screened to assess and identify health issues early and ensures the provision of medically necessary health services to address those identified health conditions. EPSDT is designed to attend to a broad range of child health needs, including preventive care; physical and mental health; oral, hearing and vision care; habilitative care; and social and emotional development. EPSDT ensures that the medically necessary health care needs of the individual child determine what services and treatments Medicaid ultimately covers for that child. Such decisions of medical necessity are based on the expertise of the pediatrician or other treating clinician, who, through years of education, clinical training, and practice, takes into consideration the widely accepted evidence-based standards of care for the condition being treated.

This regulation as proposed would usurp this process of expert clinical decision-making made in the context of the physician-patient relationship; instead, it seeks to codify a discriminatory ban on widely accepted evidence-based standards of care for transgender adolescents and other individuals. As described in detail above, these standards of care are evidence-based and recommended by the medical community. Presented under the guise of an alternative care standard, this proposed prohibition on specific treatments for gender dysphoria not only ignores the prevailing consensus of numerous medical organizations, but also seeks to jettison the role of the treating clinician in determining medically necessary care for an individual. In every way, this proposed ban is a discriminatory gutting of the practice of medicine for transgender adolescents and other individuals, seeking to stifle the physician-patient relationship and replace it with the state's entirely ideological interest in ending gender affirming care in Florida's Medicaid program. In so doing, this proposed rule ignores the health and well-being of children, adolescents, and other individuals in Florida, both now and in the future, who could benefit from these treatments, and places their health interests as secondary to that of the state. This proposed rule counters medical consensus, discriminates against transgender adolescents, obstructs the physician-patient relationship, subverts Medicaid's EPSDT protection that places medical judgment central to coverage determinations, and, if finalized as proposed, would leave transgender adolescents and other individuals enrolled in Florida Medicaid with nowhere to turn for their much-needed health care.

The consequences of such actions are likely to be many. As detailed throughout this letter, the mental and physical health and well-being of transgender children and adolescents often rely on their abilities to access much needed mental and physical health care—care that is in keeping with the widely recognized evidence-based standards of care for gender dysphoria. In proposing this rule, Florida ignores broad consensus among the medical community as to what those evidence-based standards of care are, and instead seeks, for its own discriminatory reasons, to impose alternate standards and an outright ban of specific treatments for transgender adolescents in the state's Medicaid program. As pediatricians who care for the health and well-being of all children in Florida and across the United

States, we call for the Florida Medicaid program to return to the evidence-based standards of care widely accepted among the medical community, and for this discriminatory ban to be rescinded. Only by doing so will the health and well-being of transgender children and adolescents in Florida be preserved.

Sincerely,

Moira Szilaygi, MD, PhD, FAAP
President, American Academy of Pediatrics

Lisa Gwynn, DO, MBA, MSPH, FAAP
President, Florida Chapter of the American Academy of Pediatrics, Inc

**Please note: A sourced version of this letter containing footnotes is being provided in PDF format via email.

TAB 183-37

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

BREAST PUMP
GAPMS DETERMINATION REPORT WITH RECOMMENDATION

Date: May 18, 2015

To: Justin Senior, Deputy Secretary for Medicaid

From: Bureau of Medicaid Policy

Subject: **Breast Pump Coverage**

PURPOSE

In order for a breast pump to be covered under the Florida Medicaid program, it must meet medical necessity criteria as defined in 59G-1.010(166),[A1] Florida Administrative Code. (F.A.C.), and funded through the General Appropriations Act of Chapter 216, Florida Statutes (F.S.).

Pursuant to the criteria set forth in 59G-1.010(166)(a)(3), F.A.C., breast pumps must be consistent with generally accepted professional medical standards (GAPMS) as determined by the Medicaid program, and not experimental or investigational.

In accordance with the determination process established in 59G-1.035,[A2] F.A.C., this GAPMS Determination Report with Recommendation is submitted for review to the Deputy Secretary for Medicaid.

The Deputy Secretary for Medicaid will make the final determination as to whether breast pumps are consistent with generally accepted professional medical standards and not experimental or investigational.

RECOMMENDATION

This report recommends breast pumps as a health service that is consistent with generally accepted professional medical standards. It is further recommended that the following devices be covered:

1. A rent-to-purchase electric breast pump may be considered medically necessary when a nursing mother is experiencing prolonged separation from her infant because of work, school, or a medical reason.

2. Electric hospital grade breast pump rental may be considered medically necessary when a newborn recipient has one of the following conditions:
   - Prematurity (less than 37 weeks gestation),
   - Neurologic disorder,
   - Genetic abnormalities (e.g., Down Syndrome),

Pl. Trial Ex. 333

- Anatomic and mechanical malformation (e.g., cleft lip and palate),
- Congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, central nervous system)

An electric hospital grade breast pump rental may also be considered medically necessary when the nursing mother has been diagnosed with and is receiving treatment for mastitis or related infection of the breast.

Coverage of an electric hospital grade breast pump rental would be limited to no more than a three month period. Exceptions can be made on a case by case basis, based upon medical necessity.

REPORT WITH RECOMMENDATION

This report with recommendation is presented as the summary assessment considering the factors identified in 59G-1.035 F.A.C., based on the collection of information from sources of reliable evidence. The intent is to provide a brief analysis with justification in support of the final recommendation.

The analysis described in this report includes:

- Background information and pertinent current Medicaid policies
- An overview of the health service
- Information submitted by the requestor
- Confirmation of clearance from the government regulatory body
- Evidence based clinical practice guidelines
- Coverage policies from commercial and other state Medicaid insurers.

HEALTH SERVICE SUMMARY

Breast Pumps – Device Summary

There are three basic types of breast pumps:

- Manual pumps
- Battery-powered pumps
- Electric pumps

These pumps may be offered with single or double pumping actions. Table 1 provides information on different types and descriptions of breast pumps that are available.

Pumping Type	How it works	Types of Breast Pumps
Single	Extracts milk from one breast at a time.	Most manual breast pumps are single pumps. Most battery-powered pumps are single pumps.
Double	Can be used to extract milk from both breasts at the same time.	Some electric pumps are double pumps.

Table 1

GOVERNMENT REGULATORY BODY APPROVAL

Medical devices (including breast pumps) are regulated by the United States Food and Drug Administration (FDA). Breast pumps are often used by breastfeeding women to extract ("express") their breast milk. Breast pumps can also be used to maintain or increase a woman's milk supply, relieve engorged breasts and plugged milk ducts, or pull out flat or inverted nipples so a nursing baby can latch-on to its mother's breast more easily. Many women find it convenient, or even necessary, to use a breast pump to express and store their breast milk once they have returned to work, are traveling, or are otherwise separated from their baby. A breast pump can be used as a supplement to breastfeeding and some pumps are designed to mimic the suckling of a nursing baby. A number of breast pumps have been reviewed and approved by the FDA (U.S. Food and Drug Administration, 2015).[A3]

CLINICAL OUTCOMES

The benefits of breastfeeding are widely acknowledged, and as such, breastfeeding is the infant feeding method recommended by numerous organizations, including the Association of Women's Health, Obstetric and Neonatal Nurses[A4]; the World Health Organization[A5]; the Dietitians of Canada and Breastfeeding Committee for Canada[A6]; the American Dietetic Association[A7]; and the American Academy of Pediatrics (AAP).[A8]

The American Academy of Family Physicians[A9] and most all of the organizations listed above recommends that all babies, with rare exceptions, be breastfed and/or receive expressed human milk exclusively for the first six months of life.

The AAP[A8] reports that breastfeeding is associated with reductions in middle ear infections, gastrointestinal infections, sudden infant death syndrome, and adolescent and adult obesity rates. Therefore, the AAP also recommends exclusive breastfeeding for the first 6 months after birth, and then continued breastfeeding for one year or longer, as other foods are introduced. These benefits are further supported by literature published by the Institute of Child Health and Human Development.

The Institute of Child Health and Human Development (ICHHD)[A10] also proposes certain benefits of breastfeeding for the nursing mother, including:

- Less blood loss following childbirth and improved healing
- Improved postpartum weight loss
- Lower likelihood of experiencing postpartum depression, which is seen more often in new mothers who do not breastfeed
- Less chance of developing certain health conditions, such as rheumatoid arthritis, cardiovascular disease, and certain cancers (for example, breast cancer)
- Physical and emotional benefits of breastfeeding directly from a mother's breast due to skin-to-skin contact with her infant

EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES

Both the ICHHD and in an issue paper regarding Medicaid coverage of lactation services, the Department of Health and Human Services, Centers for Medicare & Medicaid Services, provides that improving the health of the population and reducing preventable causes of poor health, such as obesity, is a priority; and current research indicates that breastfeeding or using

expressed milk for the first 6 to 12 months of life is highly beneficial for both the mother and infant in reducing these and other preventable health conditions. [A11]

On January 20, 2011, the United States Surgeon General released "The Surgeon General's Call to Action to Support Breastfeeding." This report indicates that there is a 32% higher risk of childhood obesity and a 64% higher risk of type 2 diabetes for children who are not breastfed. This report also provides recommended actions to remove some of the obstacles faced by women who want to breastfeed their babies; pointing out the health and economic benefits of breastfeeding, and offering opportunities for women to be supported in the workplace for breastfeeding including access to high-grade electric breast pumps. [A12]

In July, 2014, the National Center for Chronic Disease Prevention and Health Promotion's Division of Nutrition, Physical Activity, and Obesity, which is a division of the Centers for Disease Control and Prevention, published a Breastfeeding Report Card. Florida is within approximately two percentage points of national averages for the number of babies being breastfed with three quarters of all babies born being breastfed at some point, and around half still being breastfed at six months (Table 2). [A13]

Centers for Disease Control and Prevention National Immunization Survey (July 2014)					
Breastfeeding Rates	Ever Breastfed (%)	Breastfeeding at 6 months (%)	Breastfeeding at 12 months (%)	Exclusive breastfeeding at 3 months (%)	Exclusive breastfeeding at 6 months (%)
U.S. National	79.2	49.4	26.7	40.7	18.8
Florida	77.0	48.7	26.9	38.9	18.3

Table 2

An effective electric breast pump is an important tool for the management of breastfeeding challenges such as providing human milk to sick or premature infants. A breast pump is also, in Western culture, critical for breastfeeding mothers who return to work. Obtaining an effective electric breast pump can be difficult for uninsured or impoverished women because of the expense, complicated insurance reimbursements, and scarcity of providers that supply breast pumps to the inner-city community (Chamberlain, McMahon, Philipp, and Merewood, 2006).[A14]

Mothers who work outside the home initiate breastfeeding at the same rate as mothers who stay at home. However, the breastfeeding continuance rate declines sharply in mothers who return to work. While the work environment may be less than ideal for the breastfeeding mother, obstacles can be overcome. Electric piston pumps may be the most suitable type for mothers who work outside the home for more than 20 hours per week; however, when a mother is highly motivated, any pump type can be successful in any situation (Biagioli, 2003). [A15]

COVERAGE POLICY [A16]

Affordable Care Act

The Affordable Care Act (2010) requires most health insurance plans to cover the cost of a breast pump as part of women's preventative health services. These rules apply to health insurance marketplace plans and all other private health insurance plans, except for grandfathered plans. State Medicaid programs are not required by the Affordable Care Act to provide lactation services including breast pumps. [A11]

Florida Women, Infants, and Children (WIC)
Florida's Special Supplemental Nutrition Program covers breast pumps under certain circumstances. However, funding for breast pumps statewide is limited. Of the available pumps, local WIC offices use a priority system to determine who will receive a breast pump, as the resource is limited.

Medicare
Medicare does not cover breast pumps or breast pump supplies.

Aetna
Aetna covers the rental of breast pumps under its DME benefit when either of the following criteria is met:

- The newborn is detained in the hospital after the mother is discharged
- The infant is diagnosed with a congenital disorder that interferes with feeding

Florida Blue (Commercial Insurer Blue Cross/Blue Shield)
Florida Blue covers the following:

- One electrical or manual breast pump per member, per delivery (hospital grade electric breast pumps are excluded except when medically necessary during an inpatient hospital stay)

Minnesota Medicaid
Minnesota Medicaid covers breast pumps when ordered by the treating provider for any nursing mother experiencing separation from her infant because of work, school, illness or any other medical reason.

New York Medicaid
New York Medicaid covers hospital or professional grade breast pump under the following circumstances impacting the newborn:

- Prematurity (including multiple gestation),
- Neurologic disorders,
- Genetic abnormalities (e.g., Down's Syndrome),
- Anatomic and mechanical malformations (e.g., cleft lip and palate),
- Congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, CNS),
- Prolonged infant hospitalization.

Oregon Medicaid
Oregon Medicaid covers breast pumps taking into consideration the medical appropriateness for the infant and/or mother.

REMAINDER OF THIS PAGE WAS LEFT INTENTIONALLY BLANK

FISCAL

Reimbursement rates for electric and hospital grade breast pumps are variable, based on research and review of other states coverage polices (Table 3).

Table 1: Other States' Medicaid Rates

	Electric Pump	Electric Hospital-Grade Pump[1]
Alaska	$1.27	$91.50
Connecticut	$118.75	
Idaho	$394.34	
Illinois	$119.74	
Maryland	$87.90	$56.21
Michigan	$134.32	$61.82
Minnesota	$256.14	$51.31
New Mexico	$49.25	
New York	$173.47	$38.61
Oregon	$80.92	
Texas	$152.88	$39.15
Washington	$65.60	$80.52
Average Mean[2]	**$124.00**	**$58.07**

Table 3

In conducting the fiscal analysis for coverage breast pumps under Florida Medicaid, we utilized the average reimbursement rates, as reflected above for each device.

Electric Breast Pump Purchase
In 2013, Florida Medicaid reimbursed for 111,619 births. In Florida, while 77% of newborns born in 2013 were reported to have ever been breastfed, only about 49% are still being breastfed at six months of age (Table 2). This signals that while a large percentage (the majority) of women in Florida have attempted to breastfeed their newborn/infant, only about half continue to do so for as long as recommended. Therefore, assuming 50% of these newborns were breastfed and there was a need to utilize an electric breast pump, the total cost for Florida Medicaid is expected to be $6,920,378.

Hospital Grade Breast Pumps Rentals
During state fiscal year 2013-2014, there were approximately 60,000 infants diagnosed with prematurity (less than 37 weeks gestation), a neurologic disorder, genetic abnormalities (e.g., Down Syndrome), an anatomic and/or mechanical malformation (e.g., cleft lip and palate), and congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, central nervous system).

[1] Per month rental rate
[2] Removed outlier rates

Assuming 50% of these newborns' mothers desired to breastfeed, but due to the child's condition required a hospital grade breast pump, the total cost for Florida Medicaid is expected to be $5,226,300 (based on a maximum rental period of three months). The estimated annual fiscal impact of covering both electric and hospital grade breast pumps is $12,146,678. The cost of this may be partially offset in the short-term by reductions in middle ear and gastrointestinal infections and in the long-term by reduced rates of obesity with its associated chronic disease costs (e.g. diabetes).

GENERALLY ACCEPTED PROFESSIONAL MEDICAL STANDARDS RECOMMENDATION

This report recommends breast pumps as a health service that is consistent with generally accepted professional medical standards. It is further recommended that the following devices be covered:

1. A rent-to-purchase electric breast pump may be considered medically necessary when a nursing mother is experiencing prolonged separation from her infant because of work, school, or a medical reason.

2. Electric hospital grade breast pump rental may be considered medically necessary when a newborn recipient has one of the following conditions:
   - Prematurity (less than 37 weeks gestation),
   - Neurologic disorder,
   - Genetic abnormalities (e.g., Down Syndrome),
   - Anatomic and mechanical malformation (e.g., cleft lip and palate),
   - Congenital malformations requiring surgery (e.g., respiratory, cardiac, gastrointestinal, central nervous system).

   An electric hospital grade breast pump rental may also be considered medically necessary when the nursing mother has been diagnosed with and is receiving treatment for mastitis or related infection of the breast.

   Coverage of an electric hospital grade breast pump rental would be limited to no more than a three month period. Exceptions can be made on a case by case basis, based upon medical necessity.

✓ **Concur** ____ **Do Not Concur**

Comments:

_____

_____

_____

Signature
Deputy Secretary for Medicaid (or designee)

5/28/15
Date

Attachments

A1. 59G-1.010(166), F.A.C., "Medically Necessary"
A2. 59G-1.035, F.A.C., "Determining Generally Accepted Professional Medical Standards"
A3. FDA. 501(k) Devices: Megna Breast Pumps K142479. U.S. Food and Drug Administration. February 2015.
FDA. 501(k) Devices. Ardo Carum and Calypso Powered Breast Pumps K141742 . U.S. Food and Drug Administration. October 2014
FDA. 501(k) Devices. Expresse and Premier Powered Breast Pumps K973501. U.S. Food and Drug Administration. December 1997
A4. Association of Women's Health, Obstetric and Neonatal Nurses. AWHONN Position Statement: Breastfeeding. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 2015. 44(1);145-150.
A5. World Health Organization. Media Centre: Infant and young child feeding Fact Sheet N342. February 2014. http://www.who.int/mediacentre/factsheets/fs342/en/
A6. Infant Feeding Joint Working group. Nutrition for Health Term Infants: Recommendations from Birth to Six Months. *Health Canada* 2014 http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php#a3.
A7. American Dietetic Association. Promoting and Supporting Breastfeeding. *Journal of the American Dietetic Association*. 2009. 109;1926-1942.
A8. American Academy of Pediatrics. Policy Statement: Breastfeeding and the Use of Human Milk. *Pediatrics*. 2012. 129(3); e827-e841
A9. American Academy of Family Physicians. Breastfeeding, Family Physicians Supporting (Position Paper). *American Family Physician.* 2015. 91(1);56-57
A10. National Institutes of Health. What are the benefits of breastfeeding? Eunice Kennedy Shriver National Institute of Child Health and Human Development. 2015. https://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/Pages/benefits.aspx
A11. Center for Medicaid and CHIP Services. Issue Brief: Medicaid Coverage of Lactation Services. 2012. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf
A12. U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. U.S. Department of Health and Human Services, Office of the Surgeon General. 2011. http://www.surgeongeneral.gov
A13. Centers for Disease Control and Prevention. *Breastfeeding Report Card United states/2014.* National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. 2014. www.cdc.gov
A14. Chamberlain, L.B., McMahon, M., Philipp, B.L., Merewood, A., Breast pump access in the inner city: a hospital-based initiative to provide breast pumps for low-income women. *Journal of Human Lactation*. 2006. 22(1);94-98
A15. Biagioli, Frances, Returning to work while breastfeeding. *American Family Physician.* 2003. 68(11);2199-2207
A16. *Hardcopy*

TAB 184-21

U.S. Department of Justice

Civil Rights Division

Assistant Attorney General
950 Pennsylvania Ave, NW - RFK
Washington, DC 20530

March 31, 2022

Dear State Attorneys General:

The U.S. Department of Justice (the Department) is committed to ensuring that transgender youth, like all youth, are treated fairly and with dignity in accordance with federal law. This includes ensuring that such youth are not subjected to unlawful discrimination based on their gender identity, including when seeking gender-affirming care. We write to remind you of several important federal constitutional and statutory obligations that flow from these fundamental principles.

People who are transgender are frequently vulnerable to discrimination in many aspects of their lives, and are often victims of targeted threats, legal restrictions, and anti-transgender violence.[1] The Department and the federal government more generally have a strong interest in protecting the constitutional rights of individuals who are lesbian, gay, bisexual, transgender, queer, intersex, nonbinary, or otherwise gender-nonconforming,[2] and in ensuring compliance with federal civil rights statutes. The Department is also charged with the coordination and enforcement of federal laws that protect individuals from discrimination in a wide range of federally-funded programs and activities.[3]

Intentionally erecting discriminatory barriers to prevent individuals from receiving gender-affirming care implicates a number of federal legal guarantees. State laws and policies that prevent parents or guardians from following the advice of a healthcare professional regarding what may be medically necessary or otherwise appropriate care for transgender minors may infringe on rights protected by both the Equal Protection and the Due Process Clauses of the Fourteenth Amendment. The Equal Protection Clause requires heightened scrutiny of laws that discriminate on the basis of sex[4] and prohibits such discrimination absent an "exceedingly

[1] *See, e.g.*, Michelle M. Johns et al., Ctrs. for Disease Control and Prevention, *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, Morbidity and Mortality Weekly Report 68: 67-71 (2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6803a3.htm?s_cid=mm6803a3_w (finding that transgender youth reported higher levels of violence victimization compared to their cisgender peers).
[2] *See, e.g.*, Exec. Order No. 13,988, § 1, 86 Fed. Reg. 7023 (Jan. 20, 2021); Pamela S. Karlan, Principal Deputy Assistant Attorney General, Civ. Rts. Div., U.S. Dep't of Justice, Memorandum, *Application of Bostock v. Clayton County to Title IX of the Education Amendments of 1972* (Mar. 26, 2021), https://www.justice.gov/crt/page/file/1383026/download.
[3] Exec. Order No. 12,250, § 1-201, 45 Fed. Reg. 72,995 (Nov. 2, 1980).
[4] *See, e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 610-13 (4th Cir. 2020), *as amended* (Aug. 28, 2020), *reh'g en banc denied*, 976 F.3d 399 (4th Cir. 2020), *cert. denied*, 2021 WL 2637992 (June 28, 2021); *Whitaker* v.

Pl. Trial Ex. 356

PLAINTIFFS003379

persuasive" justification.[5] Because a government cannot discriminate against a person for being transgender "without discriminating against that individual based on sex,"[6] state laws or policies that discriminate against transgender people must be "substantially related to a sufficiently important governmental interest."[7]

A law or policy need not specifically single out persons who are transgender to be subject to heightened scrutiny. When a state or recipient of federal funds criminalizes or even restricts a type of medical care predominantly sought by transgender persons, an intent to disfavor that class can "readily be presumed."[8] For instance, a ban on gender-affirming procedures, therapy, or medication may be a form of discrimination against transgender persons, which is impermissible unless it is "substantially related" to a sufficiently important governmental interest.[9] This burden of justification is "demanding."[10] Such a law or policy will not withstand heightened scrutiny when "the alleged objective" differs from the "actual purpose" underlying the classification.[11] In addition, the Due Process Clause protects the right of parents "to seek and follow medical advice" to safeguard the health of their children.[12] A state or local government must meet the heavy burden of justifying interference with that right since it is well established within the medical community that gender-affirming care for transgender youth is not only appropriate but often necessary for their physical and mental health.[13]

In addition to these constitutional guarantees, many federal statutes require recipients of federal financial assistance to comply with nondiscrimination requirements as a condition of receiving those funds. Relevant statutes include:

- **Section 1557 of the Affordable Care Act**[14] protects the civil rights of people—including transgender youth—seeking nondiscriminatory access to healthcare in a range of health

---

Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1051 (7th Cir. 2017), *cert. dismissed*, 138 S. Ct. 1260 (2018); *see also* Brief for the United States as Amicus Curiae Supporting Plaintiffs-Appellees, *Brandt v. Rutledge*, No. 21-2875 (8th Cir. Jan. 21, 2022); En Banc Brief for the United States as Amicus Curiae Supporting Plaintiff-Appellee, *Adams v. School Board of St. John's County*, No. 18-13592 (11th Cir. Nov. 26, 2021); Brief for the United States as Amicus Curiae Supporting Plaintiffs-Appellees, *Corbitt v. Taylor*, No. 21-10486 (11th Cir. Aug. 2, 2021).

[5] *United States v. Virginia*, 518 U.S. 515, 531 (1996) ("Parties who seek to defend gender-based government action must demonstrate an 'exceedingly persuasive justification' for that action.") (quoting *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982)).

[6] *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020).

[7] *Grimm*, 972 F.3d at 608 (quoting *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985) (internal quotations omitted)).

[8] *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("Some activities may be such an irrational object of disfavor that, if they are targeted, and if they also happen to be engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed.").

[9] *Virginia*, 518 U.S. at 533.

[10] *Id.*

[11] *Miss. Univ.*, 458 U.S. at 730.

[12] *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

[13] *See, e.g.*, *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891, 893 (E.D. Ark. 2021).

[14] 42 U.S.C. § 18116.

programs and activities.[15] Categorically refusing to provide treatment to a person based on their gender identity, for example, may constitute prohibited discrimination under Section 1557. As the U.S. Department of Health and Human Services has stated, restricting an individual's ability to receive medically necessary care, including gender-affirming care, from their health care providers solely on the basis of their sex assigned at birth or their gender identity may also violate Section 1557.[16]

- **Title IX of the Education Amendments of 1972**[17] prohibits sex discrimination, including sex-based harassment, by recipients of federal financial assistance that operate education programs and activities.[18] Policies and practices that deny, limit, or interfere with access to the recipient's education program or activity because students are transgender minors receiving gender-affirming care may constitute discrimination on the basis of sex in violation of Title IX.

- The **Omnibus Crime Control and Safe Streets Act of 1968**[19] prohibits sex discrimination in certain law enforcement programs and activities receiving federal financial assistance.[20] If a law enforcement agency takes a transgender minor who is receiving gender-affirming care into custody or arrests the child's parents on suspicion of child abuse because the parents permitted such medical care, that agency may be violating the statute's nondiscrimination provision.

- **Section 504 of the Rehabilitation Act of 1973**[21] protects people with disabilities, which can include individuals who experience gender dysphoria.[22] Restrictions that prevent, limit, or interfere with otherwise qualified individuals' access to care due to their gender

---

[15] *See, e.g.*, Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972, reprinted at 86 Fed. Reg. 27,984 (May 25, 2021).
[16] U.S. Dep't Health & Hum. Servs., *Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy* (Mar. 2, 2022), https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf.
[17] 20 U.S.C. § 1681, *et seq*.
[18] *See* Karlan, *supra* note 2; *see also Doe v. Snyder*, --- F.4th ---, 2022 WL 711420, at *9 (9th Cir. Mar. 10, 2022); *Grimm*, 972 F.3d at 619.
[19] 34 U.S.C. § 10101, *et seq*.
[20] *See* 34 U.S.C. § 10228(c)(1); *see also* Kristen Clarke, Assistant Attorney General, Civ. Rts. Div., U.S. Dep't of Justice, Memorandum, *Interpretation of Bostock v. Clayton County regarding the nondiscrimination provisions of the Safe Streets Act, the Juvenile Justice and Delinquency Prevention Act, the Victims of Crime Act, and the Violence Against Women Act* (Mar. 10, 2022), https://www.justice.gov/crt/page/file/1481776/download.
[21] 29 U.S.C. § 794. Additionally, Title II of the Americans with Disabilities Act extends disability civil rights protections with respect to all programs, services and activities of state and local governments, regardless of the receipt of federal financial assistance. *See* 42 U.S.C. § 12132.
[22] *See, e.g.*, *Doe v. Penn. Dep't of Corrections*, No. 1:20-cv-00023-SPB-RAL, 2021 WL 1583556, at *12 (W.D. Pa. Feb. 19, 2021), report and recommendation adopted in relevant part, 2021 WL 1115373 (W.D. Pa. March 24, 2021); *Lange v. Houston Cnty.*, 499 F. Supp. 3d 1258, 1270 (M.D. Ga. 2020); *Doe v. Mass. Dep't of Correction*, No. 1:17-cv-12255-RGS, 2018 WL 2994403 at *6 (D. Mass. June 14, 2018); *Blatt v. Cabela's Retail, Inc.*, No. 5:14-CV-04822, 2017 WL 2178123 (E.D. Pa. May 18, 2017).

dysphoria, gender dysphoria diagnosis, or perception of gender dysphoria may violate Section 504.

All persons should be free to access the services, programs, and activities supported by federal financial assistance without fear that they might face unlawful discrimination for doing so. Courts have held that many nondiscrimination statutes contain an implied cause of action for retaliation based on the general prohibition against intentional discrimination, and agencies have made this clear in regulations.[23] Thus, any retaliatory conduct may give rise to an independent legal claim under the protections described above.

* * *

Thank you for your continued commitment to improving the well-being of children and their families. The Department is always available to help ensure that state and local governments, many of which are recipients of federal financial assistance, meet their obligations under federal law. Please feel free to contact the Department's Civil Rights Division for assistance if you have further questions.

Sincerely,

Kristen Clarke
Assistant Attorney General
Civil Rights Division
U.S. Department of Justice

[23] *See, e.g.*, *Jackson v. Birmingham Bd. of Ed.*, 544 U.S. 167, 173 (2005) ("Retaliation against a person because that person has complained of sex discrimination is another form of intentional sex discrimination…"). Examples of agency regulations that prohibit retaliation include 24 C.F.R. § 1.7(e) (Dep't of Housing and Urban Development); 34 C.F.R. § 100.7(e) (Dep't of Education); 38 C.F.R. § 18.7(e) (Dep't of Veterans Affairs); and 45 C.F.R. § 80.7(e) (Dep't of Health and Human Services). Other relevant regulations can be found in the Civil Rights Division's Title VI Legal Manual. Civ. Rts. Div., U.S. Dep't of Justice, *Title VI Legal Manual*, Section VIII, https://www.justice.gov/crt/book/file/1364106/download.

TAB 193-5

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Treatment of Gender Dysphoria for Children and Adolescents

April 20, 2022

The Florida Department of Health wants to clarify evidence recently cited on a fact sheet released by the US Department of Health and Human Services and provide guidance on treating gender dysphoria for children and adolescents.

Systematic reviews on hormonal treatment for young people show a trend of low-quality evidence, small sample sizes, and medium to high risk of bias. A paper published in the International Review of Psychiatry states that 80% of those seeking clinical care will lose their desire to identify with the non-birth sex. One review concludes that "hormonal treatments for transgender adolescents can achieve their intended physical effects, but **evidence regarding their psychosocial and cognitive impact is generally lacking**."

According to the Merck Manual, "gender dysphoria is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the sex assigned at birth."

Due to the lack of conclusive evidence, and the potential for long-term, irreversible effects, the Department's guidelines are as follows:

- Social gender transition should not be a treatment option for children or adolescents.
- Anyone under 18 should not be prescribed puberty blockers or hormone therapy.
- Gender reassignment surgery should not be a treatment option for children or adolescents.
    - Based on the currently available evidence, "encouraging mastectomy, ovariectomy, uterine extirpation, penile disablement, tracheal shave, the prescription of hormones which are out of line with the genetic make-up of the child, or puberty blockers, are all clinical practices which run an **unacceptably high risk of doing harm**."
- Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider.

These guidelines do not apply to procedures or treatments for children or adolescents born with a genetically or biochemically verifiable disorder of sex development (DSD). These disorders include, but are not limited to, 46, XX DSD; 46, XY DSD; sex chromosome DSDs; XX or XY sex reversal; and ovotesticular disorder.

The Department's guidelines are consistent with the federal Centers for Medicare and Medicaid Services age requirement for surgical and non-surgical treatment. These guidelines are also in line with the guidance, reviews, and recommendations from Sweden, Finland, the United Kingdom, and France.

Parents are encouraged to reach out to their child's health care provider for more information.

Florida Department of Health
Office of the State Surgeon General
4052 Bald Cypress Way, Bin A-00 • Tallahassee, FL 32399-1701
PHONE: 850/245-4210 • FAX: 850/922-9453
FloridaHealth.gov

TAB 193-6

Florida Medicaid

Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria

June 2022

Ron DeSantis, Governor
Simone Marstiller, Secretary

DX
6

Contents

Introductory Remarks and Abstract

Generally Accepted Professional Medical Standards

The Secretary of the Florida Agency for Health Care Administration requested that the Division of Florida Medicaid review the treatment of gender dysphoria for a coverage determination pursuant to Rule 59G-1.035, Florida Administrative Code (F.A.C.) (See Attachment A for the Secretary's Letter to Deputy Secretary Tom Wallace). The treatment reviewed within this report included "sex reassignment treatment," which refers to medical services used to obtain the primary and/or secondary physical sexual characteristics of a male or female. As a condition of coverage, sex reassignment treatment must be "consistent with generally accepted professional medical standards (GAPMS) and not experimental or investigational" (Rule 59G-1.035, F.A.C., see Attachment B for the complete rule text).

The determination process requires that "the Deputy Secretary for Medicaid will make the final determination as to whether the health service is consistent with GAPMS and not experimental or investigational" (Rule 59G-1.035, F.A.C.). In making that determination, Rule 59G-1.035, F.A.C., identifies several factors for consideration. Among other things, the rule contemplates the consideration of "recommendations or assessments by clinical or technical experts on the subject or field" (Rule 59G-1.035(4)(f), F.A.C.). Accordingly, this report attaches five assessments from subject-matter experts:

- **Attachment C:** Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.
- **Attachment D:** James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.
- **Attachment E:** Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.
- **Attachment F:** Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.
- **Attachment G:** G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

Abstract

Available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that the services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health.

Five clinical and technical expert assessments attached to this report recommend against the use of such interventions to treat what is categorized as a mental health disorder (See attachments):

- **Health Care Research:** Brignardello-Petersen and Wiercioch performed a systematic review that graded a multitude of studies. They conclude

that evidence supporting sex reassignment treatments is low or very low quality.

- **Clinical Psychology:** Cantor provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements.
- **Plastic Surgery:** Lappert provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest.
- **Pediatric Endocrinology:** Van Meter explains how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation.
- **Bioethics:** Donovan provides additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent.

Following a review of available literature, clinical guidelines, and coverage by other insurers and nations, Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to the stronger research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS and are experimental and investigational.

Health Service Summary

Gender Dysphoria

Frequently used to describe individuals whose gender identity conflicts with their natural-born sex, the term gender dysphoria has a history of evolving definitions during the past decades (Note: This report uses the term "gender" in reference to the construct of male and female identities and the term "sex" when regarding biological characteristics). Prior to the publication of the *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders* (DSM-V), the American Psychiatric Association (APA) used the diagnosis of gender identity disorder (GID) to describe individuals who sought to transition to the opposite gender. However, behavioral health clinicians sought a revision after determining that using GID created stigma for those who received the diagnosis. This is despite the APA having adopted GID to replace the previous diagnosis of transsexualism for the exact same reason (APA, 2017).[1]

When crafting its new definition and terminology, the APA sought to remove the stigma of classifying as a disorder the questioning of one's gender identity by focusing instead on the psychological distress that such questioning can evoke. This approach argues that individuals seeking behavioral health and transition services are doing so due to experiencing distress and that gender non-conformity by itself is not a mental health issue. This led to the adoption of gender dysphoria in 2013 when the APA released the DSM-V. In addition to using a new term, the APA also differentiated the diagnosis between children and adolescents and adults, listing different characteristics for the two age groups (APA, 2017).

According to the DSM-V, gender dysphoria is defined as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." As for the criteria to receive the diagnosis, the APA issued stricter criteria for children than adolescents and adults. For the former, the APA states that a child must meet six out of eight behavioral characteristics such as having "a strong desire to be of the other gender or an insistence that one is the other gender" or "a strong preference for cross-gender roles in make-believe or fantasy play." The criteria for adults and adolescents are less stringent with individuals only having to meet two out of six characteristics that include "a strong desire to be the other gender" or "a strong desire to be rid of one's primary and/or secondary sexual characteristics." The APA further notes that these criteria can also apply to young adolescents (DSM-V, 2013).

In 2021, the Merck Manual released a slightly different definition for gender dysphoria, citing that the condition "is characterized by a strong, persistent cross-gender identification associated with anxiety, depression, irritability, and often a wish to live as a gender different from the one associated with the

[1] The concept of gender being part of identity and disconnected from biological sex originated during the mid-twentieth century and was publicized by psychologist John W. Money. His research asserted that gender was a complete social construct and separate from biology, meaning that parents and/or caregivers could imprint on a young child (under three years) the identity of a boy or girl. In 1967, Money's theories led to a failed experiment on twin boys where physicians surgically transitioned one to appear as a girl. The twin that underwent sex reassignment never fully identified as a female. However, Money never publicly acknowledged this and reported the experiment as a success. Furthermore, he promoted his conclusions across the scientific community, concealing what actually unfolded. As a result, Money's ideas on gender fluidity served as a basis for performing procedures on children with hermaphroditic features or genital abnormalities. The case reveals how the understanding of a concept (e.g., gender) at any given time can lead to incorrect medical decisions with irreversible consequences (Gaetano, 2015).

sex assigned at birth." Additionally, the Merck Manual further states that "gender dysphoria is a diagnosis requiring specific criteria but is sometimes used more loosely for people in whom symptoms do not reach a clinical threshold" (Merck Manual, 2021). This definition is largely consistent with the DSM-V but does not emphasize the distress component to the same extent.[2]

Like other behavioral health diagnoses classified in the DSM-V, gender dysphoria has the following subtypes:

- **Early-Onset Gender Dysphoria:** This subtype begins during childhood and persists through adolescence into adulthood. It can be interrupted by periods where the individual does not experience gender dysphoria signs and may classify as homosexual (DSM-V, 2013).
- **Late-Onset Gender Dysphoria:** Occurring after puberty or during adulthood, this subtype does not begin until late adolescence and can emerge following no previous signs of gender dysphoria. The APA attributes this partially to individuals who did not want to verbalize their desires to transition (DSM-V, 2013).

Further studies have identified additional subtypes of gender dysphoria. In 2018, Lisa Littman introduced the concept of a rapid-onset subtype. Classified as rapid-onset gender dysphoria (ROGD), it features characteristics such as sudden beginnings during or following puberty. However, it differs from the DSM-V definitions because ROGD is associated with other causes such as social influences (e.g., peer groups, authority figures, and media). In other words, adolescents who had no history of displaying typical gender dysphoria characteristics go through a sudden change in identity following intense exposure to peers and/or media that heavily promotes transgender lifestyles (Littman, 2018). While more long-term studies are needed to confirm whether ROGD is a temporary or long-term condition, Littman's study has initiated discussions regarding potential causes of gender dysphoria as well as introduced a potential subtype.

Additionally, the frequent use of gender dysphoria in clinical and lay discourse has led to a fracturing of the definition. Studies on the topic frequently do not apply the DSM-V's criteria for the diagnosis and overlook certain key features such as distress. In a 2018 review by Zowie Davy and Michael Toze, the authors evaluated 387 articles that examine gender dysphoria and noted stark departures from the APA's definition. They further asserted that the APA intended to "reduce pathologization" by establishing a new definition for gender dysphoria in the DSM-V. This in turn would reduce diagnoses, although as Davy and Toze note, the tendency for the literature to diverge from the APA's definition may result in increased numbers of individuals classified as having gender dysphoria when they do not meet the DSM-V's criteria (Davy and Toze, 2018). This further raises the question of whether individuals are receiving potentially irreversible treatments for the condition when they might not actually have it.

The current usage of gender dysphoria is the result of discussions spanning across decades as demonstrated in the past editions of the DSM. Until 2013, the APA considered having gender identity issues a mental disorder by itself regardless of the presence of psychological distress. That perspective has since shifted to only consider the adverse psychological effects of questioning one's gender as a disorder. In addition, the APA considers gender as part of one's identity, which is not subject to a diagnosis. Whether the APA has shifted its terminology and criteria for gender identity issues due to

[2] Following the release of the Florida Department of Health's guidelines for treating gender dysphoria, Merck removed its definition for "gender dysphoria" from the Merck Manual (Fox News, 2022).

emerging clinical data or cultural changes is another question. In 1994, the APA replaced transsexualism with gender identity disorder as part of the "effort to reduce stigma" (APA, 2017). This raises questions about what influences decisions to revise definitions and criteria; is it social trends or medical evidence?

Behavioral Health Issues Co-Occurring with Gender Dysphoria

Because gender dysphoria pertains directly to the distress experienced by an individual who desires to change gender identities, secondary behavioral health issues can co-occur such as depression and anxiety. If left untreated, these conditions can lead to the inability to function in daily activities, social isolation, and even suicidal ideation. Studies do confirm that adolescents and adults with gender dysphoria report higher levels of anxiety, depression, and poor peer relationships than the general population (Kuper et al, 2019). Other associated conditions include substance abuse, eating disorders, and compulsivity. A significant proportion of individuals with gender dysphoria also have autism spectrum disorder (ASD) (Saleem and Rizvi, 2017). Although the number reporting secondary issues is increased, individuals diagnosed with gender dysphoria do not necessarily constitute the entire population that is gender non-conforming (i.e., does not identify with natal sex), and no information is available breaking down the percentage of those who are non-conforming with gender dysphoria and those who are non-conforming with no distress. Additionally, available research raises questions as to whether the distress is secondary to pre-existing behavioral health disorders and not gender dysphoria. This is evident in the number of adolescents who reported anxiety and depression diagnoses prior to transitioning (Saleem and Rizvi, 2017).

Furthermore, conventional treatments for secondary behavioral health issues are available. These include cognitive behavioral therapy, medication, and inpatient services. The APA reports that treatments for these are highly effective with 80% to 90% of individuals diagnosed with depression responding positively (APA, 2020). In addition, a high percentage of adolescents diagnosed with gender dysphoria had received psychiatric treatment for a prior or co-occurring mental health issue. A 2015 study from Finland by Kaltiala-Heino et al noted that 75% of children seeking sex reassignment services had been treated by a behavioral health professional (Kaltiala-Heino et al, 2015).

Diagnosing Gender Dysphoria

Prior to the publication of the DSM-V, diagnosing individuals experiencing gender identity issues followed a different process. Behavioral health clinicians could assign the diagnosis based on gender non-conformance alone. That has changed since 2013. Today, non-conforming to one's gender is part of personal identity and not a disorder requiring treatment. This change has led professional associations to shift the diagnostic criteria for gender dysphoria to focus on the distress caused by shifting identities (DSM-V, 2013).

For adolescents, the APA identifies "a marked incongruence between one's experienced/expressed gender and natal sex, of at least 6 months' duration" as the core component of gender dysphoria (DSM-V, 2013). What the APA does not elucidate is the threshold for "marked." This raises questions as to whether practitioners exercise uniformity when applying the diagnostic criteria or if they do so subjectively. For example, the WPATH's *Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People* provides guidance on the processes mental health practitioners should use when assessing for gender dysphoria but offers no benchmarks for meeting diagnostic criteria (WPATH, 2012).

Such processes include evaluating for gender non-conforming behaviors and other co-existing mental disorders like anxiety or depression. This involves not only interviewing the adolescent but also the family in addition to reviewing medical histories. WPATH also asserts that gender dysphoria assessments need to account for peer relationships, academic performance, and provide information of potential treatments. This last component is necessary because it might affect an individual's choices regarding transitioning, particularly if the information does not correspond to the desired outcome (WPATH, 2012).

The diagnosis of gender dysphoria is a relatively recent concept in mental health, being the product of decades of discussion and building upon previous definitions. Instead of treating gender non-conformity as a disorder, behavioral health professionals acknowledge it as part of one's identity and focus on addressing the associated distress. Considering the new criteria, this changes the dynamics of the population who would have qualified for a diagnosis before 2013 and those who would today. Given that desiring to transition into a gender different from natal sex no longer qualifies as a disorder, behavioral health professionals are treating distress and referring adolescents and adults to therapies that are used off-label and pose irreversible effects.

Current Available Treatments for Gender Dysphoria

At present, proposed treatment for gender dysphoria occurs in four stages, beginning with psychological services and ending with sex reassignment surgery. As an individual progresses through each stage, the treatments gradually become more irreversible with surgical changes being permanent. Because of the increasing effects, individuals must have attempted treatment at the previous stage before pursuing the next one (Note: late adolescents and adults have already completed puberty and do not require puberty blockers). Listed in order, the four stages are as follows:

- **Behavioral Health Services:** Psychologists and other mental health professionals are likely the first practitioners individuals with gender dysphoria will encounter. In accordance with clinical guidelines established by the World Professional Association for Transgender Health (WPATH)[3], behavioral health professionals are supposed to "find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment." WPATH further discourages services for attempting to change someone's gender identity. Instead, it instructs practitioners to assess for the condition and readiness for puberty blockers or cross-sex hormones while offering guidance to function in a chosen gender. WPATH does assert that the clinicians do need to treat any other underlying mental health issues secondary or co-occurring with gender dysphoria (WPATH, 2012). However, the organization provides conflicting guidance because it also advises practitioners to prescribe cross-sex hormones on demand (Levine, 2018).
- **Puberty Suppression:** Used only on individuals in the earliest stages of puberty (Tanner stage 2), preventing pubertal onset provides additional time to explore gender identities before the physical characteristics of biological sex develop. This treatment is intended to reduce distress and anxiety related to the appearance of adult sexual physical features. To suppress puberty, pediatric endocrinologists inject gonadotropin releasing hormone (Gn-RH) at specific intervals (e.g., 4 weeks or 12 weeks). The Gn-RH suppresses gonadotropin receptors that allow for the

[3] The World Professional Association for Transgender Health asserts that it is a professional organization. However, it functions like an advocacy group by allowing open membership to non-clinicians (WPATH, 2022).

development of primary and secondary adult sexual characteristics. Prior to receiving puberty suppression therapy, individuals must have received a diagnosis of gender dysphoria and have undergone a mental health evaluation (Kyriakou et al, 2020).

- **Cross-Sex Hormones:** For adults and late adolescents (16 years or older), the next treatment phase recommended is taking cross-sex hormones (e.g., testosterone or estrogen) to create secondary sex characteristics. In men transitioning into women, these include breast development and widening around the pelvis. Women who transition into men experience deeper voices, redistribution of fat deposits, and growing facial hair. According to the Endocrine Society, late adolescents who qualify for cross-sex hormones must have a confirmed diagnosis of gender dysphoria from a mental health practitioner with experience treating that population. Some physical changes induced by these hormones are irreversible (Endocrine Society, 2017).
- **Sex Reassignment Surgery:** Sometimes referred to as "gender affirming" surgery, this treatment does not consist of just one procedure but several, depending on the desires of the transitioning individual. Primarily, sex reassignment procedures alter the primary and secondary sexual characteristics. Men transitioning into women (trans-females) undergo a penectomy (removal of the penis), orchiectomy (removal of the testes), and vulvoplasty (creation of female genitals). Other procedures trans-females may undergo include breast augmentation and facial feminization. For women that transition into men (trans-males), procedures include mastectomy (removal of the breasts), hysterectomy (removal of the uterus), oophorectomy (removal of the ovaries), and phalloplasty (creation of male genitals). Because of the complexities involved in phalloplasty, many trans-males do not opt for this procedure and limit themselves to mastectomies. Additionally, the effects of sex reassignment surgery, such as infertility, are permanent (WPATH, 2012).

While some clinical organizations assert that they are the standard of care for gender dysphoria, the U.S. Food and Drug Administration (FDA) currently has not approved any medication as clinically indicated for this condition (Unger, 2018). Although puberty blockers and cross-sex hormones are FDA approved, the FDA did not approve them for treating gender dysphoria, meaning that their use for anything other than the clinical indications listed is off-label (American Academy of Pediatrics, 2014). As for surgical procedures, the FDA does not evaluate or approve them, but it does review all surgical devices (FDA, 2021). In addition, the Endocrine Society concedes that its practice guidelines for sex reassignment treatment does *not* constitute a "standard of care" and that its grades for available services are low or very low (Endocrine Society, 2017).[4]

[4] Disagreement over how to treat gender dysphoria, gender identity disorder, and transsexualism has persisted since sex reassignment surgery first became available in the 1960s. In a 2006 counterargument, Paul McHugh highlights how individuals seeking surgery had other reasons that extended beyond gender identity, including sexual arousal and guilt over homosexuality. In addition, he asserts that undergoing sex reassignment procedures did not improve a patient's overall behavioral health and that providing a "surgical alteration to the body of these unfortunate people was to collaborate with a mental disorder rather than to treat it" (McHugh, 2006).

Literature Review: Introduction

Currently, an abundance of literature and studies on gender dysphoria is available through academic journals, clinical guidelines, and news articles. Similar to other mental health issues, the material addresses a broad range of topics consisting of available treatments, etiology (i.e., causes), risks, benefits, and side effects. Although most stories reported by the media indicate that treatments such as cross-sex hormones and sex reassignment surgery are the most effective, research reveals that numerous questions still exist. These include what are the long-term health effects of taking cross-sex hormones, what are the real causes of gender dysphoria, and how many individuals that transition will eventually want to revert to their natal sex. Additionally, much of the available research is inconclusive regarding the effectiveness of sex reassignment treatments with multiple studies lacking adequate sample sizes and relying on subjective questionnaires. While much of the scientific literature leans in favor of cross-sex hormones and surgery as options for improving the mental health of individuals with gender dysphoria, it does not conclusively demonstrate that the benefits outweigh the risks involved, either short or long-term. What studies do reveal with certainty is that sex reassignment surgery and cross-sex hormones pose permanent effects that can result in infertility, cardiovascular disease, and disfigurement. All of this indicates that further research is necessary to validate available treatments for gender dysphoria. Thus, physicians, who recommend sex reassignment treatment, are not adhering to an evidence-based medicine approach and are following an eminence-based model.

The following literature review addresses the multiple facets of this condition and presents areas of ongoing debate and persisting questions. Beginning with the condition's etiology and continuing with evaluations of puberty blockers, cross-sex hormones, and surgery, the review explains each area separately and in context of gender dysphoria at large. Additionally, the review provides an analysis on available research on mental health outcomes as well as the condition's persistence into adulthood. Taken as a whole, the available studies demonstrate that existing gender dysphoria research is inconclusive and that current treatments are used to achieve cosmetic benefits while posing risky side effects as well as irreversible changes.

Literature Review: Etiology of Gender Dysphoria

What causes gender dysphoria is an ongoing debate among experts in the scientific and behavioral health fields. Currently, the research indicates that diagnosed individuals have higher proportions of autism spectrum disorder (ASD), history of trauma or abuse, fetal hormone imbalances, and co-existing mental illnesses. Also, experts acknowledge that genetics may factor into gender dysphoria. Another potential cause is social factors such as peer and online media influence. At the moment, none of the studies provides a definite cause and offer only correlations and weakly supported hypotheses. In addition, evidence favoring a biological explanation is highly speculative. However, the research does raise questions about whether treatments with permanent effects are warranted in a population with disproportionately high percentages of ASD, behavioral health problems, and trauma.

In a 2017 literature review by Fatima Saleem and Syed Rizvi, the authors examine gender dysphoria's numerous potential causes and the remaining questions requiring further research. In conclusion, the pair indicate that associations exist between the condition and ASD, schizophrenia, childhood abuse, genetics, and endocrine disruption chemicals but that more research is needed to improve understanding of how these underlying issues factor into a diagnosis. Throughout the review, Saleem and Rizvi identify the following as potential contributing elements to the etiology of gender dysphoria:

- **Neuroanatomical Etiology:** During fetal development, the genitals and brain develop during different periods of a pregnancy, the first and second trimesters respectively. Because the processes are separate, misaligned development is possible where the brain may have features belonging to the opposite sex. The authors identify one study where trans-females presented with a "female-like putamen" (structure at the base of the brain) when undergoing magnetic resonance imaging (MRI) scans.[5]
- **Psychiatric Associations:** Saleem and Rizvi identify multiple studies reporting that individuals with gender dysphoria have high rates of anxiety and depressive disorders with results ranging as high as 70% having a mental health diagnosis. In addition, the pair note that schizophrenia may also influence desires to transition. However, the review does not assess whether the mental health conditions are secondary to gender dysphoria.
- **Autism Spectrum Disorder:** Evidence suggests a significant percentage of individuals diagnosed with gender dysphoria also have ASD. The authors note that the available studies only establish a correlation and do not identify mechanisms for causation.
- **Childhood Abuse:** Like the above causes, Saleem and Rizvi note that those with gender dysphoria tended to experience higher rates of child abuse across all categories, including neglect, emotional, physical, and sexual.
- **Endocrine Disruptors:** Although this cause still requires substantial research, it is a valid hypothesis regarding how phthalates found in plastics can create an imbalance of testosterone in fetuses during gestation, which can potentially lead to gender dysphoria. The authors point to one study that makes this suggestion.

[5] Research on neuroanatomical etiology for gender dysphoria remains highly speculative due to limitations of brain imaging (Mayer and McHugh, 2016). In addition, neuroscience demonstrates that exposures to certain environments and stimuli as well as behaviors can affect brain changes (Gu, 2014). Furthermore, available research indicates that male and female brains have different physical characteristics but cannot be placed in separate categories due to extensive overlap of white/grey matter and neural connections (Joel et al, 2015).

Saleem and Rizvi's review reveal that gender dysphoria's etiology can have multiple factors, most of which require treatments and therapies not consisting of cross-sex hormones or surgery. (Saleem and Rizvi, 2017).

Out of the research on the condition's etiology, a large portion focuses on the correlation with ASD. One of the more substantial studies by Van der Miesen et al published in 2018 evaluates 573 adolescents and 807 adults diagnosed with ASD and compares them to 1016 adolescents and 846 adults from the general population. The authors' findings note that adolescents and adults with ASD were approximately 2.5 times more likely to indicate a desire of becoming the opposite sex. Although the methodology used to reach this conclusion consisted of surveys where respondents had a choice of answering "never," "sometimes," or "often," the results correspond with those of similar studies. Van der Miesen et al also indicate that most responses favoring a change in gender responded with "sometimes." Additionally, the authors do not state how many in their sample group actually had a gender dysphoria diagnosis. (Van der Miesen et al, 2018).

Another study by Shumer et al from 2016 utilizes a smaller sample size (39 adolescents) referred to an American hospital's gender clinic. Unlike Van der Miesen et al's research, Shumer et al evaluate subjects with a diagnosis of gender dysphoria for possible signs of ASD or Asperger's syndrome. Their findings revealed that 23% of patients presenting at the clinic would likely have one of the two conditions. Possible explanations for the high percentage are the methods used to gather the data. Shumer et al requested a clinical psychologist to administer the Asperger Syndrome Diagnostic Scale to the parents of the sample patients, four of whom already had an ASD diagnosis. The authors conclude that the evidence to support high incidence of gender dysphoria in individuals with ASD is growing and that further research is needed to determine the specific cause (Shumer et al, 2016).

Research indicating a strong correlation between ASD and gender dysphoria is not the only area where new studies are emerging. Discussions about the effects of prenatal testosterone levels are also becoming more prevalent. One such example is Sadr et al's 2020 study that looks at the lengths of the index and ring fingers (2D:4D) of both left and right hands of 203 individuals diagnosed with gender dysphoria. The authors used this method because prenatal testosterone levels can affect the length ratios of 2D:4D. By comparing the ratios of a group with gender dysphoria to a cohort from the general population, Sadr et al could assess for any significant difference. Their results indicated a difference in trans-females who presented with more feminized hands. For trans-males, the difference was less pronounced. The results for both groups were slight, and the meta-analysis that accompanies the study notes no statistically significant differences in multiple groups from across cultures. However, Sadr et al further assert that the evidence strongly suggests elevated prenatal testosterone levels in girls and reduced amounts in boys may contribute to gender dysphoria, requiring additional research (Sadr et al, 2020).

In addition to biological factors and correlations with ASD, researchers are exploring psychological and social factors to assess their role in gender dysphoria etiology. This literature examines a range of potential causative agents, including child abuse, trauma, and peer group influences. One such study by Kozlowska et al from 2021 explores patterns in children with high-risk attachment issues who also had gender dysphoria. The authors wanted to assess whether past incidents of abuse, loss, or trauma are associated with higher rates of persons desiring to transition. As a basis, Kozlowska et al cite John Bowlby's research on childhood brain development, noting that the process is not linear and depends

heavily on lived experiences. The study further acknowledges that biological factors combined with life events serve as the foundation for the next developmental phase and that early poor-quality attachment issues increase the risk for psychological disorders in adolescence and adulthood. Such disorders include mood and affective disorders, suicidal ideations, and self-harm. Kozlowska et al also cite other studies that indicate a high correlation between gender dysphoria and "adverse childhood events" and further assert that the condition "needs to be conceptualized in the context of the child's lived experience, and the many different ways in which lived experience is biologically embedded to shape the developing brain and to steer each child along their developmental pathway" (Kozlowska et al, 2021).

For their study, Kozlowska et al recruited 70 children diagnosed with gender dysphoria and completed family assessments going back three generations. This in-depth level was necessary to ascertain any and all events that could affect a child's developmental phases. Additionally, the researchers individually assessed the diagnosed children. To establish comparisons, Kozlowska et al performed assessments on a non-clinical group and a mixed-psychiatric group. Their results demonstrate that children with gender dysphoria have significantly higher rates of attachment issues as well as increased reports of "adverse childhood events" such as trauma (e.g., domestic violence and physical abuse). Furthermore, the authors indicate that a high proportion of families reported "instability, conflict, parental psychiatric disorder, financial stress, maltreatment events, and relational ruptures." These results led Kozlowska et al to conclude that gender dysphoria can be "associated with developmental pathways – reflected in at-risk patterns of attachment and high rates of unresolved loss and trauma – that are shaped by disruptions to family stability and cohesion." The study also cites that treatment requires "a comprehensive biopsychosocial assessment with the child and family, followed by therapeutic interventions that address, insofar as possible, the breadth of factors that are interconnected with each particular child's presentation" (Kozlowska et al, 2021).

This recent study raises questions regarding the medical necessity of gender dysphoria treatments such as puberty blockers and cross-sex hormones for adolescents. If high percentages of children diagnosed with gender dysphoria also have histories of trauma and attachment issues, should conventional behavioral health services be utilized without proposing treatments that pose irreversible effects? Would that approach not provide additional time to address underlying issues before introducing therapies that pose permanent effects (i.e., the watchful waiting approach)?

Aside from the notion that childhood abuse and adversity can potentially cause gender dysphoria, other possible explanations such as social factors (e.g., peer influences and media) may be contributing factors. Research on rapid onset gender dysphoria (ROGD) links this phenomenon to peer and social elements. In an analysis utilizing parent surveys, Lisa Littman asserts that the rapid rise of ROGD is not associated with the traditional patterns of gender dysphoria onset (i.e., evidence of an individual's gravitation to the opposite sex documented over multiple years) but rather exposure to "social and peer contagion." Littman uses this term in the context of definitions cited in academic literature, stating that "social contagion is the spread of affect or behaviors through a population" and that "peer contagion is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially undermine their own development or harm others." Examples of the latter's negative effects include depression, eating disorders, and substance abuse. What prompted this study is a sudden increase of parents reporting their daughters declaring themselves to be transgender without any previous signs of gender dysphoria. Littman also indicates

that these parents cite that their daughters became immersed in peer groups and social media that emphasized transgender lifestyles (Littman, 2018).

In addition to identifying characteristics of ROGD, the study examines social media content that provides information to adolescents regarding how to obtain cross-sex hormones through deception of physicians, parents, and behavioral health professionals. Such guidance includes coaching on how to fit a description to correspond to the DSM-V and pressures to implement treatment during youth to avoid a potential lifetime of unhappiness in an undesirable body. Littman further states that "online content may encourage vulnerable individuals to believe that non-specific symptoms and vague feelings should be interpreted as gender dysphoria." The study also notes that none of the individuals assessed using the parental surveys qualified for a formal diagnosis using the DSM-V criteria (Littman, 2018).

The survey responses revealed similar data to Kozlowska et al's study with 62.5% of the adolescents having a mental health or neurodevelopmental disorder. Furthermore, the responses indicate a rapid desire to bypass behavioral health options and pursue cross-sex hormones. 28.1% of parents surveyed stated that their adolescents did not want psychiatric treatments. One parent even reported that their daughter stopped taking prescribed anti-depressants and sought advice only from a gender therapist. Littman's research further reveals that 21.2% of parents responded that their adolescent received a prescription for puberty blockers or cross-sex hormones at their first visit (Littman, 2018). These responses indicate that practitioners do not uniformly follow clinical guidelines when making diagnoses or prescribing treatment.

In the discussion, Littman proposes two hypotheses for the appearance of ROGD. The first states that social and peer contagion is one of the primary causes, and the second asserts that ROGD is a "maladaptive coping mechanism" for adolescents dealing with emotional and social issues. While the surveyed parents did not report early signs of gender dysphoria, a majority noted that their daughters had difficulty in handling negative emotions. Littman concludes that ROGD is distinct from gender dysphoria as described in the DSM-V and that further research is needed to assess whether the condition is short or long-term (Littman, 2018). What the study does not explore, but raises the question, is what proportion of those being treated for gender dysphoria are adolescents with ROGD.

Littman's study along with the others reveal that the causes of gender dysphoria are still a mystery and could have multiple biological and social elements. Because of this ongoing uncertainty, treatments that pose irreversible effects should not be utilized to address what is still categorized as a mental health issue. That allows adequate opportunity for individuals to receive treatment for co-existing mental disorders, establish their gender dysphoria diagnoses, and understand how cross-sex hormones and surgery will alter the appearance of their bodies as well as long-term health.

Literature Review: Desistance of Gender Dysphoria and Puberty Suppression

The World Professional Association for Transgender Health (WPATH) and the Endocrine Society both endorse the use of gonadotropin releasing hormones (Gn-RH) to suppress puberty in young adolescents who have gender dysphoria. Both organizations state that the treatment is safe and fully reversible. In addition, they state that delaying pubertal onset can provide extra time for adolescents to explore the gender in which they choose to live. The associations further state that puberty suppression is necessary to prevent the development of primary and secondary sexual characteristics that can inhibit successful transitions into adulthood (WPATH, 2012; Endocrine Society, 2017). Of the two groups, WPATH offers clinical criteria an individual should meet to qualify for puberty suppression such as addressing psychological co-morbidities and assessing whether gender dysphoria has intensified (WPATH, 2012).

Neither organization explains that the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex and that the puberty suppression can have side effects. Both organizations neglect to mention that using Gn-RH for gender dysphoria by altering the appearance is not an FDA-approved clinical indication. Furthermore, the research used to justify puberty suppression is low or very-low quality and little information is available on long-term effects (Hruz, 2019). Additionally, in his assessment, Quentin Van Meter explained that physical differences between central precocious puberty and natural onset puberty demonstrate that Gn-RH does not have permanent adverse effects for those treated for the former but can for the latter such as insufficient bone-mineral density and neural development (Van Meter, 2022). Also, as recently as May 17, 2022, during a U.S. Senate Committee on Appropriations hearing, Lawrence Tabak, acting director of the National Institutes of Health, responded to Senator Marco Rubio, acknowledging that no long-term studies are available evaluating the effects of puberty blockers when used for gender dysphoria (U.S. Senate Committee on Appropriations, 2022).

Currently, some studies provide weak support for this treatment but leave too many questions as to its effectiveness and medical necessity, especially considering how many children decide against transitioning. In addition, puberty blockers halt development of primary and secondary sexual characteristics and deny opportunities for adolescents to adapt and become comfortable with their natal sex. Instead, puberty blockers can serve as a potential “gateway drug” for cross-sex hormones by denying them the experience of physically maturing (Laidlaw et al, 2018).

A 2013 study by Steensma et al offers data on the percentage of children who opt not to transition after experiencing gender dysphoria. The authors follow 127 adolescents (mean age of 15 during the evaluation period) for four years who had been referred to a Dutch gender dysphoria clinic. Out of this cohort, 47 (37%; 23 boys and 24 girls) continued experiencing the condition and applied for sex reassignment treatment. The other 80 adolescents never returned to the clinic. Because this clinic was the only one that treated gender dysphoria in the Netherlands, Steensma et al assumed that those who did not return no longer desired transitioning. The study indicates one of the key predictors for persisting gender dysphoria was the age of first presentation. Older adolescents that started going to the clinic were more likely to persist, while younger adolescents tended not to follow through. Steensma et al provide further insight into other predicting factors, particularly on how each individual views his or her gender identity. The authors note that adolescents who “wished they were the other sex” were more likely to become desisters and that those who “believed that they were the other sex” persisted

and later sought sex reassignment treatment (Steensma et al, 2013). While the study focuses on factors that contribute to the condition's persistence or desistance, it raises the question as to whether puberty suppression is necessary when age plays such an important role regarding the decision to transition.

WPATH and the Endocrine Society state that the primary reason for initiating pubertal suppression is not to treat a physical condition but to improve the mental health of adolescents with gender dysphoria. However, available research does not yield definitive results that this method is effective at addressing a mental health issue. The "gold standard" for medical studies is the randomized-controlled trial (RCT). Because RCTs utilize large sample sizes, have blind testing groups (i.e, placebos), and use objective controls, they can offer concrete conclusions and shape the array of established treatments. In addition, RCTs require comparisons between cohort outcomes and ensure that participants are randomly assigned to each group. These measures further reduce the potential for bias and subjectivity (Hariton and Locascio, 2018).

Presently, no RCTs that evaluate puberty suppression as a method to treat gender dysphoria are available. Instead, the limited number of published studies on the topic utilize small sample sizes and subjective methods (Hruz, 2019). A 2015 article by Costa et al is one such example. The study asserts that "psychological support and puberty suppression were both associated with an improved global psychological functioning in gender dysphoric adolescents." To reach this conclusion, the authors selected 201 children diagnosed with the condition and divided them into two groups, one to receive psychological support only and the other to get puberty blockers in addition to psychological support. Costa et al did not create a third group that lacked a gender dysphoria diagnosis to serve as a control. To assess whether puberty suppression is an effective treatment, the authors administered two self-assessments (Utrect Gender Dysphoria Scale and Children's Global Assessment Scale)[6] to the groups at 6-month intervals during a 12-month period. Because the study relies heavily on self-assessments, the conclusions are likely biased and invalid. Another problem that is also present and common throughout articles supporting puberty suppression is the short-term period of the study. Costa et al's conclusions may not be the same if additional follow-ups occurred three or five years later (Costa et al, 2015). This further raises the question whether low-quality studies like Costa et al's should serve as the basis for clinical guidelines advising clinicians to prescribe drugs for off-label purposes.

Aside from questionable research, information regarding the full physical effects of puberty suppression is incomplete. In a 2020 consensus parameter prepared by Chen et al, 44 experts in neurodevelopment, gender development, and puberty/adolescence reached a conclusion stating that "the effects of pubertal suppression warrant further study." The basis for this was that the "full consequences (both beneficial and adverse) of suppressing endogenous puberty are not yet understood." The participating experts emphasized that the treatment's impact on neurodevelopment in adolescents remains unknown. Chen et al explain that puberty-related hormones play a role in brain development as documented in animal studies and that stopping these hormones also prevents neurodevelopment in addition to sexual maturation. The authors further raise the question whether normal brain development resumes as if it had not been interrupted when puberty suppression ceases. Because this

[6] Behavioral health practitioners use the Children's Global Assessment Scale (CGAS) to measure child functioning during the evaluation process to determine diagnoses. Available evidence indicates that the CGAS is not effective for evaluating children who experienced trauma and presented with mental health symptoms (Blake et al, 2006).

question remains unanswered, it casts doubt on the veracity of organizations' assertions that puberty suppression is "fully reversible" (Chen et al, 2020).

In addition to the unanswered questions and low-quality research, puberty suppression causes side effects, some of which have the potential to be permanent. According to a 2019 literature review by De Sanctis et al, most side effects associated with Gn-RH are mild, consisting mostly of irritation around injection sites. However, clinicians have linked the drug to long-term conditions such as polycystic ovarian syndrome, obesity, hypertension, and reduced bone mineral density. While reports of these events are low and the authors indicate that Gn-RH is safe for treating central precocious puberty (Note: De Sanctis et al do not consider gender dysphoria in their analysis), the review raises questions about whether off-label use to treat a psychological condition is worth the risks (De Sanctis et al, 2019).

Furthermore, De Sanctis et al cite studies noting increased obesity rates in girls who take Gn-RH but that more research is needed to gauge the consistency. Additionally, the authors note that evidence is strong regarding reduced bone mineral density during puberty suppression but indicate that the literature suggests it is reversible following treatment (De Sanctis et al, 2019). While research leans toward the reversibility of effects on bone mineral density, the quantity of studies available on this subject are limited. Also, no long-term research has been completed on how puberty suppression affects bone growth. This is significant because puberty is when bone mass accumulates the most (Kyriakou et al, 2020). One example of a complication involving bone growth and Gn-RH is slipped capital femoral epiphysis. This condition occurs when the head of the femur (i.e., thighbone) can slip out of the pelvis, which can eventually lead to osteonecrosis (i.e., bone death) of the femoral head. Although the complication is rare, its link to puberty suppression indicates that the "lack of adequate sex hormone exposure" could be a cause (De Sanctis et al, 2019).

The current literature on puberty suppression indicates that using it to treat gender dysphoria is off-label, poses potentially permanent side effects, and has questionable mental health benefits. The limited research and lack of FDA approval for that clinical indication prompt questions about whether medications with physically altering effects should be used to treat a problem that most adolescents who experience it will later overcome by conforming to their natal sex. Additional evidence is required to establish puberty suppression as a standard treatment for gender dysphoria.

Literature Review: Cross-Sex Hormones as a Treatment for Gender Dysphoria

Currently, the debate surrounding the use of cross-sex hormones to treat gender dysphoria revolves around their ability to improve mental health without causing irreversible effects. It is not about whether taking cross-sex hormones can alter someone's appearance. The evidence demonstrating the effectiveness of cross-sex hormones in achieving the secondary sexual characteristics of the opposite sex is abundant. Also, the overall scientific consensus concludes that individuals who take cross-sex hormones will reduce the primary sexual function of his or her natal sex organs. What researchers continue evaluating are the short and long-term effects on mental health, impacts on overall physical health, and how the changes affect the ability to detransition. Of these, benefits to mental health overshadow the other discussions. Prescribers of cross-sex hormones focus so heavily on behavioral health outcomes that they de-emphasize that these drugs cause permanent physical changes and side effects that can lead to premature death (Hruz, 2020). Some clinical guidelines such as WPATH's do not even indicate that some of the changes are irreversible.

Like puberty suppression, the Endocrine Society and WPATH provide guidance on administering cross-sex hormones to individuals with gender dysphoria. Both organizations state that this treatment should not be administered without a confirmed diagnosis of gender dysphoria and only after a full psychosocial assessment. In addition, behavioral health practitioners must ensure that any mental comorbidities are not affecting the individual's desire to transition. WPATH and the Endocrine Society further state that clinicians should administer hormone replacements such as testosterone and Estradiol (estrogen) in gradual phases, where the dose increases over several months. For trans-females, the organizations state that progesterone (anti-androgen) is also necessary to block the effects of naturally produced testosterone (WPATH, 2012; Endocrine Society, 2017). When taking cross-sex hormones, trans-males need increased doses for the first six months. After that, the testosterone's effects are the same on lower doses. Once started, individuals cannot stop taking hormones unless they desire to detransition (Unger, 2016).

Although the two groups provide similar guidance, they vary on statements that can have significant impact on long-term outcomes, particularly regarding age. According to WPATH's standards, 16 years is the general age for initiating cross-sex hormones, but the organization acknowledges that the treatment can occur for younger individuals depending on circumstances (WPATH, 2012). This differs from the Endocrine Society, which states no specific age for appropriateness and explains the disagreements in assigning a number. The group highlights that most adolescents have attained sufficient competence by age 16 but may not have developed adequate abilities to assess risk (Endocrine Society, 2017). This raises the question whether adolescents can make sound decisions regarding their long-term health. Additionally, the varying guidance raises an issue with WPATH not only using age 16 as a standard but also indicating that younger adolescents are capable of making that choice.

WPATH's guidance also does not stress the irreversible nature of cross-sex hormones, citing the treatment as "partially reversible" and not indicating which changes are permanent. Furthermore, parts of WPATH's information are misleading and directly conflict with guidance issued by clinics and other sources. One such example consists of WPATH stating that "hormone therapy *may* (emphasis added) lead to irreversible changes." This statement is misleading in light of existing research, which indicates that multiple physical changes are permanent. In addition, WPATH claims that certain effects of cross-

sex hormones such as clitoral enlargement can last one to two years when it is actually irreversible (UCSF, 2020). WPATH also does not explain the risks to male fertility, noting that lowered sperm count or sterility is "variable." The University of California at San Francisco (UCSF) provides starkly different information by stating that trans-females should expect to become sterile within a few months of starting cross-sex hormones. UCSF also advises trans-females to consult a sperm bank if they may want to father children after transitioning (WPATH, 2012; UCSF, 2020). Below is a chart that outlines the effects of cross-sex hormones and identifies which ones are reversible or permanent.

Physical Changes Effectuated by Cross-Sex Hormones	
Physical Changes in Trans-Males (Female-to-Male Transitions)	
Physical Change	**Reversible or Irreversible**
Oily Skin or Acne	Reversible
Facial and Body Hair Growth	Irreversible
Male-Pattern Baldness	Irreversible
Increased Muscle Mass	Reversible
Body Fat Redistribution	Reversible
Ceasing of Menstruation	Reversible
Enlarged Clitoris	Irreversible
Vaginal Atrophy	Reversible
Deepening of Voice	Irreversible
Physical Changes in Trans-Females (Male-to-Female Transitions)	
Body Fat Redistribution	Reversible
Decreased Muscle Mass	Reversible
Skin Softening or Decrease in Oiliness	Reversible
Lower Libido	Reversible
Fewer Spontaneous Erections	Reversible
Male Sexual Dysfunction	Possibly Irreversible
Breast Growth	Irreversible
Decrease in Testicular Size	Reversible
Decrease in Sperm Production or Infertility	Likely Irreversible
Slower Facial and Body Hair Growth	Reversible

Sources: UCSF, 2020; WPATH, 2012; Endocrine Society, 2017[7]

The above chart demonstrates that trans-males and trans-females experience different effects from cross-sex hormones that can cause myriad issues in later life. For example, trans-males who opt to detransition may face challenges related to permanent disfigurement (e.g., facial hair and deepened voices). Trans-females, on the other hand, may not endure the same issues pertaining to visible physical changes but might become despondent over being unable to reproduce. This can occur regardless of whether the transitioning individual is satisfied with sex reassignment. Given that the clinical guidelines do not provide uniform information on the permanent effects of cross-sex hormones, clinicians are unable to make sound recommendations to patients. This treatment can supposedly alleviate symptoms

[7] This chart consists of conclusions regarding physical changes made by three different clinical organizations. If one organization determined that a physical change was irreversible, that was sufficient to meet the criteria to be listed as "irreversible" in the chart.

of distress. However, cross-sex hormones' permanent effects also have the potential to cause psychological issues.

Arguments favoring cross-sex hormones assert that the desired physical changes can alleviate mental health issues in individuals with gender dysphoria but do not consider that hormones used in this manner, like puberty blockers, are off-label. While the FDA has approved estrogen and testosterone for specific clinical indications (e.g., hypogonadism), it has not cleared these drugs for treating gender dysphoria. Additionally, these arguments do not acknowledge that the U.S. Drug Enforcement Administration (DEA) lists testosterone as a Schedule III controlled substance, meaning that it has a high probability of abuse (DEA, 2022). Furthermore, evidence of psychological benefit from cross-sex hormones is low-quality and relies heavily on self-assessments taken from small sample groups (Hruz, 2020).

A 2019 study by Kuper et al seeks to demonstrate that adolescents desiring cross-sex hormones have elevated rates of depression, anxiety, and challenges with peer relationships. To make their findings, the authors provided questionnaires to 149 adolescents who presented at a gender clinic in Dallas, Texas and concluded that half of the sample group experienced increased psychological issues. One problem with the study is that it relies on parent or self-assessments such as the Youth-Self Report, Body-Image Scale, and the Child Behavior Checklist. While these assessments have strong reliability, the sample is cross-sectional, consisting of gender dysphoric individuals who presented for an initial visit at the clinic. Also, Kuper et al do not directly link these psychological symptoms to gender dysphoria but rather insinuate a strong connection. Without an analysis of the longitudinal histories of the participants, the study cannot demonstrate whether gender dysphoria was a direct cause of the psychological issues, which could possibly result from trauma, abuse, or family dysfunction. Kuper et al's study only presents weak correlation between adolescents who report symptoms of distress and gender dysphoria. While the authors do not claim that the participants' psychological problems caused the condition, they fail to explicitly state that no demonstrable relationship exists and explain that their findings are "broadly consistent with the previous literature" (Kuper et al, 2019).

Additionally, a more comprehensive literature review from 2019 by Nguyen et al evaluates the effect of cross-sex hormones on mental health outcomes. Although the authors argue that the evidence supports the treatment, they do note that available studies use "uncontrolled observational methods" and "rely on self-report." The review also asserts that "future research should focus on applying more robust study designs with large sample sizes, such as controlled prospective cohort studies using clinician-administered ratings and longitudinal designs with appropriately matched control groups." All of these are characteristics of RCTs. While Nguyen et al highlight flaws in the studies in their conclusion, they do not emphasize them in their analysis, opting to focus primarily on results. Another problem with the studies selected for the review is the short-term periods for evaluation. Out of 11 studies Nguyen et al discuss, only one tracks its participants for 24 months. The others only follow their cohorts for 6 or 12 months (Nguyen et al, 2019). Without long-term data to support assertions that cross-sex hormones substantially improve the mental health of individuals with gender dysphoria, the review cannot make definitive conclusions on the treatment's benefits.

Basing their stances on this low-quality evidence, clinical associations such as the American Academy of Pediatrics (AAP) and the American Psychology Association endorse the use of cross-sex hormones as treatments for gender dysphoria. In particular, the AAP discourages use of the term "transition" and

asserts that medical treatments used to obtain secondary characteristics of the opposite sex are "gender affirming." This decision mirrors the DSM-V's interpretation of gender being part of identity. The AAP further states that taking cross-sex hormones is an "affirmation and acceptance of who they (i.e., patient) have always been" (AAP, 2018). The American Psychological Association also takes a similar stance in its *Resolution on Gender Identity Change Efforts* by asserting that medical treatments such as puberty suppression, cross-sex hormones, and surgery improve mental health and quality of life and reinforce the notion that transitioning and seeking sex reassignment therapies do not constitute a psychological disorder (American Psychological Association, 2021). Stances like these can substantially influence practitioners and their treatment recommendations. Given that low-quality evidence serves as the basis for supportive positions, this raises questions about whether clinicians can make informed decisions for their patients that will promote the best outcomes.

James Cantor published a critique in 2020 of the AAP's endorsement of "gender affirming" treatments, arguing that the organization did not base its recommendations on established medical evidence. He asserts that the AAP's position is based on research that does not support intervention but rather supports "watchful waiting" because most transgender youths desist and identify as their natal sex during puberty. Cantor further argues that the AAP not only disregards evidence but also cites "gender affirming" interventions as the only effective method. To conclude, he states the organization is "advocating for something far in excess of mainstream practice and medical consensus" (Cantor, 2020).

Given those evidentiary problems, those who rely on the AAP's endorsement as a basis for "gender affirming" treatments are practicing eminence-based medicine as opposed to evidence-based medicine. Eminence-based medicine refers to clinical decisions made by relying on the opinions of prominent health organizations rather than relying on critical appraisals of scientific evidence (Nhi Le, 2016). While it is true that the AAP has more knowledge than a lay person and a degree of credibility in the medical community, the opinions of such organizations are not valid unless they are based on quality evidence.

Research on sex reassignment also does not adequately address the reasons for and prevalence of detransitioning. Although no definite numbers are available regarding the percentage of transgender people who decide to detransition, research indicates that roughly 8% decide to return to their natal sex. The reasons range from treatment side effects to more self-exploration that provided insight on individuals' gender dysphoria. In a 2020 study by Lisa Littman, 101 people who had detransitioned provided their basis for doing so. Out of the sample group, 96% had taken cross-sex hormones and 33% had sex reassignment surgery. The average age for transitioning was 22 years, and the mean duration for the transition was 4 years. This indicates that even allowing additional time beyond the recommended age of 16 years can still lead to regrets. The study also raises the question as to whether individuals who transitioned at 16 or younger wanted to detransition in greater numbers. The author further offers reasons why these individuals sought cross-sex hormones and surgery, which include having endured trauma (mental or sexual), homophobia (challenged to accept oneself as a homosexual), peer and media influences, and misogyny (applicable only to trans-males). To obtain the results, the participants responded to a survey that asked about their backgrounds (e.g., reasons for transitioning, mental health comorbidities), and motivations for detransitioning. Littman noted that half of the women (former trans-males) had a mental health disorder and/or had experienced trauma within a year of deciding to transition. Men (former trans-females) reported much lower numbers of behavioral health issues and trauma after de-transitioning. Additionally, 77% of men surveyed identified as the opposite gender prior to transition, whereas just 58% of women had (Littman, 2020).

Of the reasons cited for detransitioning, the majority (60%) noted that they became more comfortable with their natal sex. Other reasons included concerns over complications from the treatments, primarily cross-sex hormones, and lack of improved mental health. Other less-cited explanations include concerns about workplace discrimination and worsening physical health. The study also notes that approximately 36% of participants experienced worse mental health symptoms. Based on the findings, Littman concludes that more research is needed in tracking the transgender population to obtain accurate percentages of those who decide to detransition and that men and women reported varying reasons for deciding to transition and later return to their natal sex. The author notes that higher rates of trauma and peer group influences might have contributed to women's decisions, which Littman attributes partially to rapid onset gender dysphoria (Littman, 2020). What the study also indicates is that cross-sex hormones are not a validated treatment for gender dysphoria. Nearly all of the participants had taken them and decided against maintaining the physical changes. Given that the majority of surveyed detransitioners cited that they were comfortable with their biological sex, the study indicates that gender dysphoria is not necessarily a lifelong issue. This necessarily raises doubts about whether cross-hormones, which cause permanent physical damage, is justified.

In addition to the psychological factors, cross-sex hormones pose significant long-term health risks to transitioning individuals. Currently, little information is available given that researchers have not had adequate time to study the effects in this population. However, use of hormones for other conditions has yielded data on how these drugs can affect the body and the cardiovascular system in particular. Because of the high dosages required to achieve physical change and the need to continuously take the drugs, cross-sex hormones can potentially harm quality of life and reduce life expectancy for transitioning individuals. According to Dutra et al, trans-females are three times more likely to die from a cardiovascular event than the general population. In their 2019 literature review, Dutra et al examined the results of over 50 studies evaluating the effects of cross-sex hormones on not only transgender individuals but those with menopause and other endocrine disorders, all of which indicate that use of estrogen or testosterone can increase risks for cardiovascular disease. Throughout their review, Dutra et al cite examples of trans-females having higher triglyceride levels after 24 months of cross-sex hormones and how researchers halted a study on estrogen due to an increase in heart attacks among participants. Another article the authors reference indicates a higher risk for thromboembolisms (i.e., blood clots) in trans-females. For trans-males, Dutra et al explain that research shows significant increased risk for hypertension, high cholesterol, obesity, and heart attacks. One study noted that trans-males have a four times greater risk of heart attack compared to women identifying as their natal sex. Dutra et al conclude that most transgender individuals are younger than 50 and that more studies are needed as this population ages. They do note that available studies indicate that cross-sex hormones pose dangers to long-term cardiovascular health (Dutra et al, 2019).

In sum, the literature reveals that the evidence for cross-sex hormones as a treatment for gender dysphoria is weak and insufficient. Between the permanent effects, off-label use, and consequences to long-term health, cross-sex hormones are a risky option that does not promise a cure but does guarantee irreversible changes to both male and female bodies. Additionally, the inadequate studies serving as the basis for recommendations by clinical associations can lead to providers making poorly informed decisions for their patients. Research asserting that taking cross-sex hormones improves mental health is subjective and short-term. More studies that utilize large sample sizes and appropriate

methods is required before the medical profession should consider cross-sex hormones as one of gender dysphoria's standard treatments.

Literature Review: Sex Reassignment Surgery

The final phase of treatment for gender dysphoria is sex reassignment surgery. This method consists of multiple procedures to alter the appearance of the body to resemble an individual's desired gender. Some procedures apply to the genitals (genital procedures) while others affect facial features and vocal cords (non-genital procedures). While the surgery creates aesthetical aspects, it does not fully transform someone into the opposite biological sex. Transgender persons who undergo the procedures must continue taking cross-sex hormones to maintain secondary sexual characteristics. Additionally, all physical changes are irreversible, and the success rate of a surgery varies depending on the procedure and the population. For example, surgeries for trans-females have much better results than those for trans-males. Complications such as post-operative infections can also arise with the urinary tract system. However, sex reassignment surgery supposedly can provide drastic, if not complete, relief from gender dysphoria (Endocrine Society, 2017). The following is a list of procedures (both genital and non-genital) for trans-females and trans-males that create physical features of the desired sex.

Procedures for Trans-Females

- **Genital Surgeries:** These consist of penectomy (removal of the penis), orchiectomy (removal of the testicles), vaginoplasty (construction of a neo-vagina), clitoroplasty (construction of a clitoris), and vulvoplasty (construction of a vulva and labia). To perform, a surgeon begins by deconstructing the penis and removing the testicles. The penile shaft and glans are repurposed to serve as a neo-vagina and artificial clitoris (Note: These are not actual female genitalia but tissue constructed to resemble female anatomy). If the shaft tissue is insufficient, the surgeon may opt to use a portion of intestine to build a neo-vagina. The scrotum serves as material for fashioning a vulva and labia. In addition to constructing female genitalia, the surgeon reroutes the urethra to align with the neo-vagina. Genital surgeries for trans-females result in permanent sterility (Bizic et al, 2014).
- **Chest Surgery:** To attain full breasts, trans-females can undergo enlargement. The procedure is similar to breast augmentation for women where a surgeon places implants underneath breast tissue. Prior to surgery, trans-females need to take cross-sex hormones for roughly 24 months to increase breast size to get maximum benefit from the procedure (Endocrine Society, 2017).
- **Cosmetic and Voice Surgeries:** Designed to create feminine facial features, fat deposits, and vocal sounds, these procedures are secondary to genital procedures and intended to alter trans-females' appearances to better integrate into society as a member of the desired gender (WPATH, 2012).

Procedures for Trans-Males

- **Mastectomy:** This is the most performed sex reassignment surgery on trans-males because cross-sex hormones and chest-binding garments are often insufficient at diminishing breasts. To remove this secondary sexual characteristic, trans-males can undergo a mastectomy where a surgeon removes breast tissue subcutaneously (i.e., under the skin) and reconstructs the nipples to appear masculine. The procedure can result in significant scarring (Monstrey et al, 2011).
- **Genital Surgeries:** Unlike the procedures for trans-females, genital surgeries for trans-males are more complex and have lower success rates. Consisting of hysterectomy, oophorectomy

(removal of the ovaries), vaginectomy (removal of the vagina), phalloplasty (construction of a penis), and scrotoplasty (construction of prosthetic testicles), a team of surgeons must manufacture a penis using skin from the patient (taken from an appendage) while removing the vagina and creating an extended urethra. The functionality of the artificial penis can vary based on how extensive the construction was. Attaining erections requires additional surgery to implant a prosthesis, and the ability to urinate while standing is often not achieved. Genital procedures for trans-males result in irreversible sterility (Monstrey et al, 2011).

- **Cosmetic Surgeries:** Similar to trans-females, these procedures create masculine facial features, fat deposits, and artificial pectoral muscles. They aid trans-males with socially integrating as their desired gender. Surgery to deepen voices is also available but rarely performed (WPATH, 2012).

Because sex reassignment surgery is irreversible, the criteria for receiving these procedures is the strictest of all gender dysphoria treatments. WPATH and the Endocrine Society suggest rigorous reviews of patient history and prior use of other therapies before approving. Furthermore, the two organizations recommend that only adults (18 years old) undergo sex reassignment surgery.[8] WPATH and the Endocrine Society also recommend ensuring a strongly documented diagnosis of gender dysphoria, addressing all medical and mental health issues, and at least 12 months of cross-sex hormones for genital surgeries. Although the organizations agree on most criteria, they differ on whether hormones should be taken prior to mastectomies. WPATH asserts that hormones should not be a requirement, whereas the Endocrine Society advises up to 2 years of cross-sex hormones before undergoing the procedure (WPATH, 2012; Endocrine Society, 2017). What this indicates is that trans-males might undergo breast removal without having first pursued all options if their clinician adheres to WPATH's guidelines, which can lead to possible regret over irreversible effects.

As with cross-sex hormones, sex reassignment surgery's irreversible physical changes can potentially show marked mental health improvements and prevent suicidality in people diagnosed with gender dysphoria. In April 2022, the chair of the University of Florida's pediatric endocrinology department, Dr. Michael Haller, advocated for the benefits of "gender affirming" treatments (WUSF, 2020). However, the available evidence calls such statements into question. Recent research assessing both cross-sex hormones and sex reassignment surgery indicate that the effects on "long-term mental health are largely unknown." In studies regarding the benefits of surgery, the results have the same weaknesses as the research for the effectiveness of cross-sex hormones. These include small sample sizes, self-report surveys, and short evaluation periods, all of which are insufficient to justify recommendations for irreversible treatments (Bränström et al, 2020).

Two studies conducted in Sweden provide insight on the effectiveness of sex reassignment surgery in improving the behavioral health of transgender persons. Because Sweden has a nationalized health system that collects data on all residents, this country can serve as a resource to assess service utilization and inpatient admissions. Both studies, one by Dhejne et al from 2011 and another by Bränström et al published in 2020, assessed individuals who had received sex reassignment surgery and examined outcomes over several decades. Dhejne et al's findings indicate that sex reassignment

[8] Although practice guidelines indicate the minimum age to undergo sex reassignment surgery is 18, available evidence demonstrates that mastectomies have been performed on adolescent girls as young as 13 who experience "chest dysphoria" (Olson-Kennedy et al, 2018).

procedures do not reduce suicidality. The authors explained that individuals who underwent sex reassignment surgery were still more likely to attempt or commit suicide than those in the general population. This study is unique because it monitored the subjects over a long period of time. Dhejne et al note that the transgender persons tracked for the study did not show an elevated suicide risk until ten years after surgery (Dhejne et al, 2011). Given that a high proportion of research follows sex reassignment patients for much shorter timeframes, this evidence indicates that surgery might have little to no effect in preventing suicides in gender dysphoric individuals over the long run.

In addition to having an increased suicide risk, Dhejne et al discuss how individuals who underwent sex reassignment procedures also had higher mortality due to cardiovascular disease. The authors do not list the specific causes but establish the correlation. Given that cross-sex hormones can damage the heart, the increased risk could be related to the drugs and not the surgery. Furthermore, the study explains that the tracked population had higher rates of psychiatric inpatient admissions following sex reassignment. Dhejne et al established this by examining the rates of psychiatric hospitalizations in these individuals prior to surgery and noted higher utilization in the years following the procedures. These results are in comparison to the Swedish population at large. While the study contradicts other research emphasizing improvements in mental health issues, it has its limitations. For example, the sample size is small. Dhejne et al identified only 324 individuals who had undergone sex reassignment surgery between 1973 and 2003. In addition, the authors noted that while the tracked population had increased suicide risks when compared to individuals identifying as their natal sex, the rates could have been much higher if the procedures were not available (Dhejne et al 2011). What this study postulates is that sex reassignment surgery does not necessarily serve as a "cure" to the distress resulting from gender dysphoria and that ongoing behavioral health care may still be required even after a complete transition.

Bränström et al's study evaluating the Swedish population used a larger sample (1,018 individuals who had received sex reassignment surgery) but tracked them for just a ten-year period (2005 to 2015).[9] Unlike Dhejne et al, the authors did not track suicides and focused primarily on mood or anxiety disorder treatment utilization. Their results indicate that transgender persons who had undergone surgery utilized psychiatric outpatient services at lower rates and were prescribed medications for behavioral health issues at an annual decrease rate of 8%. Bränström et al also did not limit comparisons to Sweden's overall population and factored in transgender persons who take cross-sex hormones but have not elected to have surgery. Those results still presented a decrease in outpatient mental health services. However, Bränström et al note that individuals only on cross-sex hormones showed no significant reduction in that category, which calls into question claims regarding effectiveness of cross-sex hormones in ameliorating behavioral issues.

The Bränström et al study prompted numerous responses questioning its methodology. The study lacked a prospective cohort or RCT design, and it did not track all participants for a full ten-year period (Van Mol et al, 2020). These criticisms resulted in a retraction, asserting that Bränström et al's conclusions were "too strong" and that further analysis by the authors revealed that the new "results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related

[9] Although Bränström et al claim to follow individuals for a ten-year period, peer reviews of the research revealed that this was not the case, noting the authors had varying periods of tracking, ranging from one to ten years (Van Mol et al, 2020).

health care visits or prescriptions or hospitalizations following suicide attempts in that comparison" (Kalin, 2020).

There are multiple explanations for why the Bränström et al study reached different results than the Dhejne et al study. For starters, Bränström et al tracked a larger sample group over a later period (2005 to 2015 as opposed to 1973 to 2003) during which gender dysphoria underwent a dramatic shift in definition. Also, Dhejne et al did not see elevated suicides until after ten years, raising the question as to whether sex reassignment surgery has temporary benefits on mental health rather than long-term or permanent benefits. Like the other Swedish study, Bränström et al's findings are a correlation and do not specifically state that the procedures cause reduced psychiatric service utilization (Bränström et al, 2020).

A 2014 study by Hess et al in Germany evaluated satisfaction with sex reassignment procedures by attempting to survey 254 trans-females on their quality of life, appearance, and functionality as women. Out of the participants selected, only 119 (47%) returned completed questionnaires, which Hess et al indicate is problematic because dissatisfied trans-females might not have wanted to provide input. The results from the collected responses noted that 65.7% of participants reported satisfaction with their lives following surgery and that 90.2% indicated that the procedures fulfilled their expectations for life as women. While these results led Hess et al to conclude that sex reassignment surgery generally benefits individuals with gender dysphoria, the information is limited and raises questions (Hess et al, 2014). Such questions include whether the participants had mental health issues before or after surgery and did their satisfaction wane over time. Hess et al only sent out one questionnaire and not several to ascertain consistency over multiple years. Questions like these raise doubts about the validity of the study. Although Hess et al's research is just one study, numerous others utilize the same subjective methods to reach their conclusions (Hruz, 2018).

In his assessment, Patrick Lappert contributes additional insight on the appropriate clinical indications for mastectomies, noting that removal of breast tissue is necessary following the diagnosis of breast cancer or as a prophylactic against that disease. He cites that this basis is verifiable through definitive laboratory testing and imaging, making it an objective diagnosis, whereas gender dysphoria has no such empirical methods to assess and depends heavily on the patient's perspective. Also, Lappert notes that trans-males who make such decisions are doing so on the idea that the procedure will reduce their dysphoria and suicide risk. However, they are making an irreversible choice based on anticipated outcomes supported only by weak evidence, and thus cannot provide informed consent (Lappert, 2022).

The literature is inconclusive on whether sex reassignment surgery can improve mental health for gender dysphoric individuals. Higher quality research is needed to validate this method as an effective treatment. This includes studies that obtain detailed participant histories (e.g., behavioral diagnoses) and track participants for longer periods of time. These are necessary to evaluate the full effects of treatments that cause irreversible physical changes. In addition, sex reassignment procedures can result in severe complications such as infections in trans-females and urethral blockage in trans-males. Health issues related to natal sex can also persist. For example, trans-males who undergo mastectomy can still develop breast cancer and should receive the same recommended screenings (Trum et al, 2015). Until more definitive evidence becomes available, sex reassignment surgery should not qualify as a standard treatment for gender dysphoria.

Literature Review: Quality of Available Evidence and Bioethical Questions

Quality of Available Evidence

Clinical organizations that have endorsed puberty suppression, cross-sex hormones, and sex reassignment surgery frequently state that these treatments have the potential to save lives by preventing suicide and suicidal ideation. The evidence, however, does not support these conclusions. James Cantor notes that actual suicides (defined as killing oneself) are low, occur at higher rates for men, and that interpretations of available research indicate a blurring of numbers between those with gender dysphoria and homosexuals (Cantor, 2022). Although information exists that contradicts certain arguments, media outlets continue to report stories emphasizing the "lifesaving" potential of sex reassignment treatment. A May 2022 story by NBC announced survey results under the headline "Almost half of LGBTQ youths 'seriously considered suicide in the past year'" (NBC, 2022). This is a significant claim that can have a sensational effect on patients and providers alike, but how strong is the evidence supporting it? Almost all of the data backing this assertion are based on surveys and cross-studies, which tend to yield low-quality results (Hruz, 2018). In addition, how many gender dysphoric individuals are seeing stories in the media and not questioning the narrative? Because research on the effectiveness of treatments is ongoing, a debate persists regarding their use in the adolescent and young-adult populations, and much of it is due to the low-quality studies serving as evidence.

In their assessment, Romina Brignardello-Petersen and Wojtek Wiercioch examined the quality of 61 articles published between 2020 and 2022 (Note: See Attachment A for the full study). They identified research on the effectiveness of puberty blockers, cross-sex hormones, and sex reassignment surgery and assigned a grade (high, moderate, low, or very low) in accordance with the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. Out of the articles reviewed, all with a few exceptions received grades of low or very low quality when demonstrating outcomes regarding improvements in mental health and overall satisfaction with transitioning. For puberty blockers, Brignardello-Petersen and Wiercioch identified low quality evidence for alleviating gender dysphoria and very low quality for reducing suicidal ideation. The authors also had nearly identical findings for cross-sex hormones. However, they noted moderate quality evidence for the likelihood of cardiovascular side effects. Regarding surgery, Brignardello-Petersen and Wiercioch graded articles that examined overall satisfaction and complication rates. None of the studies received grades higher than low quality. These findings led the authors to conclude that "there is great uncertainty about the effects" of sex reassignment treatments and that the "evidence alone is not sufficient to support" using such treatments. Among the studies graded was one the U.S. Department of Health and Human Services cited in its information on "gender affirming" treatments. The authors noted this research had a "critical risk of bias" and was of low quality (Brignardello-Petersen and Wiercioch, 2022).

For his part, James Cantor provided a review of available literature, which addresses studies on etiology, desistance, effectiveness of puberty blockers and cross-sex hormones, suicidal behaviors, and clinical association and international guidelines. Throughout his analysis, Cantor cites weak evidence, poor methodologies (e.g., retrospective versus prospective studies), and lack of professional endorsements in research that indicates the benefits of sex reassignment treatment. Additionally, he notes that improvements in the behavioral health of adolescents who take cross-sex hormones can be attributed to the counseling they receive concurrently and that suicidality is not likely to result from gender

dysphoria but from co-occurring mental disorders. The reasoning behind the third point is based on the blending of suicide and suicidality, which are two distinct concepts. The former refers specifically to killing oneself, and the second regards ideation and threats in attempts to receive help. Cantor specifically notes that actual suicides are highly unlikely among gender dysphoric individuals, particularly trans-males. His other conclusions indicate that young children who experience gender identity issues will most likely desist by puberty, that multiple phenomena can cause the condition, and that Western European health services are not recommending medical intervention for minors. The basis for these statements is the paucity of high to moderate quality evidence on the effectiveness of sex reassignment treatments and numerous studies demonstrating desistance (Cantor, 2022).

Despite the need for stronger studies that provide definitive conclusions, many practitioners stand by the recommendations of the AAP, Endocrine Society, and WPATH. This is evident in a letter submitted to the *Tampa Bay Times*, which was a rebuttal to the Florida Department of Health's (DOH) guidance on treatment for gender dysphoria (Note: The guidance recommends against using puberty blockers, cross-sex hormones, or surgery for minors) (DOH, 2022). The authors, led by six professors at the University of Florida's College of Medicine, state that recommendations by clinical organizations are based on "careful deliberation and examination of the evidence by experts." However, evaluations of these studies show otherwise. Not only does the available research use cross-sectional methods such as surveys, but it provides insufficient evidence based on momentary snapshots regarding mental health benefits. These weak studies are the foundation for the clinical organizations' guidelines that the University of Florida professors tout as a gold standard. In addition, the letter's authors state that DOH's guidance is based on a "non-representative sample of small studies and reviews, editorials, opinion pieces, and commentary" (Tampa Bay Times, 2022). That statement misses the point when it comes to evidence demonstrating whether treatments with irreversible effects are beneficial because the burden of proof is on those advocating for this treatment, not on those acknowledging the need for further research. This raises the question concerning how much academic rigor these professors are applying to practice guidelines released by clinical organizations and whether they also apply the same level of rigor to novel treatments for other conditions (e.g., drugs, medical devices).

Another example of a lack of rigor is a 2019 article by Herman et al from the University of California at Los Angeles (UCLA) that evaluated responses to a 2015 national survey on transgender individuals and suicide. Unlike other studies, this one utilized a large cohort with 28,000 participants from across the U.S. responding. However, the researchers used no screening criteria and did not randomly select individuals. In addition, responses consisted entirely of self-reports with no supporting evidence to even prove a diagnosis of gender dysphoria. Although Herman et al conclude that the U.S. transgender population is at higher risk for suicidal behaviors, the authors' supporting evidence is subjective and serves as a weak basis. Additionally, the survey results do not establish gender dysphoria as a direct cause of suicide or suicidal ideation. The questions required participants to respond about their overall physical and mental health. Out of those that indicated "poor" health, 77.7% reported suicidal thoughts or attempts during the previous year, whereas just 29.1% of participants in "excellent" health had. These percentages indicate that causes beyond gender dysphoria could be affecting suicidal behaviors. Other reasons cited include rejection by family or religious organizations and discrimination. The authors also acknowledge that their findings are broad, not nationally representative, and should serve as a basis for pursuing future research (Herman et al, 2019).

Yet another example is a study published in 2022 by Olson et al tracks 300 young children that identify as transgender over a 5-year period, and asserts low probabilities for detransitioning, while supporting interventions such as puberty blockers. The authors found that children (median age of 8 years) who identified as a gender that differed from their natal sex were unlikely to desist at a rate of 94% and conclude that "transgender youth who socially transitioned at early ages" will continue "to identify that way." While this appears to contradict earlier studies that demonstrate most young adolescents who change gender identities return to their "assigned gender at birth," the authors note differences and limitations with the results. For example, Olson et al notes that they did not verify whether the participants met the DSM-V's diagnostic criteria for gender dysphoria and that the children's families supported the decisions to transition. Instead, the authors relied on a child's chosen pronouns to classify as transgender. Also, Olson et al acknowledged that roughly 66% of the sample was biologically male. This is particularly significant considering that the majority of transitioning adolescents in recent years were natal females. Another issue with the study includes the median age at the end of follow-up (13 years), which is when boys begin puberty. Furthermore, the authors cite that the participants received strong parental support regarding the transitions, which constitutes positive reinforcement (Olson et al, 2022). Other research demonstrates that such feedback on social transitioning from parents and peers can prevent desistance following pubertal onset (Zucker, 2019). Despite these limitations, the New York Times announced the study's publication under the headline "Few Transgender Children Change Their Minds After 5 Years" (New York Times, 2022). Such a title can add to the public's perception that gender dysphoria requires early medical intervention to address.

Bioethical Questions

The irreversible physical changes and potential side effects of sex reassignment treatment raise significant ethical questions. These questions concern multiple bioethical principles including patient autonomy, informed consent, and beneficence. In a 2019 article, Michael Laidlaw, Michelle Cretella, and Kevin Donovan argue that prescribing puberty blockers or cross-sex hormones on the basis that they will alleviate psychological symptoms should not be the standard of care for children with gender dysphoria. Additionally, the three authors assert that such treatments "constitute an unmonitored, experimental intervention in children without sufficient evidence of efficacy or safety." The primary ethical question Laidlaw, Cretella, and Donovan pose is whether pushing physical transitioning, particularly without parental consent, violates fully informed consent (Laidlaw et al, 2019).

In accordance with principles of bioethics, several factors must be present to obtain informed consent from a patient. These consist of being able to understand and comprehend the service and potential risks, receiving complete disclosure from the physician, and voluntarily providing consent. Bioethicists generally do not afford the ability of giving informed consent to children who lack the competence to make decisions that pose permanent consequences (Varkey, 2021). Laidlaw, Cretella, and Donovan reinforce this point regarding sex reassignment treatment when they state that "children and adolescents have neither the cognitive nor the emotional maturity to comprehend the consequences of receiving a treatment for which the end result is sterility and organs devoid of sexual function" (Laidlaw et al, 2019). This further raises the question whether clinicians who make such treatment recommendations are providing full disclosure about the irreversible effects and truly obtaining informed consent.

Another issue is the conflict between consumerism and the practitioner's ability to provide appropriate care. Consumerism refers to patients learning about treatments through media/marketing and requesting their health care provider to prescribe it, regardless of medical necessity. Considering that social media is rife with individuals promoting "gender affirmative" drugs and surgeries, children are making self-assessments based on feelings they may not understand and that can lead to deep regret in the future (Littman, 2018). This can contribute to patients applying pressure on their doctors to prescribe medications not proven safe or effective for the condition. Consumerism can also affect bioethical compliance because it constrains clinicians from using their full "knowledge and skills to benefit the patient," which is "tantamount to a form of patient abandonment and therefore is ethically indefensible" (Varkey, 2021).

In his assessment, G. Kevin Donovan explains the bioethical challenges related to sex reassignment treatment, emphasizing the lack of informed consent when administering these services. He asserts that gender dysphoria is largely a self-diagnosis practitioners cannot verify with empirical tests (e.g., labs and imaging) and that providing such treatments is experimental. Because of the lack of consent and off-label use of puberty blockers and cross-sex hormones, Donovan raises the question as to how "experienced and ethical physicians so mislead others or be so misled themselves?" He further attributes this phenomenon to societal and peer pressures that influence self-diagnosis and confirm decisions to transition. As a result, these pressures lead to individuals wanting puberty blockers, cross-sex hormones, and surgery. Donovan goes on to identify several news stories where embracing sex reassignment treatment is a "cult-like" behavior. To conclude, he links these factors back to the failure to obtain informed consent from transgender patients and how that violates basic bioethical principles (Donovan, 2022).

Coverage Policies of the U.S. and Western Europe

U.S. Federal Level Coverage Policies

Medicare: In 2016, the Centers for Medicare and Medicaid Services (CMS) published a decision memo announcing that Medicare Administrative Contractors (MACs) can evaluate sex reassignment surgery coverage on a "case-by-case" basis.[10] CMS specifically noted that the decision memo is not a National Coverage Determination and that "no national policy will be put in place for the Medicare program" (CMS, 2016). This memo was the result of CMS reviewing over 500 studies, reports, and articles to the validity of the procedures. Following its evaluation, CMS determined that "the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . small sample sizes, lack of validated assessment tools, and considerable (number of participants in the studies) lost to follow up." In 2017, CMS reinforced this position with a policy transmittal that repeated the 2016 memo's criteria (CMS, 2017).

The basis for Medicare's decision is that the "clinical evidence is inconclusive" and that "robust" studies are "needed to ensure that patients achieve improved health outcomes." In its review of available literature, CMS sought to answer whether there is "sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria." After evaluating 33 studies that met inclusion criteria, CMS's review concludes that "not enough high-quality evidence" is available "to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively." Additionally, out of the 33 studies, just 6 provided "useful information" on the procedures' effectiveness, revealing that their authors "assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies" that "did not demonstrate clinically significant changes or differences in psychometric test results" following sex reassignment surgery (CMS, 2016).

U.S. Department of Defense – Tricare: Tricare does not cover sex reassignment surgery, but it will cover psychological services such as counseling for individuals diagnosed with gender dysphoria and cross-sex hormones when medically necessary (Tricare, 2022).[11]

U.S. Department of Veterans Affairs: The U.S. Department of Veterans Affairs (VA) does not cover sex reassignment surgery, although it will reimburse for cross-sex hormones and pre- and post-operative care related to transitioning. Because the VA only provides services to veterans of the U.S. armed forces, it cannot offer sex reassignment treatment to children (VA, 2020).[12]

---

[10] The Centers for Medicare and Medicaid Services is part of the U.S. Department of Health and Human Services. Its primary functions are to administer the entire Medicare system and oversee federal compliance of state Medicaid programs. In addition, CMS sets reimbursement rates and coverage criteria for the Medicare program.
[11] Tricare is the insurance program that covers members of the U.S. armed forces and their families. This includes children of all ages.
[12] The U.S. Department of Veterans Affairs oversees the Veterans Health Administration (VHA), which consists of over 1,000 hospitals, clinics, and long-term care facilities. As the largest health care network in the U.S., the VHA provides services to veterans of the U.S. armed forces.

State-Level Coverage Policies

Florida: In April 2022, DOH issued guidance for the treatment of gender dysphoria, recommending that minors not receive puberty blockers, cross-sex hormones, or sex reassignment surgery. [13] The justification offered for recommending against these treatments is that available evidence is low-quality and that European countries also have similar guidelines. Accordingly, DOH provided the following guidelines:

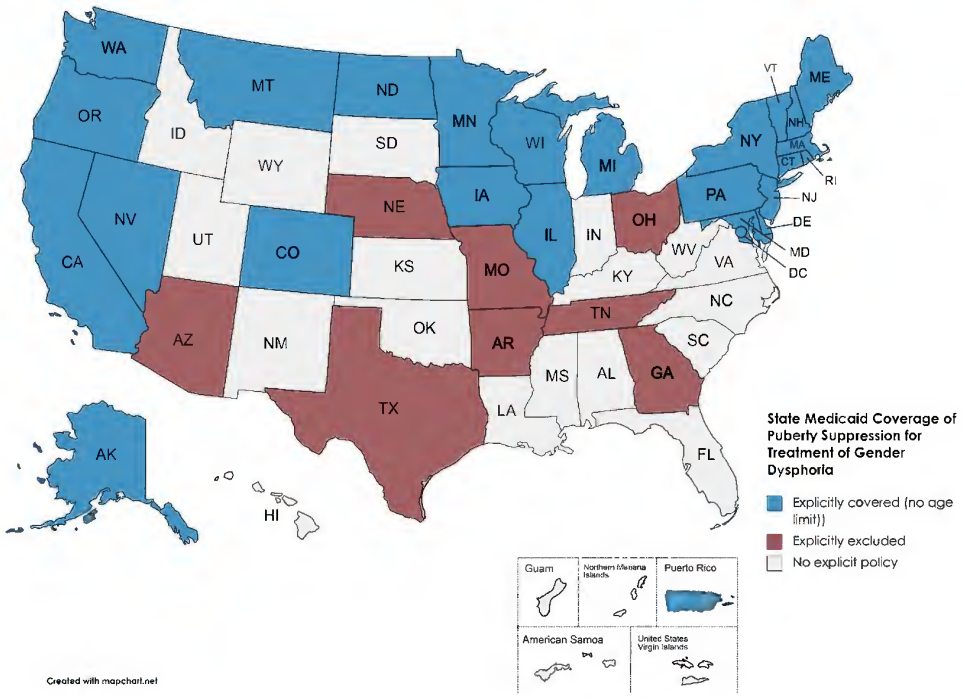
- "Social gender transition should not be a treatment option for children or adolescents."
- "Anyone under 18 should not be prescribed puberty blockers or hormone therapy."
- "Gender reassignment surgery should not be a treatment option for children or adolescents."
- "Children and adolescents should be provided social support by peers and family and seek counseling from a licensed provider."

In a separate fact sheet released simultaneously with the guidance, DOH further asserts that the evidence cited by the federal government cannot establish sex reassignment treatment's ability to improve mental health (DOH, 2022).

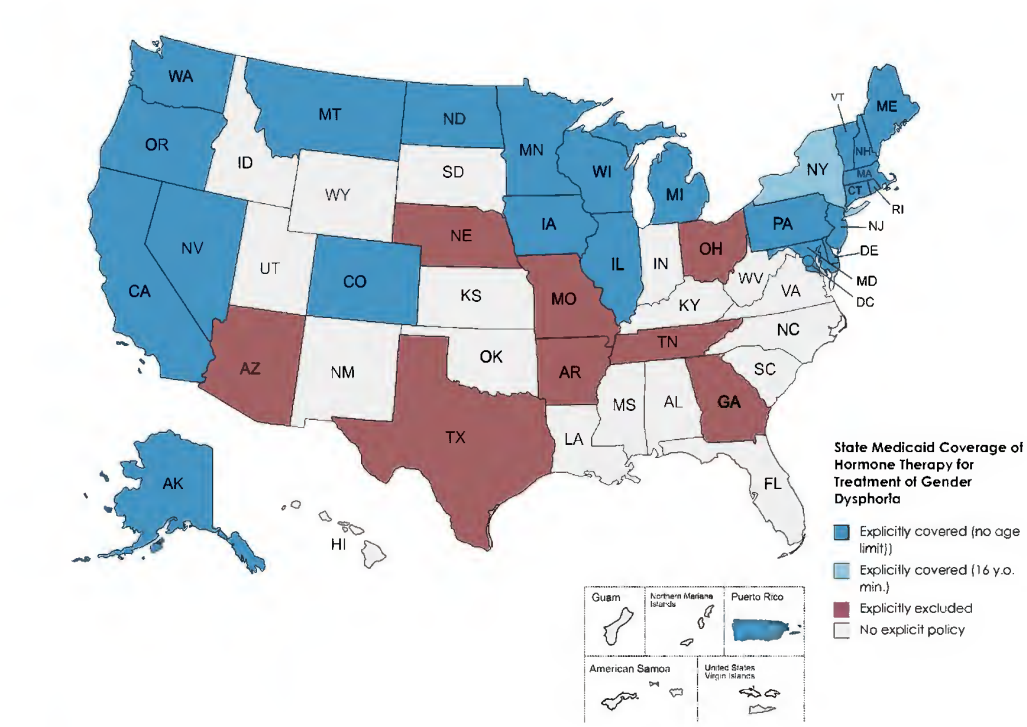
State Medicaid Programs: Because individual states differ in health services offered, Medicaid programs vary in their coverage of sex reassignment treatments. The following maps identify states that cover sex reassignment treatments, states that have no policy, and states that do not cover such treatments.

[13] Unlike the federal government, the State of Florida delegates responsibilities for Medicaid and health care services to five separate agencies (Agency for Health Care Administration, Department of Health, Department of Children and Families, Department of Elder Affairs, and Agency for Persons with Disabilities). Each agency has its own separate head (secretary or surgeon general), which reports directly to the Executive Office of the Governor. As Florida's public health agency, DOH oversees all county health departments, medical professional boards, and numerous health and welfare programs (e.g., Early Steps and Women, Infants, and Children). Because it oversees the boards, DOH has authority to release practice guidelines.

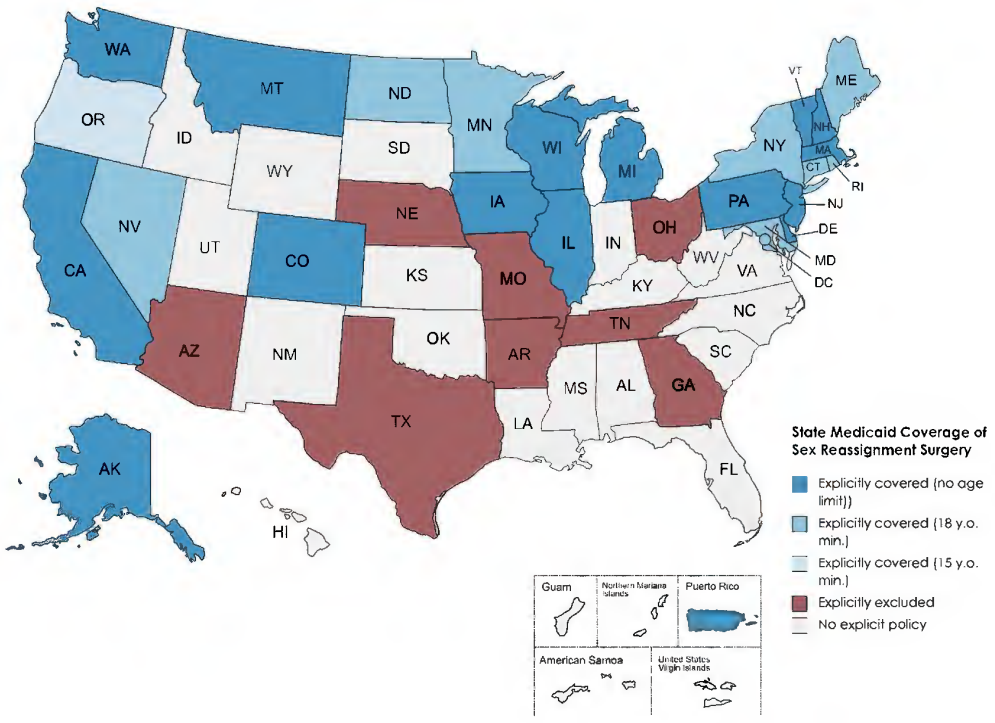
State Medicaid programs with coverage decisions regarding puberty blockers:



State Medicaid programs with coverage decisions regarding cross-sex hormones:



State Medicaid programs with coverage decisions regarding sex reassignment surgery:



Western Europe

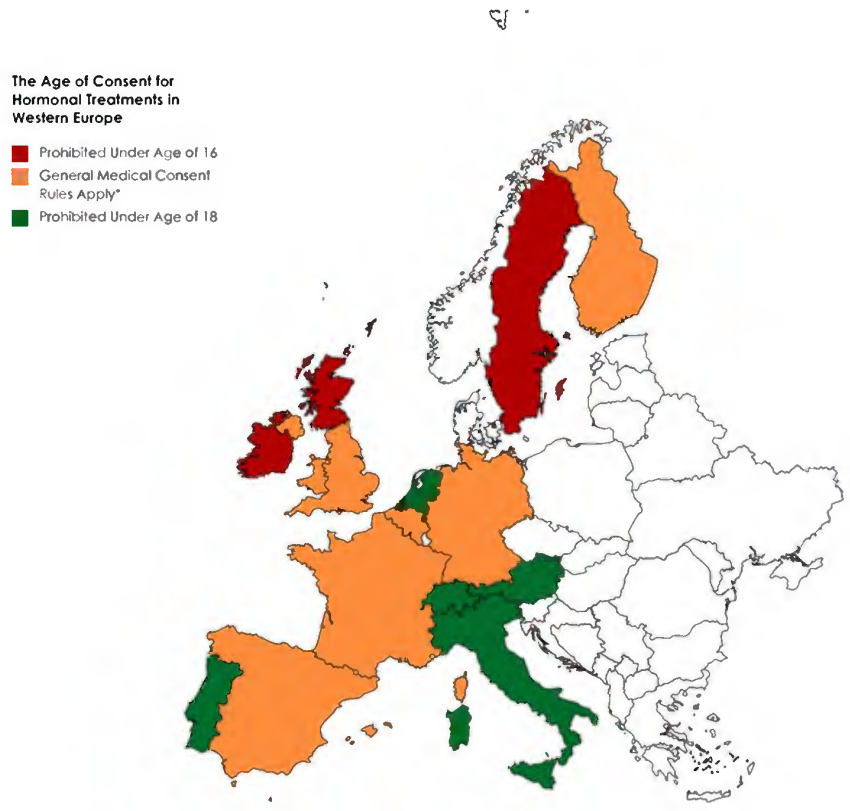
Scandinavian countries such as Sweden and Finland have released new guidelines on sex reassignment treatment for children. In 2022, the Swedish National Board of Health stated that "the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits." With the exception of youths who exhibited "classic" signs of gender identity issues, adolescents who present with the condition will receive behavioral health services and gender-exploratory therapy (Society for Evidence Based Gender Medicine, 2022).

In Finland, the Palveluvalikoima issued guidelines in 2020 stating that sex reassignment in minors "is an experimental practice" and that "no irreversible treatment should be initiated." The guidelines further assert that youths diagnosed with gender dysphoria often have co-occurring psychiatric disorders that must be stabilized prior to prescribing any cross-sex hormones or undergoing sex reassignment surgery (Palveluvalikoima, 2020).

The United Kingdom (U.K.) is also reassessing the use of irreversible treatments for gender dysphoria due the long-term effects on mental and physical health. In 2022, an independent interim report commissioned by the U.K.'s National Health Service (NHS) indicates that additional research and systematic changes are necessary to ensure the safe treatment of gender dysphoric youths. These include reinforcing the diagnosis process to assess all areas of physical and behavioral health, additional training for pediatric endocrinologists, and informing parents about the uncertainties regarding puberty blockers. The interim report is serving as a benchmark until the research is completed for final guidelines (The Cass Report, 2022).

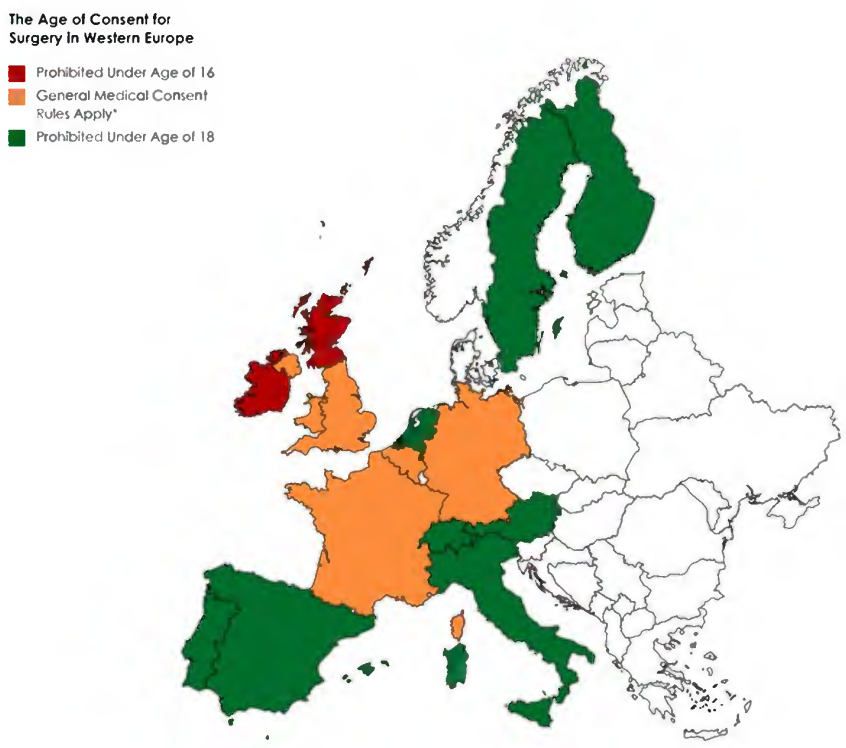
Like state Medicaid programs, health systems across Western Europe also vary in their coverage of sex reassignment treatment.

Western European nations' requirements for cross-sex hormones:



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Western European nations' requirements for sex reassignment surgery:



In this context, the age requirement for access to any medical treatment without consent of parents or of a public authority. This age may range from 16 to 18 years depending on each country's laws.

Generally Accepted Professional Medical Standards Recommendation

This report does not recommend sex reassignment treatment as a health service that is consistent with generally accepted professional medical standards. Available evidence indicates that the services are not proven safe or effective treatments for gender dysphoria.

Rationale

The available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. As this report demonstrates, the evidence favoring "gender affirming" treatments, including evidence regarding suicidality, is either low or very low quality:

- **Puberty Blockers:** Evidence does not prove that puberty blockers are safe for treatment of gender dysphoria. Evidence that they improve mental health and reduce suicidality is low or very low quality.
- **Cross-Sex Hormones:** Evidence suggesting that cross-sex hormones provide benefits to mental health and prevents suicidality is low or very low quality. Rather, evidence shows that cross-sex hormones cause multiple irreversible physical consequences as well as infertility.
- **Sex Reassignment Surgery:** Evidence of improvement in mental health and reduction in suicidality is low or very low quality. Sex reassignment surgery results in irreversible physical changes, including sterility.

While clinical organizations like the AAP endorse the above treatments, none of those organizations relies on high quality evidence. Their eminence in the medical community alone does not validate their views in the absence of quality, supporting evidence. To the contrary, the evidence shows that the above treatments pose irreversible consequences, exacerbate or fail to alleviate existing mental health conditions, and cause infertility or sterility. Given the current state of the evidence, the above treatments do not conform to GAPMS and are experimental and investigational.

✓ **Concur** ____ **Do not Concur**

Comments:

_____

_____

_____

Tom Wilson
Deputy Secretary for Medicaid (or designee)

6/2/22
Date

Works Cited

Almost Half of LGBTQ Youths 'Seriously Considered' Suicide in Past Year, Survey Says. *NBC News*. 4 May 2022.

American Academy of Pediatrics. Policy Statement: Off-Label Use of Drugs in Children. *Pediatrics*. 2014. 133(3).

American Psychiatric Association. *Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders*. 2013.

American Psychiatric Association. *Gender Dysphoria Diagnosis*. 2017.

American Psychiatric Association. *What Is Depression*. 2020.

American Psychological Association. *APA Resolution on Gender Identity Change Efforts*. 2021.

Baker GM, Guzman-Arocho YD, Bret-Mounet VC, Torous VF, Schnitt SJ, Tobias AM, Bartlett RA, Fein-Zachary VJ, Collins LC, Wulf GM, Heng YJ. Testosterone Therapy and Breast Histopathological Features in Transgender Individuals. *Mod Pathol*. 2021. 34(1).

Blake K, Cangelosi S, Johnson-Brooks S, Belcher HME. Reliability of the GAF and CGAS with Children Exposed to Trauma. *Child Abuse and Neglect*. 2007. 31: 909-915.

Bizic MR, Jeftovic M, Pusica S, Stojanovic B, Duisin D, Vujovic S, Rakic V, Djordjevic ML. Gender Dysphoria: Bioethical Aspects of Medical Treatment. *BioMed Research International*. 2018: 9652305.

Bizic M, Kojovic V, Duisin D, Stanojevic D, Vujovic S, Milosevic A, Korac G, Djordjevic ML. An Overview of Neovaginal Reconstruction Options in Male to Female Transsexuals. *The Scientific World Journal*. 2014. 638919.

Bränström R, Pachankis JE. Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. *American Journal of Psychiatry*. 2020. 177(8).

Brignardello-Petersen R, Wiercioch W. Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence. Unpublished: Commissioned by the Florida Agency for Health Care Administration. 2022.

Bruggeman BS, Dayton K, Diaz A, Evans J, Haller MJ, Hudak ML, Mathews CA, Shapiro M. We 300 Florida Health Care Professionals Say the State Gets Transgender Guidance Wrong. *Tampa Bay Times*. 27 April 2022.

Cantor J. Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy. *Journal of Sex and Marital Therapy*. 46(4).

Cantor J. *Science of Gender Dysphoria and Transsexualism*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Cass H. *The Cass Review: Independent Review of Gender Identity Services for Children and Young People, Interim Report*. 2022.

The Centers for Medicare and Medicaid Services. Decision Memo: Gender Dysphoria and Gender Reassignment Surgery. 30 August 2016.

The Centers for Medicare and Medicaid Services. Pub 100-03 Medicare National Coverage Determinations. 3 March 2017.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, Steinberg L, Sisk CL, Roth J, Paus T, Mueller SC, McCarthy MM, Micevych PE, Martin CL, Kreukels BPC, Kenworthy L, Herting MM, Herlitz A, Heraldsen RJH, Dahl R, Crone EA, Chelune GJ, Burke SM, Berenbaum SA, Beltz AM, Bakker J, Eliot L, Vilain E, Wallace GL, Nelson EE, Garofalo R. Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth. *Transgender Health*. 2020. 5(4).

Claahsen-van der Grinten H, Verhaak C, Steensma T, Middelberg T, Roeffen J, Klink D. Gender Incongruence and Gender Dysphoria in Childhood and Adolescence – Current Insights in Diagnostics, Management, and Follow-Up. *European Journal of Pediatrics*. 2020. 180: 1349-1357.

Costa R, Colizzi M. The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review. *Neuropsychiatric Disease and Treatment*. 2016. 12: 1953-1966.

Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria. *Journal of Sexual Medicine*. 2015. 12(11).

Davy Z, Toze M. What Is Gender Dysphoria? A Critical Systematic Narrative Review. *Transgender Health*. 2018. 3(1).

De Sanctis V, Soliman AT, Di Maio S, Soliman N, Elsedfy H. Long-Term Effects and Significant Adverse Drug Reactions (ADRs) Associated with the Use of Gonadotropin-Releasing Hormone Analogs (GnRHa) for Central Precocious Puberty: A Brief Review of Literature. *Acta Biomed*. 2019. 90(3).

De Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment. *Pediatrics*. 2014. 134(4).

Dhejne C, Lichtenstein P, Boman M, Johansson ALV, Langstrom N, Landen M. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. *PLoS One*. 6(2).

Donovan GK. *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Dutra E, Lee J, Torbati T, Garcia M, Merz CNB, Shufelt C. Cardiovascular Implications of Gender-Affirming Hormone Treatment in the Transgender Population. *Maturitas*. 2019. 129: 45-49.

Few Transgender Children Change Their Minds After 5 Years, Study Finds. *New York Times*. 4 May 2022.

Gaetano P. David Reimer and John Money Gender Reassignment Controversy: The John/Joan Case. *The Embryo Project Encyclopedia*. 2017.

Geffen S, Horn T, Smith KJ, Cahill S. Advocacy for Gender Affirming Care: Learning from the Injectable Estrogen Shortage. *Transgender Health*. 2018. 3(1).

Go JJ. Should Gender Reassignment Surgery Be Publicly Funded? *Bioethical Inquiry*. 2018. 15: 527-534.

Gu J, Kanai, R. What contributes to individual differences in brain structure. *Front Hum Neurosci*. 2014. 8:262.

Hariton E, Locascio JJ. Randomised Controlled Trials – The Gold Standard for Effectiveness Research. *BJOG: An International Journal of Obstetrics and Gynecology*. 2018. 125(13).

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, Rosenthal SM, Safer JD, Tangpricha V, T'Sjoen GG. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinological Metabolism*. 2017. 102(11).

Herman JL, Brown TNT, Haas AP. *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey*. University of California at Los Angeles School of Law Williams Institute. 2019.

Hess J, Neto RR, Panic L, Rubben H, Senf W. Satisfaction with Male-to-Female Gender Reassignment Surgery. *Deutsches Arzteblatt International*. 2014. 111: 795-801.

Hruz PW. Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria. *Catholic Medical Association*. 2020. 87(1).

James HA, Chang AY, Imhof RL, Sahoo A, Montenegro MM, Imhof NR, Gonzalez CA, Lteif AN, Nippoldt TB, Davidge-Pitts CJ. A Community-Bases Study of Demographics, Medical and Psychiatric Conditions, and Gender Dysphoria/Incongruence Treatment in Transgender/Gender Diverse Individuals. *Biology of Sex Differences*. 2020. 11(55).

Jensen RK, Jensen JK, Simons LK, Chen D, Rosoklija I, Finlayson C. Effect of Concurrent Gonadotropin-Releasing Hormone Against Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients. *Transgender Health*. 2019. 4(1).

Joel D., Berman Z., Tavor L. Sex beyond the Genitalia: The Human Brain Mosaic. *Proceedings of the National Academy of Sciences of the United States of America*. 2015. 112(50).

Kalin NH. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals after Gender-Affirming Surgeries: A Comment by the Editor on the Process (Letter). *American Journal of Psychiatry*. 2020. 177:765.

Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*. 2015. 9(9).

Kozlowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR. Attachment Patterns in Children and Adolescents with Gender Dysphoria. *Frontiers in Psychology*. 2021. 11: 582688.

Kuper LE, Mathews S, Lau M. Baseline Mental Health and Psychosocial Functioning of Transgender Adolescents Seeking Gender-Affirming Hormone Therapy. *Journal of Developmental Behavior Pediatrics*. 2019. 40(8).

Kyriakou A, Nicolaides NC, Skordis N. Current Approach to the Clinical Care of Adolescents with Gender Dysphoria. *Acta Biomed*. 2020. 91(1).

Laidlaw M, Cretella M, Donovan K. The Right to Best Care for Children Does Not Include the Right to Medical Transition. *The American Journal of Bioethics*. 2019. 19(2).

Laidlaw M, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: Endocrine Treatment of Gender-Dsyphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *Journal of Clinical Endocrinological Metabolism*. 2018.

Lappert P. *Surgical Procedures and Gender Dysphoria*. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Lee JY, Finlayson C, Olson-Kennedy J, Garofalo R, Chan YM, Glidden DV, Rosenthal SM. Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings from the Trans Youth Care Study. *Journal of the Endocrine Society*. 2020. 4(9).

Levine SB. Informed Consent for Transgendered Patients. *Journal of Sex & Marital Therapy*. 2018. 10:1080.

Littman L. Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners. *Archives of Sexual Behavior*. 2021. 50: 3353-3369.

Littman L. Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports. *PLOS One*. 2018. 13(8).

Mayer L, McHugh PR. Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences. *The New Atlantis*. 2016. Fall Edition. 103.

McHugh PR. *The Mind Has Mountains: Reflections on Society and Psychiatry*. The Johns Hopkins University Press. 2006.

Medical Textbook Strips Gender Dysphoria Definition after Being Cited by Florida. *Fox News*. 8 May 2022.

Merck Pharmaceuticals. *Merck Manual: Professional Version*. 2021.

Monstrey SJ, Ceulemans P, Hoebeke P. Sex Reassignment Surgery in the Female-to-Male Transsexual. *Seminars in Plastic Surgery*. 2011. 25(3).

Nguyen HB, Chavez AM, Lipner E, Hantsoo L, Kornfield SL, Davies RD, Epperson CN. Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition. *Curr Psychiatry Rep*. 2019. 20(12).

Nhi Le HP. *Eminence-Based Medicine vs. Evidence-Based Medicine*. Students 4 Best Evidence. 12 January 2016. https://s4be.cochrane.org/blog/2016/01/12/eminence-based-medicine-vs-evidence-based-medicine/#:~:text=What%20is%20eminence-based%20medicine,appraisal%20of%20scientific%20evidence%20available

Olson KR, Durwood L, DeMeules M, McLaughlin KL. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*. 2015. 137(3).

Olson KR, Durwood L, Horton R, Gallagher NM, Devor A. Gender Identity 5 Years After Social Transition. *Pediatrics*. 2022; doi: 10.1542/peds.2021-056082.

Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts. *JAMA Pediatrics*. 2018. 172(5).

Palveluvalikoima of Finland. Recommendation of the Council for Choices in Health Care in Finland (Palko/Cohere Finland): Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors. 2020.

Rafferty J, AAP Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, AAP Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018. 142(4).

Sadr M, Korashad BS, Talaei A, Fazeli N, Honekopp J. 2D:4D Suggests a Role of Prenatal Testosterone in Gender Dysphoria. *Archives of Sexual Behavior*. 2020. 49: 421-432.

Saleem F, Rizvi SW. Transgender Associations and Possible Etiology: A Literature Review. *Cureus*. 9(12).

Shumer DE, Reisner SL, Edwards-Leeper L, Tishelman A. Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic. *LGBT Health*. 2016. 3(5).

Society for Evidence Based Gender Medicine. Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW). 2022.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2013. 52(6).

Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Open Network*. 2022; 59(2).

Trum H, Hoebeke P, Gooren L. Sex Reassignment of Transsexual People from a Gynecologist's and Urologist's Perspective. *Acta Obstetrica et Gynecologica*. 2016. 94: 563-567.

Turban JL, Loo SS, Almazan AN, Keuroghlian AS. Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Method Analysis *LGBT Health*. 2021. 8(4).

UF Doctor Says Gender-Affirming Care Works for Kids Who Need It, and Can Even Save Lives. *Health News Florida*. 26 April 2022.

Unger CA. Hormone Therapy for Transgender Patients. *Translational Andrology and Urology*. 2016. 5(6).

University of California at San Francisco Health System. *Overview of Feminizing Hormone Therapy*. 2020.

University of California at San Francisco Health System. *Overview of Masculinizing Hormone Therapy*. 2020.

U.S. Department of Defense, Tricare. *Gender Dysphoria Services*. 2022.

U.S. Department of Health and Human Services: Office for Civil Rights. HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy. 2 March 2022.

U.S. Drug Enforcement Administration. *Drug Fact Sheet: Steroids*. 2020.

A Review of the President's FY 2023 Funding Request and Budget Justification for the National Institutes of Health. U.S. Senate Committee on Appropriations. Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 17 May 2022. https://www.appropriations.senate.gov/hearings/a-review-of-the-presidents-fy-2023-funding-request-and-budget-justification-for-the-national-institutes-of-health

Van Meter QL. Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent. Unpublished. Commissioned by the Florida Agency for Health Care Administration. 2022.

Van der Miesen AIR, Hurley H, Bal AM, de Vries ALC. Prevalence of the Wish to Be of the Opposite Gender in Adolescents and Adults with Autism Spectrum Disorder. *Archives of Sexual Behavior*. 2018. 47: 2307-2317.

Van Mol A, Laidlaw MK, Grossman M, McHugh PR. Gender-Affirmation Surgery Conclusion Lacks Evidence. *American Journal of Psychiatry*. 2020. 177:765.

Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Medical Principles and Practice*. 2021. 30: 17-28.

World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. 2012.

Zhao JJ, Marchaim D, Palla MB, Bogan CW, Hayakawa K, Tansek R, Moshos J, Muthusamy A, Kotra H, Lephart PR, Wilson AN, Kaye KS. Surgical Site Infections in Genital Reconstruction Surgery for Gender Reassignment, Detroit: 1984-2008. *Surgical Infections*. 2014. 15(2).

Zucker K. Debate: Different strokes for different folks. *Child and Adolescent Mental Health*. 2019. doi.org/10.1111/camh.12330.

Attachments

Attachment A: Secretary for the Florida Agency for Health Care Administration's Letter to Deputy Secretary Thomas Wallace. 20 April 2022.

Attachment B: Complete text of Rule 59G-1.035, F.A.C.

Attachment C: Romina Brignardello-Petersen, DDS, MSc, PhD and Wojtek Wiercioch, MSc, PhD: *Effects of Gender Affirming Therapies in People with Gender Dysphoria: Evaluation of the Best Available Evidence*. 16 May 2022.

Attachment D: James Cantor, PhD: *Science of Gender Dysphoria and Transsexualism*. 17 May 2022.

Attachment E: Quentin Van Meter, MD: *Concerns about Affirmation of an Incongruent Gender in a Child or Adolescent*. 17 May 2022.

Attachment F: Patrick Lappert, MD: *Surgical Procedures and Gender Dysphoria*. 17 May 2022.

Attachment G: G. Kevin Donovan, MD: *Medical Experimentation without Informed Consent: An Ethicist's View of Transgender Treatment for Children*. 16 May 2022.

ATTACHMENT A

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

April 20, 2022

Tom Wallace
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Deputy Secretary Wallace:

On April 20, 2022, the Florida Department of Health released guidance on the treatment of gender dysphoria for children and adolescents.[1] The Florida Medicaid program does not have a policy on whether to cover such treatments for Medicaid recipients diagnosed with gender dysphoria. Please determine, under the process described in Florida Administrative Code Rule 59G-1035, whether such treatments are consistent with generally accepted professional medical standards and not experimental or investigational. Pursuant to Rule 59G-1035(5), I look forward to receiving your final determination.

Sincerely,

Simone Marstiller
Secretary

[1] *See* https://www.floridahealth.gov/newsroom/2022/04/20220420-gender-dysphoria-press-release.pr.html (last visited Apr. 20, 2022).

ATTACHMENT B

59G-1.035 Determining Generally Accepted Professional Medical Standards.

(1) Definitions.

(a) Generally accepted professional medical standards – Standards based on reliable scientific evidence published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations' recommendations.

(b) Health service(s) – Diagnostic tests, therapeutic procedures, or medical devices or technologies.

(c) Relevant – Having a significant and demonstrable bearing on the matter at hand.

(2) Pursuant to the criteria set forth in subparagraph 59G-1.010(166)(a)3., Florida Administrative Code (F.A.C.), the Agency for Health Care Administration (hereafter referred to as Agency) will determine when health services are consistent with generally accepted professional medical standards and are not experimental or investigational.

(3) Health services that are covered under the Florida Medicaid program are described in the respective coverage and limitations handbooks, policies, and fee schedules, which are incorporated by reference in the F.A.C. The public may request a health service be considered for coverage under the Florida Medicaid program by submitting a written request via e-mail to HealthServiceResearch@ahca.myflorida.com. The request must include the name, a brief description, and any additional information that supports coverage of the health service, including sources of reliable evidence as defined in paragraph 59G-1.010(84)(b), F.A.C.

(4) To determine whether the health service is consistent with generally accepted medical standards, the Agency shall consider the following factors:

(a) Evidence-based clinical practice guidelines.

(b) Published reports and articles in the authoritative medical and scientific literature related to the health service (published in peer-reviewed scientific literature generally recognized by the relevant medical community or practitioner specialty associations).

(c) Effectiveness of the health service in improving the individual's prognosis or health outcomes.

(d) Utilization trends.

(e) Coverage policies by other creditable insurance payor sources.

(f) Recommendations or assessments by clinical or technical experts on the subject or field.

(5) Based upon the information collected, a report with recommendations will be submitted to the Deputy Secretary for Medicaid (or designee) for review. The Deputy Secretary for Medicaid (or designee) will make a final determination as to whether the health service is consistent with generally accepted professional medical standards and not experimental or investigational.

(6) In order for the health service to be covered under the Florida Medicaid program, it must also meet all other medical necessity criteria as defined in subsection 59G-1.010(166), F.A.C., and funded through the General Appropriations Act or Chapter 216, F.S.

Rulemaking Authority 409.919 FS. Law Implemented 409.902, 409.906, 409.912, 409.913 FS. History–New 2-26-14, Amended 9-28-15.

ATTACHMENT C

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence

Romina Brignardello-Petersen, DDS, MSc, PhD
Wojtek Wiercioch, MSc, PhD

1. Introduction

We prepared this report to fulfill a request from the Florida Agency for Health Care Administration. This report contains three documents: 1. Main document (this document) summarizing the methodology used and the findings, 2. Methods document, which provides a detailed description of the systematic methodology used to find, prioritize, appraise, and synthesize the evidence, and 3. Results document, which describes the evidence available, the estimates of the effects of gender affirming therapies, and the certainty (also known as quality) of the evidence.

This document is organized in four parts. First, we describe the credentials and expertise of the health research methodologists conducting this evidence evaluation. Second, we summarize the methodology used. Third, we summarize the main findings. Finally, we briefly discuss strengths and limitations of our process and of the evidence.

2. Credentials and expertise

Two experts in health research methodology, who specialize in evidence synthesis to support decision making, prepared this report. Their relevant credentials and expertise are described below.

Dr. Romina Brignardello-Petersen: Assistant Professor at the Department of Health Research Methods, Evidence, and Impact, at McMaster University. Dr. Brignardello-Petersen obtained a DDS degree (University of Chile) in 2007, an MSc degree in Clinical Epidemiology and Health Care Research (University of Toronto) in 2012, and MSc in Biostatistics (University of Chile) in 2015, and a PhD in Clinical Epidemiology and Health Care Research (University of Toronto) in 2016. Dr. Brignardello-Petersen has worked in evidence synthesis projects since 2010, and her research has focused on the methodology for the development of Systematic Reviews and Clinical Practice Guidelines since 2012. Through January 2022, she has published 122 peer reviewed scientific articles (24 as a first author and 9 as a senior author). Dr. Brignardello-Petersen has acted as a research methodologist for several groups and organizations, including the World Health Organization, the Pan-American Health Organization, the American Society of Hematologists, the American College of Rheumatology, and the Society for Evidence Based Gender Medicine, among others. Her research program has been awarded over $2M CAD from the Canadian Institutes for Health Research. Dr. Brignardello-Petersen has no lived experience as a person or family member of a person with gender dysphoria, and her research interests are not in this area.

Dr. Wojtek Wiercioch: Postdoctoral Research Fellow at the Department of Health Research Methods, Evidence, and Impact, at McMaster University. Dr. Wiercioch obtained an MSc degree (2014, McMaster University) and a PhD degree (2020, McMaster University) in Health Research Methodology. Dr. Wiercioch has worked in evidence syntheses projects since 2011, and his research focuses on evidence synthesis, guideline development methodology, and the guideline development process. Through April

2022, he has published 86 peer-reviewed scientific articles. Dr. Wiercioch has acted as a guideline methodologist for several groups and organizations, including the World Health Organization, the American Society of Hematologists, the Endocrine Society (of America), and the American Association for Thoracic Surgeons, among others. Dr. Wiercioch has no lived experience as a person or family member of a person with gender dysphoria, and his research interests are not in this area.

3. Methods

We conducted an overview of systematic reviews. We used a reproducible approach to search, select, prioritize, appraise, and synthesize the available evidence, following high methodological standards. We describe full details of the methodology in an accompanying document.

In brief, we searched for systematic reviews published in English language in Epistemonikos, OVID Medline, and grey literature sources, through April 30, 2022. We selected systematic reviews which included studies on young individuals with a diagnosis of gender dysphoria, who received puberty blockers, cross-sex hormones, or surgeries; and in which authors reported data regarding outcomes important to patients: gender dysphoria, depression, anxiety, quality of life, suicidal ideation, suicide, adverse effects, and complications. Systematic reviews could have included any type of primary study design.

The two reviewers screened all titles and abstracts, followed by full text of potentially relevant systematic reviews. We then prioritized the most useful systematic review providing evidence for each of the outcomes, using pre-established criteria that considered date of publication, applicability, availability of outcome data, methodological quality of the systematic review, and usefulness of the data synthesis conducted in the systematic review (see methods document for details).

After abstracting data from the systematic reviews, we synthesized the best available evidence for each of the outcomes, and assessed the certainty (also known as quality) of the evidence using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach. We conducted GRADE assessments using the information provided by the systematic review authors (risk of bias of primary studies, characteristics of included studies, results reported by the studies). We present the all the information about outcomes in GRADE summary of findings tables.

In addition, to evaluate the robustness of our conclusions, we systematically searched for and evaluated primary studies answering the questions of interest published after the authors of the included systematic reviews conducted their searches.

4. Results

We included 61 systematic reviews, from which 3 addressed the effects of puberty blockers, 22 addressed the effects of cross-sex hormones, 30 addressed the effects of surgeries, and 6 addressed the effects of more than one of these interventions. After our prioritization exercise, we included information from 2 systematic reviews on puberty blockers, 4 on cross-sex hormones, and 8 on surgeries.

4.1 Puberty blockers

For most outcomes (except suicidality), there is no evidence about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. There is very low certainty about the effects of puberty blockers on suicidal ideation.

The studies included in the systematic review reported outcomes among a group of people with gender dysphoria after receiving puberty blockers. Low certainty evidence suggests that after treatment with puberty blockers, people with gender dysphoria experience a slight increase in gender dysphoria, and an improvement in depression, and anxiety. Low certainty evidence also suggests that a moderate percentage of patients experience adverse effects. The findings must be interpreted considering that these studies did not have a comparison group, and that it is unknown if people with gender dysphoria that do not use puberty blockers experience similar or different outcomes.

4.2 Cross sex hormones

For almost all outcomes (except breast cancer) there is no evidence about the effect of cross sex hormones compared to not using cross sex hormones. In other words, no studies compared the outcomes between a group of people with gender dysphoria using cross sex hormones and another group of people with gender dysphoria not using them. Therefore, it is unknown whether people with gender dysphoria who use cross-sex hormones experience more improvement in gender dysphoria, depression, anxiety, quality of life, and suicidality than those with gender dysphoria who do not use cross-sex hormones. There is low certainty evidence suggesting that cross-sex hormones may not increase the risk of breast cancer.

The studies included in the systematic reviews reported changes in the outcomes among a group of patients with gender dysphoria after the use of cross-sex hormones. Low certainty evidence suggests that after treatment with cross-sex hormones, people with gender dysphoria experience an improvement in gender dysphoria, depression, anxiety, and suicidality. There is very low certainty evidence about the changes in quality of life. There is moderate certainty evidence suggesting a low prevalence of venous thromboembolism after treatment with cross-sex hormones. The findings must be interpreted considering that these studies did not have a comparison group, and that it is unknown if people with gender dysphoria that do not use cross-sex hormones experience similar or different outcomes.

4.3 Surgeries

There were no systematic reviews and studies reporting on gender dysphoria, depression, anxiety, and suicidality. Therefore, the effects of surgeries on these outcomes (when compared to a group of patients with gender dysphoria who do not undergo surgery), or the changes in these outcomes (improvements or deterioration) among patients who undergo any gender-affirming surgery is unknown. Because of the lack of comparative studies, it is also unknown whether people with gender dysphoria who undergo surgeries experience more improvement in quality of life or less regret than those with gender dysphoria who do not undergo any surgeries. There is low certainty evidence suggesting that a low percentage of participants experience regret, and very low certainty evidence about changes in quality of life after surgery.

In assigned females at birth, low certainty evidence suggests that a high percentage of people are satisfied after chest surgery. There is very low certainty evidence, however, about satisfaction after bottom surgery, and about complications after both chest and bottom surgery. In assigned males at birth, low certainty evidence suggests a high percentage of people satisfied and a low percentage of people experiencing regret after vaginoplasty. There is very low certainty, however, about satisfaction with chest surgery and complications and reoperations after bottom surgery.

4.4 Evidence published after the systematic reviews selected

We found 10 relevant studies that were published after the systematic reviews were conducted. This evidence was not sufficient to importantly change the conclusions previously made.

5. Discussion

5.1 Summary of the evidence

In this report, we systematically summarized the best available evidence regarding the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria. We did not find evidence about the effect of these interventions on outcomes important to patients when compared to not receiving the intervention. We found low and very low certainty evidence suggesting improvements in gender dysphoria, depression, anxiety, and quality of life, as well as low rates of adverse events, after treatment with puberty blockers and cross-sex hormones.

5.2 Completeness and applicability

There are several gaps in the evidence regarding the effects of puberty blockers, cross-sex hormones, and surgeries in patients with gender dysphoria. Although we found some evidence for all the outcomes of interest, the evidence is suboptimal: several limitations included the lack of studies with a comparison group, and the risk of bias and imprecision, resulting in low or very low certainty evidence for all outcomes.

The applicability of the evidence may also be limited. Although we only rated down for indirectness when it was considered a serious problem (i.e., in evidence about the effects of surgeries, which was collected from people who were importantly older than the target population in this report), there are also potential applicability issues to consider in the evidence regarding the effects of puberty blockers and cross-sex hormones. It is not clear to what extent the people included in the studies were similar enough to the people seeking these treatment options today. For example, some of the included studies were conducted in people who had a diagnosis of gender dysphoria confirmed with strict criteria, as well as a supportive environment. It is important to take into account to what extent this may compromise the applicability of the results to people who are not in the same situation.

5.3 Strengths and limitations of the process for developing this report

We followed a reproducible process for developing this report. We used the highest methodological standards and the approach to evidence synthesis we generally use when supporting organizations in the development of their guidelines. This approach is based on prioritizing the sources of evidence most likely to be informative (i.e., to identify and use the evidence with the highest certainty level).

To follow the principles for evidence-based decision making, which require using the best available evidence to inform decisions, we summarized the best available evidence. Because knowing the best

available evidence necessitates being aware of all the available evidence, we based this report on systematic reviews of the literature. We chose the most trustworthy and relevant systematic reviews among many published reviews.

One potential limitation of the process is that, due to feasibility concerns, we relied on the information reported by the systematic reviewers. Most of the systematic reviews we used, unfortunately, were judged at moderate or low methodological quality, which may raise concerns about the trustworthiness of the evidence presented in this report. We believe, however, that the results and conclusions of this report would not be importantly different had the systematic reviews been conducted following higher methodological standards. Because there are no randomized controlled trials, well-conducted comparative observational studies, or very large case series (which include a large sample of consecutive patients who are representative of the whole population) addressing the effects of puberty blockers, cross-sex hormones, and surgeries; the certainty of the evidence about the effects of these interventions is likely to continue being low or very low, even if a few more studies are included (as observed after searching for primary studies published after the reviews were conducted) or some data points were reported inaccurately in the systematic reviews.

Also due to feasibility concerns, the scope of this report was limited to outcomes that are important to patients. Although some may question the decision of not including surrogate outcomes for which there is evidence available (e.g. bone density, blood pressure), decision makers should rarely consider these outcomes and should instead focus on outcomes that do matter to people and stakeholders (e.g., fractures, cardiovascular events).

5.4 Implications

The evidence evaluating the effects of puberty blockers, cross-sex hormones, and surgeries in people with gender dysphoria has important limitations. Therefore, decisions regarding their use should carefully consider other relevant factors. At a patient level, these factors include patients' values and preferences (how patients trade off the potential benefit and harms - what outcomes are more important to them), and resources needed to provide the interventions (and the availability of such resources). At a population level, in addition to these factors, it would be important to consider resources needed to implement the interventions, feasibility, acceptability by relevant stakeholders, and equity.

It is important to note that when there is low or very low certainty evidence, it is rarely appropriate to make decisions that will be applied to the majority of the patients (equivalent to strong recommendations). This implies, at the patient level, that shared decision making is a key part of the decision-making process. At a policy level, extensive debate may be needed.

6. Conclusions

Due to the important limitations in the body of evidence, there is great uncertainty about the effects of puberty blockers, cross-sex hormones, and surgeries in young people with gender dysphoria. This evidence alone is not sufficient to support whether using or not using these treatments. We encourage decision makers to be explicit and transparent about which factors play an important role in their decision, and how they are weighed and traded off.

Methods

To ensure completeness and feasibility of the evidence review, we used an approach in which we prioritized the types of studies according to the design that was more likely to provide the best available evidence. First, we searched for systematic reviews of the literature. Second, we appraised all existing systematic reviews to select the most trustworthy (highest methodological quality, most up-to-date, most applicable) from which to draw conclusions. Third, we used the information presented in the systematic reviews to abstract information regarding the effects of the interventions of interest. Fourth, we assessed the certainty of the evidence (also known as quality of the evidence) abstracted from the selected systematic reviews. We planned to search for primary studies if systematic reviews were not found.

Information sources: We searched for existing systematic reviews in:

1. Epistemonikos (https://www.epistemonikos.org), an electronic database that focuses on systematic reviews. We used a comprehensive search strategy based on the population, using the terms “gender dysphoria”, “gender identity disorder” and “transgender”. We conducted this search on April 23, 2022.
2. OVID Medline. We used a search strategy based on the population and the interventions of interest, as well as an adaptation of a filter for systematic reviews from the Health Information Research Unit at McMaster University. We conducted this search on April 23, 2022.
3. Grey literature: we conducted a manual search in the websites of specific health agencies: National Institutes for Health and Care Excellence (NICE), Agency for Healthcare Research and Quality (AHRQ), Canada’s Drug and Health Technology Agency (CADTH), and the website from the Society for Evidence-Based Gender Medicine (SEGM). We conducted these searches between April 27-30, 2022.

We used no date limits for the searches, but we did limit to systematic reviews published in English. Search strategies are available in Appendix 1.

Eligibility criteria: We included systematic reviews, which we defined as:

1. Reviews in which the authors searched for studies to include in at least one electronic database, and in which there were eligibility criteria for including studies and a methodology for assessing and synthesizing the evidence, or
2. Reviews in which the authors searched for studies to include in at least one electronic database, and although there was no description of eligibility criteria or methodology, the presentation of the results strongly suggested that the authors used systematic methods (e.g. flow chart depicting study selection, tables with the same information from all included studies, synthesis of data at the outcome level).

We screened systematic reviews using the following criteria for inclusion:

- ***Type of participants:*** Young individuals (< 25 years old) with a diagnosis of gender dysphoria/gender identity disorder. We included reviews in which authors used any label and diagnostic criteria for this condition. We included reviews in which the participants in the reported studies were older if it was the only evidence available for a specific question. We excluded reviews with mixed populations (i.e. with and without gender dysphoria) in which people without gender dysphoria constituted more than 20% of the total sample.

- ***Type of Interventions*:** Puberty blockers, cross-sex hormones, gender affirming surgeries. We included any type of puberty blockers and cross-sex hormones, provided with any regimen. We included the following surgeries: phalloplasty, vaginoplasty, and chest surgery (mastectomy or breast implants/augmentation). We only included these when they were performed for the first time (i.e., not revision surgeries).

- ***Type of comparison:*** When the systematic reviews included comparative studies, the comparator of interest was no intervention. Participants could have received psychotherapy or counselling as a cointervention (in both groups).

- ***Type of outcomes:*** Gender dysphoria, mental health outcomes (depression and anxiety), quality of life, suicidal ideation, suicide, adverse effects (for puberty blockers and cross-sex hormones only), and satisfaction, complications, reoperation, and regret (for surgeries only). We included any length of follow-up. We excluded surrogate outcomes such as blood pressure, bone mineral density, kidney or liver function test values, etc.

- ***Type of studies included in the systematic reviews:*** Any clinical study (studies in which the researchers recruited and measured outcomes in humans) regardless of study design. This included randomized clinical trials, comparative observational studies, and case series. Because we could not quantify effect measures, incidence, or prevalence, we excluded case reports.

We excluded systematic reviews published only in abstract format, and those that we could not retrieve in full text (no access through the McMaster University library, or open access online).

Selection process: The two reviewers screened all titles and abstracts independently and in duplicate, followed by screening of full texts of potentially eligible systematic reviews independently and in duplicate, using the systematic review online application Covidence (https://www.covidence.org). We solved disagreements by consensus.

To select the most useful systematic reviews among all of those that met the eligibility criteria, we used the following prioritization criteria:

1. Date of publication: we prioritized systematic reviews published within the last 3 years (2020-2022)

2. Match between eligibility criteria of the review and the question of interest: we prioritized reviews in which the authors specifically included the population, intervention, comparison, and outcomes of interest for this evidence review
3. Outcome data available: we prioritized systematic reviews in which the authors report outcome data
4. Methodological quality: we used a modified version of the items in AMSTAR 2.[1] We modified the items to ensure assessment of methodological rather than reporting quality (Table 1). We rated each systematic review as having high, moderate, low, or critically low methodological quality, according to the guidance from the developers of the tool.[1] We reached consensus on critical items that determined this rating (Table 1). We prioritized selection of systematic reviews with highest methodological quality.

For surgical interventions, in addition, we prioritized systematic reviews that covered all gender affirming surgeries (instead of focusing on a specific type of surgery).

We selected a systematic review specifically for each of the outcomes of interest. In other words, we chose the best systematic review to inform each outcome. Each systematic review, however, could inform more than one outcome.

Table 1: Items used to rate the methodological quality of the eligible systematic reviews

AMSTAR Item	Modification to measure methodological quality
1. Did the research questions and inclusion criteria for the review include the components of PICO?	Does the review have a clear question and are the eligibility criteria for studies consistent with the question?
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	No modification needed
3. Did the review authors explain their selection of the study designs for inclusion in the review?	No modification needed
4. Did the review authors use a comprehensive literature search strategy?	Did the authors search in at least 2 electronic databases, using a reproducible search strategy?
5. Did the review authors perform study selection in duplicate?	No modification needed
6. Did the review authors perform data extraction in duplicate?	No modification needed
7. Did the review authors provide a list of excluded studies and justify the exclusions?	No modification needed
8. Did the review authors describe the included studies in adequate detail?	No modification needed
9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?	No modification needed

10. Did the review authors report on the sources of funding for the studies included in the review?	Did the review authors consider conflicts of interest and how they may have affected the results of the primary studies?
11. If meta-analysis was performed, did the review authors use appropriate methods for statistical combination of results?	Was the synthesis of evidence done appropriately? (outcome level, appropriate meta analysis or narrative synthesis)
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	Did authors use subgroup or sensitivity analysis to assess the effect of risk of bias in meta-analytic results? Likely not applicable to most cases
13. Did the review authors account for RoB in primary studies when interpreting/discussing the results of the review?	Did the review authors incorporate an assessment of risk of bias at the outcome level when drawing conclusions?
14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?	Did the review authors incorporate an assessment of heterogeneity at the outcome level when drawing conclusions?
15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?	Did the authors address publication bias? (regardless of whether synthesis was using a meta-analysis or narrative)
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	Did the authors report conflicts of interest and did they manage any existing conflict of interest appropriately?

Shaded items were items considered critical.

Data abstraction: We abstracted outcome data from each of the systematic reviews. To ensure feasibility, we used the data as reported by the authors of the review and did not re-abstract data from the primary studies. One reviewer abstracted the data and a second reviewer checked the data for accuracy.

Data synthesis: Using the systematic reviews prioritized, we synthesized the evidence at the outcome level. Because of the higher likelihood of it resulting in higher certainty of evidence (details below) for each outcome, when there was comparative data (i.e. comparison of outcomes between an untreated and a treated group) and non-comparative data (i.e. changes from before to after treatment in one group, or only outcomes after treatment), we prioritized comparative data.

We prioritized numerical results (i.e. magnitudes of effect) and reported estimates and their 95% confidence intervals (CIs). When results were not reported in that way, we calculated the estimates and CIs when systematic review authors provided sufficient information. When necessary, we assumed moderate correlation coefficients for the changes between baseline and follow up (coefficient= 0.4). When this information was not available we reported narratively the effect estimates and ranges.

When a specific study reported the same outcome measured by more than one scale, we chose the scale presented first. We highlighted situations when the results obtained with other scales were importantly different.

When the same outcome was reported by more than one study but we could not pool the results, we created narrative syntheses.

Certainty of evidence: For each outcome, we assessed the certainty of the evidence (also known as quality of the evidence) using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach.[2] The certainty of evidence can be rated as high, moderate, low, or very low (Table 2). For effects of interventions, the certainty of the evidence started as high and could be rated down due to serious concerns about risk of bias, inconsistency, indirectness, imprecision, and publication bias. For inferences about the effect of using a treatment versus no treatment, when there was no comparison group, we assessed risk of bias as very serious and rated down the certainty of the evidence 2 levels by default. We used the same principles when assessing the certainty of the evidence in estimates of prevalence or rates, but did not judge risk of bias as resulting in very serious concerns due to lack of a comparison group. For all assessments, we used the information presented by the authors of the systematic review (e.g. assessments of risk of bias of the included studies, effect estimates from studies).

Table 2: GRADE levels of certainty of the evidence

Certainty level	Definition
High ⊕⊕⊕⊕	We are very confident that the true result (effect estimate/ prevalence/ mean, etc.) lies close to that of the estimate of the result
Moderate ⊕⊕⊕◯	We are moderately confident in the result: the true result is likely to be close to the estimate of the result, bur there is a possibility that it is substantially different
Low ⊕⊕◯◯	Our confidence in the result is limited: the true result may be substantially different from the estimate of the result
Very low ⊕◯◯◯	We have very little confidence in the result: the true result is likely to be substantially different from the estimate of the result

Presentation of results: We created GRADE Summary of Findings tables in which we describe the evidence available for each of the outcomes, and the certainty of the evidence. These tables contain the following information:

- Outcomes: measurement method (including scales, if applicable) and follow-up
- Estimates of effect: absolute and relative estimates of effect, and their corresponding 95% CIs.
- Number of studies and participants providing evidence for the outcome
- GRADE certainty of the evidence, with a link to detailed explanations (provided at the bottom of the table) of why the certainty of the evidence was rated at a specific level
- A narrative statement about what happens with the outcome, based on the estimate of effect and certainty of evidence.

Searching for new evidence not included in the systematic reviews: To assess if newer evidence not included in the included systematic reviews would change the conclusions importantly, we searched for and assessed primary studies answering the questions of interest that were published after the authors of such systematic reviews conducted their searches. We defined an important change in conclusions as a change in the certainty of the evidence (from low/ very low/ not available to high/ moderate).

We searched OVID Medline from January 1, 2019 through May 12, 2022, for studies published in English. We included studies if they enrolled young individuals (< 25 years old, with at least 20% of the people being this age) with a diagnosis of gender dysphoria/gender identity disorder, who received puberty blockers, cross-sex hormones, or surgeries; and measured any of the outcomes of interest.

For outcomes that should be evaluated in a comparative manner (e.g., depression, anxiety, etc.), because they are the only type of study design that would change the conclusions importantly, we selected comparative clinical studies (studies in which the researchers recruited and measured outcomes in humans, and compared a group of people who received the intervention with another one who did not receive the intervention). This included randomized clinical trials, and comparative observational studies. For outcomes that can only occur when the treatment is administered, we included non-comparative observational studies (case series). For these to change conclusions, they should have a sufficiently large sample size, and therefore we excluded case series in which the researchers reported information from <100 people.

Two reviewers screened the potentially relevant articles at title and abstract and full text screening stage. We abstracted relevant study characteristics and outcome data, and assessed risk of bias of comparative studies using the most relevant domains of the Risk of Bias for non-Randomized studies of Interventions (ROBINS-I) tool[3] (table 3). For non-comparative studies, we used a list of custom items that captured the most important potential risk of bias concerns of case series (table 4). We judged the risk of bias of each study as the highest risk of bias of any of the domains assessed (e.g., one domain judged at critical risk of bias resulted in the study judged at critical risk of bias). We summarized this information at the study and judged whether it would have changed the conclusions importantly if added to the body of evidence from the systematic reviews.

Table 3: Domains used to assess risk of bias of comparative studies

Domain	Low	Critical
Confounding	Adjusted for all relevant confounding factors	No adjustment
Classification of intervention	Intervention recorded prospectively or from medical records	Asked patients to recall whether they received the intervention
Deviation from intended interventions	No cointerventions or cointerventions balanced between the groups	Cointerventions unbalanced between the groups

Missing data	More than 90% of patients who started the study provided outcome data	Less thank 50% of patients who started the study provided outcome data
Measurement of outcome	All outcomes measured in the same way in both groups	Outcomes measured differently in both groups

Each domain could be judged at low, moderate, serious, or critical risk of bias. In addition, information could be insufficient to make a judgment. The table describes the criteria used to judge a domain in the extreme categories.

Table 4: Domains used to assess risk of bias of non- comparative studies

Domain	Low	High
Representativeness of the sample	Included all consecutive patients	Highly selected sample based on specific characteristics related with the prognosis after treatment
Classification of the intervention	Intervention recorded prospectively or from medical records	Asked patients to recall whether they received the intervention
Deviation from intended interventions	No cointerventions outside what would be observed in practice (or in a small proportion of patients)	Most patients received co interventions that could influence the outcomes
Missing data	More than 90% of patients who started the study provided outcome data	Less thank 50% of patients who started the study provided outcome data
Measurement of outcome	Outcomes measured prospectively or from medical records	Outcomes reported by the patients and/ or needed to recall what happened a long time ago

Each domain could be judged at low, moderate, or high risk of bias. In addition, information could be insufficient to make a judgment. The table describes the criteria used to judge a domain in the extreme categories.

References

1. Shea BJ, Reeves BC, Wells G, et al. AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *Bmj* 2017;358:j4008. doi: 10.1136/bmj.j4008 [published Online First: 2017/09/25]
2. Blashem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of the evidence. *Journal of clinical epidemiology* 2011;64:401-06.
3. Sterne JA, Hernan MA, Reeves BC, et al. ROBINS-I: a tool for assessing risk of bias in non-randomised studies of interventions. *BMJ (Clinical research ed)* 2016;355:i4919. doi: 10.1136/bmj.i4919 [published Online First: 2016/10/14]

Search Strategies

Questions Covered:

PICO questions:

1. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **puberty blockers (gonadotrophin releasing hormone (GnRH) analogues)** compared to no puberty blockers?

2. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **cross-sex hormones** compared to no cross-sex hormones?

3. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of **gender-affirming surgeries** compared to no surgery?

Search Strategies:

Note: Population, puberty blocker, cross-sex hormones search blocks adapted from NICE (2020) evidence reviews. Gender-affirming search block adapted from Wernick *et al.* 2019. Systematic reviews filter adapted from McMaster University Health Information Research Unit (HIRU).

Databases: Medline, Epistemonikos
Grey Literature: CADTH, AHRQ, SEGM, NICE

Medline

OVERVIEW	
Interface:	Ovid
Databases:	OVID Medline Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present
Study Types:	Systematic Reviews
Search Run:	April 23, 2022

Search Strategy: search terms [number of results]

Population

1	exp "Sexual and Gender Minorities"/	12385
2	Gender Dysphoria/	774
3	Gender Identity/	20481
4	Gender Role/	197
5	"Sexual and Gender Disorders"/	81
6	Transsexualism/	4236
7	Transgender Persons/	5303
8	Health Services for Transgender Persons/	186

9 exp Sex Reassignment Procedures/ 1208
10 gender identity disorder.mp. 492
11 non-binary.mp. 566
12 transgender.mp. 9989
13 (gender* adj3 (dysphori* or disorder* or distress or nonconform* or non-conform* or atypical or incongru* or identi* or disorder* or confus* or minorit* or queer* or variant or diverse or creative or explor* or question* or expan* or fluid)).tw. 16428
14 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition* or expression*)).tw. 13749
15 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).tw. 19665
16 (genderfluid or genderqueer or agender).mp. 130
17 ((correct or chosen) adj3 name).mp. 591
18 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).tw. 135313
19 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition* or expression*)).tw. 13749
20 (male-to-female or m2f or female-to-male or f2m).tw. 148579
21 or/1-20 342948

Cross-Sex Hormones

22 Hormones/ad, tu, th 4676
23 exp Progesterone/ad, tu, th 11265
24 exp Estrogens/ad, tu, th 29635
25 exp Gonadal Steroid Hormones/ad, tu, th 35375
26 (progesteron* or oestrogen* or estrogen*).tw. 223307
27 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medici* or drug* or intervention* or care)).tw. 1488
28 exp Estradiol/ad, tu, th 11197
29 exp Testosterone/ad, tu, th 8710
30 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).tw. 86509
31 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).tw. 100252
32 or/22-31 345895

Puberty Blockers

33 Gonadotropin-Releasing Hormone/ 28809
34 (pubert* adj3 block*).ti,ab. 141
35 ((gonadotrophin or gonadotropin) and releasing).ti,ab. 20121
36 (GnRH adj2 analog*).ti,ab. 2878
37 GnRH*.ti,ab. 24390
38 "GnRH agonist*".ti,ab. 4749
39 Triptorelin Pamoate/ 1981
40 triptorelin.ti,ab. 821
41 arvekap.ti,ab. 1

42	("AY 25650" or AY25650).ti,ab.	1
43	("BIM 21003" or BIM21003).ti,ab.	0
44	("BN 52014" or BN52014).ti,ab.	0
45	("CL 118532" or CL118532).ti,ab.	0
46	Debio.ti,ab.	119
47	diphereline.ti,ab.	28
48	moapar.ti,ab.	0
49	pamorelin.ti,ab.	1
50	trelstar.ti,ab.	3
51	triptodur.ti,ab.	1
52	("WY 42422" or WY42422).ti,ab.	0
53	("WY 42462" or WY42462).ti,ab.	0
54	gonapeptyl.ti,ab.	0
55	decapeptyl.ti,ab.	225
56	salvacyl.ti,ab.	0
57	Buserelin/	2137
58	buserelin.ti,ab.	1395
59	onist.ti,ab.	0
60	("hoe 766" or hoe-766 or hoe766).ti,ab.	72
61	profact.ti,ab.	2
62	receptal.ti,ab.	31
63	suprecur.ti,ab.	5
64	suprefact.ti,ab.	25
65	tiloryth.ti,ab.	0
66	histrelin.ti,ab.	78
67	"LHRH-hydrogel implant".ti,ab.	1
68	("RL 0903" or RL0903).ti,ab.	1
69	("SPD 424" or SPD424).ti,ab.	1
70	goserelin.ti,ab.	1016
71	Goserelin/	1643
72	("ici 118630" or ici118630).ti,ab.	51
73	("ZD-9393" or ZD9393).ti,ab.	0
74	zoladex.ti,ab.	388
75	leuprorelin.ti,ab.	525
76	carcinil.ti,ab.	0
77	enanton*.ti,ab.	26
78	ginecrin.ti,ab.	0
79	leuplin.ti,ab.	15
80	Leuprolide/	3018
81	leuprolide.ti,ab.	2004
82	lucrin.ti,ab.	16
83	lupron.ti,ab.	183
84	provren.ti,ab.	0
85	procrin.ti,ab.	3
86	("tap 144" or tap144).ti,ab.	41
87	(a-43818 or a43818).ti,ab.	3
88	Trenantone.ti,ab.	2
89	staladex.ti,ab.	0

90 prostap.ti,ab. 6
91 Nafarelin/ 327
92 nafarelin.ti,ab. 263
93 ("76932-56-4" or "76932564").ti,ab. 0
94 ("76932-60-0" or "76932600").ti,ab. 0
95 ("86220-42-0" or "86220420").ti,ab. 0
96 ("rs 94991 298" or rs94991298).ti,ab. 0
97 synarel.ti,ab. 13
98 deslorelin.ti,ab. 306
99 gonadorelin.ti,ab. 237
100 ("33515-09-2" or "33515092").ti,ab. 0
101 ("51952-41-1" or "51952411").ti,ab. 0
102 ("52699-48-6" or "52699486").ti,ab. 0
103 cetrorelix.ti,ab. 520
104 cetrotide.ti,ab. 52
105 ("NS 75A" or NS75A).ti,ab. 0
106 ("NS 75B" or NS75B).ti,ab. 0
107 ("SB 075" or SB075).ti,ab. 1
108 ("SB 75" or SB75).ti,ab. 67
109 gonadoliberin.ti,ab. 151
110 kryptocur.ti,ab. 7
111 cetrorelix.ti,ab. 520
112 cetrotide.ti,ab. 52
113 antagon.ti,ab. 18
114 ganirelix.ti,ab. 160
115 ("ORG 37462" or ORG37462).ti,ab. 3
116 orgalutran.ti,ab. 26
117 ("RS 26306" or RS26306).ti,ab. 5
118 ("AY 24031" or AY24031).ti,ab. 0
119 factrel.ti,ab. 13
120 fertagyl.ti,ab. 12
121 lutrelef.ti,ab. 5
122 lutrepulse.ti,ab. 3
123 relefact.ti,ab. 10
124 fertiral.ti,ab. 0
125 (hoe471 or "hoe 471").ti,ab. 6
126 relisorm.ti,ab. 4
127 cystorelin.ti,ab. 19
128 dirigestran.ti,ab. 5
129 or/33-128 47108

Gender-affirming Surgeries

130 virilization/ 2309
131 (virilism or virili?ation or masculini?ation).mp. 5657
132 feminization/ 797
133 femini?ation.mp. 3420
134 (vaginoplasty or vaginoplasties).mp. 1022

135 exp Vagina/ or *Reconstructive Surgical Procedures/ 78841
136 (vaginoplasty or vaginoplasties).mp. 1022
137 (phalloplasty or phalloplasties).mp. 561
138 exp Penile Prosthesis/ 1636
139 "penile reconstruction".mp. 292
140 (vagina reconstruction or vaginal reconstruction).mp. 549
141 (genitoplasty or genitoplasties).mp. 263
142 transsexualism/su [Surgery] 1007
143 sex reassignment.mp. 1668
144 sex transformation.mp. 42
145 or/130-144 91560

Systematic Review Filter

147 meta-analysis/ 158633
148 (meta anal* or meta-anal* or metaanal*).ti,ab. 231876
149 ((systematic or evidence) adj2 (review* or overview*)).ti,ab. 279806
150 ((pool* or combined) adj2 (data or trials or studies or results)).ab. 65411
151 (search strategy or search criteria or systematic search or study selection or data extraction).ab. 70886
152 (search* adj4 literature).ab. 84593
153 or/146-152 521554

Combine Interventions and Population

154 32 or 129 or 145 459771
155 21 and 154 17838

Limit to Systematic Reviews in English Language

156 153 and 155 295
157 limit 156 to english language 288

Epistemonikos

OVERVIEW	
Interface:	https://www.epistemonikos.org/
Database:	Epistemonikos
Study Types:	Systematic Reviews
Search Run:	April 23, 2022
Search Strategy: search terms [number of results]	

Population

(title:((title:(gender dysphoria) OR abstract:(gender dysphoria)) OR (title:(gender identity disorder) OR abstract:(gender identity disorder)) OR (title:(transgender) OR abstract:(transgender))) OR abstract:((title:(gender dysphoria) OR abstract:(gender dysphoria)) OR (title:(gender identity disorder) OR abstract:(gender identity disorder)) OR (title:(transgender) OR abstract:(transgender))))

Limit to Systematic Reviews

*Limited by publication type "systematic review" [425]

Canadian Agency for Drugs and Technologies in Health (CADTH)

OVERVIEW	
Interface:	https://www.cadth.ca/
Database:	CADTH
Study Types:	Systematic Reviews, Health Technology Reviews
Search Run:	April 27, 2022
Search Strategy: search terms [number of results]	

"gender dysphoria" [10]
Limit to Health Technology Review [2]

"transgender" [9]
Limit to Health Technology Review [5]

"gender identity disorder" [1]

Agency for Healthcare Research and Quality (AHRQ)

OVERVIEW	
Interface:	https://search.ahrq.gov/
Database:	AHRQ
Study Types:	Evidence Based Practice (EPC) Centre Reports, Full Research Reports, Health Technology Assessments
Search Run:	April 29, 2022
Search Strategy: search terms [number of results]	
Search titles only. "gender identity disorder" "gender dysphoria" "transgender" [7]	

Society for Evidence-based Gender Medicine (SEGM)

OVERVIEW	
Interface:	https://segm.org/news
Database:	SEGM News
Study Types:	Systematic Reviews
Search Run:	April 30, 2022
Search Strategy: search terms [number of results]	
Find in page: "systematic" [5]	

National Institute for Health and Care Excellence (NICE)

OVERVIEW	
Interface:	https://www.nice.org.uk/
Database:	NICE
Study Types:	Systematic Reviews, Guidelines with Systematic Reviews
Search Run:	April 30, 2022
Search Strategy: search terms [number of results]	
gender dysphoria [1] *Limit to Guidance* [1] transgender [10] *Limit to Guidance* [7]	

gender identity disorder [9] *Limit* to *Guidance* [8]

Search Strategies – Individual Studies

Questions Covered:

PICO questions:

1. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **puberty blockers (gonadotrophin releasing hormone (GnRH) analogues)** compared to no puberty blockers?

2. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of treatment with **cross-sex hormones** compared to no cross-sex hormones?

3. For children, adolescents, and young adults (<21) with gender dysphoria, what are the effects of **gender-affirming surgeries** compared to no surgery?

Search Strategies:

Note: Population, puberty blocker, cross-sex hormones search blocks adapted from NICE (2020) evidence reviews. Gender-affirming search block adapted from Wernick *et al.* 2019.

Databases: Medline

Medline

OVERVIEW	
Interface.	Ovid
Databases:	OVID Medline Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to Present
Study Types:	Any
Search Run:	May 12, 2022

Search Strategy: search terms [number of results]		
Population		
1	exp "Sexual and Gender Minorities"/	12631
2	Gender Dysphoria/	781
3	Gender Identity/	20586
4	Gender Role/	204
5	"Sexual and Gender Disorders"/	81
6	Transsexualism/	4259
7	Transgender Persons/	5371
8	Health Services for Transgender Persons/	187
9	exp Sex Reassignment Procedures/	1211
10	gender identity disorder.mp.	492

11 non-binary.mp. 574
12 transgender.mp. 10079
13 (gender* adj3 (dysphori* or disorder* or distress or nonconform* or non-conform* or atypical or incongru* or identi* or disorder* or confus* or minorit* or queer* or variant or diverse or creative or explor* or question* or expan* or fluid)).ti,ab. 16546
14 ((sex or gender*) adj3 (reassign* or chang* or transform* or transition*)).ti,ab. 9375
15 (transgend* or transex* or transsex* or transfem* or transwom* or transma* or transmen* or transperson* or transpeopl*).ti,ab. 19788
16 (genderfluid or genderqueer or agender).mp. 132
17 ((correct or chosen) adj3 name).mp. 591
18 (trans or crossgender* or cross-gender* or crossex* or cross-sex* or genderqueer*).ti,ab. 135744
19 (male-to-female or m2f or female-to-male or f2m).ti,ab. 149067
20 or/1-19 341083

Cross-sex Hormones

21 Hormones/ad, tu, th 4690
22 exp Progesterone/ad, tu, th 11270
23 exp Estrogens/ad, tu, th 29646
24 exp Gonadal Steroid Hormones/ad, tu, th 35401
25 (progesteron* or oestrogen* or estrogen*).ti,ab. 223689
26 ((cross-sex or crosssex or gender-affirm*) and (hormon* or steroid* or therap* or treatment* or prescri* or pharm* or medici* or drug* or intervention* or care)).ti,ab. 1507
27 exp Estradiol/ad, tu, th 11200
28 exp Testosterone/ad, tu, th 8722
29 (testosteron* or sustanon* or tostran or testogel or testim or restandol or andriol or testocaps* or nebido or testavan).ti,ab. 86670
30 (oestrad* or estrad* or evorel or ethinyloestrad* or ethinylestrad* or elleste or progynova or zumenon or bedol or femseven or nuvelle).ti,ab. 100411
31 or/21-30 346508

Puberty Blockers

32 Gonadotropin-Releasing Hormone/ 28845
33 (pubert* adj3 block*).ti,ab. 142
34 ((gonadotrophin or gonadotropin) and releasing).ti,ab. 20158
35 (GnRH adj2 analog*).ti,ab. 2879
36 GnRH*.ti,ab. 24437
37 "GnRH agonist*".ti,ab. 4763
38 Triptorelin Pamoate/ 1983
39 triptorelin.ti,ab. 822
40 arvekap.ti,ab. 1
41 ("AY 25650" or AY25650).ti,ab. 1
42 ("BIM 21003" or BIM21003).ti,ab. 0
43 ("BN 52014" or BN52014).ti,ab. 0
44 ("CL 118532" or CL118532).ti,ab. 0

45	Debio.ti,ab.	119
46	diphereline.ti,ab.	28
47	moapar.ti,ab.	0
48	pamorelin.ti,ab.	1
49	trelstar.ti,ab.	3
50	triptodur.ti,ab.	1
51	("WY 42422" or WY42422).ti,ab.	0
52	("WY 42462" or WY42462).ti,ab.	0
53	gonapeptyl.ti,ab.	0
54	decapeptyl.ti,ab.	225
55	salvacyl.ti,ab.	0
56	Buserelin/	2137
57	buserelin.ti,ab.	1396
58	onist.ti,ab.	0
59	("hoe 766" or hoe-766 or hoe766).ti,ab.	72
60	profact.ti,ab.	2
61	receptal.ti,ab.	31
62	suprecur.ti,ab.	5
63	suprefact.ti,ab.	25
64	tiloryth.ti,ab.	0
65	histrelin.ti,ab.	78
66	"LHRH-hydrogel implant".ti,ab.	1
67	("RL 0903" or RL0903).ti,ab.	1
68	("SPD 424" or SPD424).ti,ab.	1
69	goserelin.ti,ab.	1017
70	Goserelin/	1644
71	("ici 118630" or ici118630).ti,ab.	51
72	("ZD-9393" or ZD9393).ti,ab.	0
73	zoladex.ti,ab.	388
74	leuprorelin.ti,ab.	529
75	carcinil.ti,ab.	0
76	enanton*.ti,ab.	26
77	ginecrin.ti,ab.	0
78	leuplin.ti,ab.	15
79	Leuprolide/	3018
80	leuprolide.ti,ab.	2003
81	lucrin.ti,ab.	16
82	lupron.ti,ab.	183
83	provren.ti,ab.	0
84	procrin.ti,ab.	3
85	("tap 144" or tap144).ti,ab.	41
86	(a-43818 or a43818).ti,ab.	3
87	Trenantone.ti,ab.	2
88	staladex.ti,ab.	0
89	prostap.ti,ab.	6
90	Nafarelin/	327
91	nafarelin.ti,ab.	263
92	("76932-56-4" or "76932564").ti,ab.	0

93	("76932-60-0" or "76932600").ti,ab.	0
94	("86220-42-0" or "86220420").ti,ab.	0
95	("rs 94991 298" or rs94991298).ti,ab.	0
96	synarel.ti,ab.	13
97	deslorelin.ti,ab.	310
98	gonadorelin.ti,ab.	238
99	("33515-09-2" or "33515092").ti,ab.	0
100	("51952-41-1" or "51952411").ti,ab.	0
101	("52699-48-6" or "52699486").ti,ab.	0
102	cetrorelix.ti,ab.	520
103	cetrotide.ti,ab.	52
104	("NS 75A" or NS75A).ti,ab.	0
105	("NS 75B" or NS75B).ti,ab.	0
106	("SB 075" or SB075).ti,ab.	1
107	("SB 75" or SB75).ti,ab.	67
108	gonadoliberin.ti,ab.	152
109	kryptocur.ti,ab.	7
110	cetrorelix.ti,ab.	520
111	cetrotide.ti,ab.	52
112	antagon.ti,ab.	18
113	ganirelix.ti,ab.	161
114	("ORG 37462" or ORG37462).ti,ab.	3
115	orgalutran.ti,ab.	26
116	("RS 26306" or RS26306).ti,ab.	5
117	("AY 24031" or AY24031).ti,ab.	0
118	factrel.ti,ab.	13
119	fertagyl.ti,ab.	12
120	lutrelef.ti,ab.	5
121	lutrepulse.ti,ab.	3
122	relefact.ti,ab.	10
123	fertiral.ti,ab.	0
124	(hoe471 or "hoe 471").ti,ab.	6
125	relisorm.ti,ab.	4
126	cystorelin.ti,ab.	19
127	dirigestran.ti,ab.	5
128	or/32-127	47179

Surgery

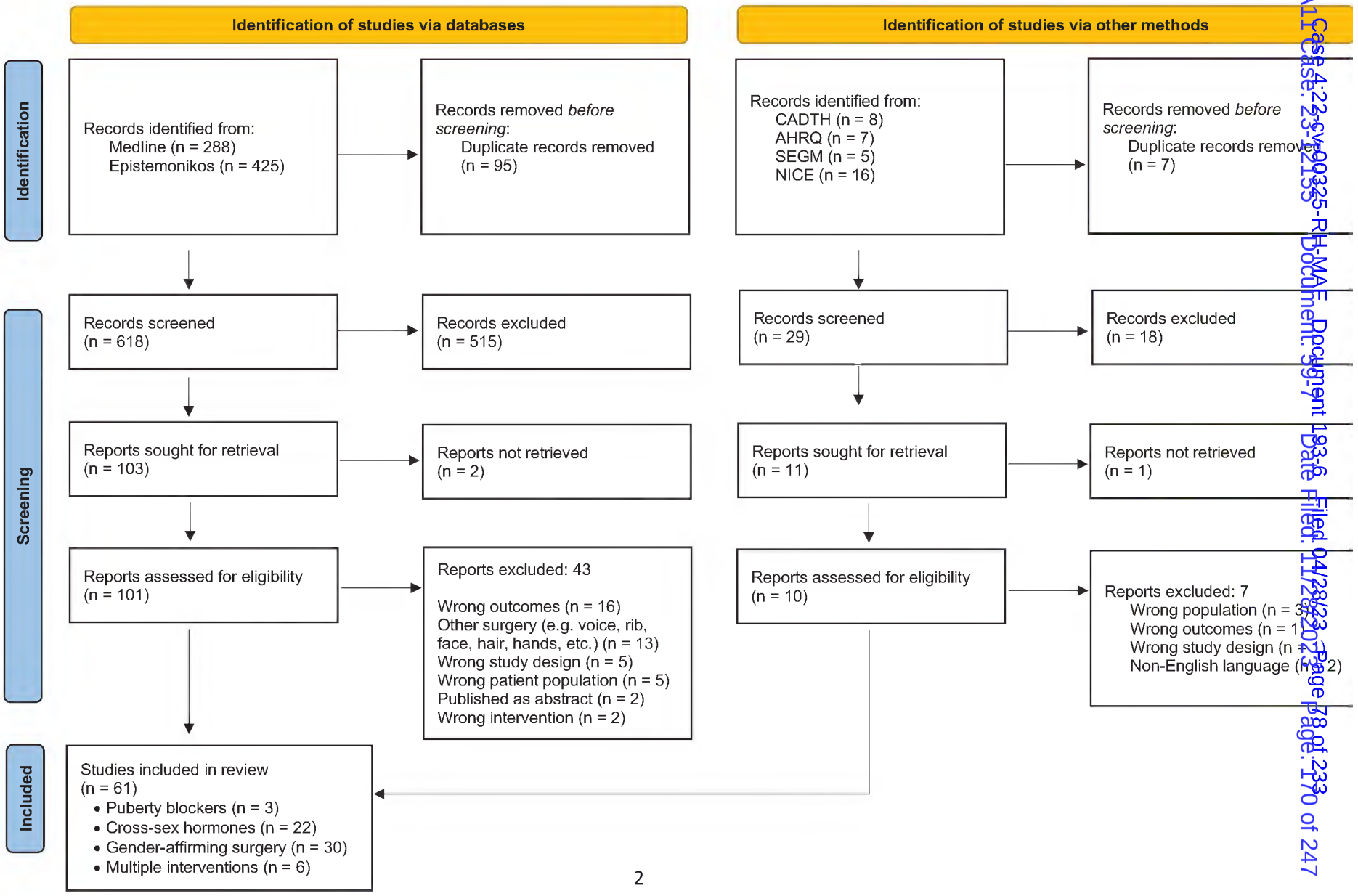
129	virilization/	2309
130	(virilism or virili?ation or masculini?ation).mp.	5664
131	feminization/	798
132	femini?ation.mp.	3425
133	(vaginoplasty or vaginoplasties).mp.	1032
134	(vaginoplasty or vaginoplasties).mp.	1032
135	(phalloplasty or phalloplasties).mp.	561
136	exp Penile Prosthesis/	1642
137	"penile reconstruction".mp.	292

138	(vagina reconstruction or vaginal reconstruction).mp.	550
139	(genitoplasty or genitoplasties).mp.	263
140	transsexualism/su [Surgery]	1007
141	sex reassignment.mp.	1674
142	sex transformation.mp.	42
143	or/129-142	14290
	Any intervention AND population	
144	31 or 128 or 143	386835
145	20 and 144	16516
	Limit to Humans	
146	animals/ not humans/	4972586
147	145 not 146	9281
148	limit 147 to humans	7901
	Limit to Publication Year 2019 to Current	
149	limit 148 to yr="2019 -Current"	1859

Results

Search results and eligible reviews: After screening 647 records found through our searches, we found 61 eligible systematic reviews. From these, 27 were published between 2020 and 2022 (Figure 1). Overall, 4% (1/27) of the reviews were judged to be of high methodological quality, 15% (4/27) were moderate methodological quality, 37% (10/27) were low methodological quality, and 44% (12/27) were critically low methodological quality.

We provide reasons for excluding systematic reviews in appendix 1.



Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Results; May 16, 2022

Figure 1: PRISMA flow diagram for the selection of systematic reviews. *From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

Outcomes:

1. **Puberty blockers:** We found 4 systematic reviews assessing the effects of puberty blockers published between 2020 and 2022.[1-4] From these, we judged 2 as having moderate methodological quality, and 2 as having critically low methodological quality. Details of the assessment are provided in Figure 2.

   Table 1 summarizes the evidence about the effects of puberty blockers on the outcomes of interest. We used information from 2 systematic reviews.[2 3] For most outcomes (except suicidality), there is no evidence about the effect of puberty blockers compared to not using puberty blockers. In other words, no studies compared the outcomes between a group of people with gender dysphoria using puberty blockers and another not using them. Therefore, it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them. There is very low certainty about the effects of puberty blockers on suicidal ideation (see details in Table 1).

   Studies, however, reported outcomes among a group of people with gender dysphoria after receiving puberty blockers. The findings are:
   - There is low certainty evidence suggesting that treatment with puberty hormones may slightly increase gender dysphoria severity (mean change score in the Utrecht Gender Dysphoria scale, 0.7 points [95% CI, -4.2 to 5.6], range 12-60, with higher scores reflecting more severe gender dysphoria)
   - There is low certainty evidence suggesting that treatment with puberty blockers may decrease depression (mean change score in the Beck Depression Inventory, -3.4 [95% CI, -5.7 to -1.0], range 0-63, with higher scores reflecting more severe depression)
   - There is low certainty evidence suggesting that treatment with puberty blockers may decrease anxiety (mean change score in the Trait Anxiety Scale, trait subscale, -1.5 [95% CI, -4.7 to -1.8], range 0-80, with higher scores reflecting more severe anxiety)
   - There is low certainty evidence suggesting a moderate percentage of patients reporting adverse events after treatment with puberty blockers (see Table 1 for details)
   - There is very low certainty evidence about how puberty blockers affect suicidality

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Results; May 16, 2022

Figure 2: AMSTAR assessment judgements for systematic reviews addressing puberty blockers

Review ID	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Methodological quality
AHRQ 2021																	MODERATE
NICE 2020a																	MODERATE
Ramos 2020																	CRITICALLY LOW
Rew 2020																	CRITICALLY LOW

Figure legend:

Yes

Probably yes

Probably no

No

Not applicable

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	**Risk / mean with puberty blockers**				
Gender dysphoria assessed with: difference (effect) in gender dysphoria proportion or severity	Not reported					The effects of puberty blockers on gender dysphoria are unknown
Gender dysphoria assessed with: mean change score in the Utrecht Gender Dysphoria Scale (12-60, higher scores reflect more gender dysphoria, 40 points or more indicate a diagnosis of gender dysphoria) (NICE, 2020a) Follow up: mean 1.9 years (range 0.4 to 5.1 years)	NA	0.7 (-4.2 to 5.6)	NA	41 (1 study)	⨁⨁◯◯ LOW[1]	The mean gender dysphoria score may increase by 0.7 points after puberty blockers
Depression assessed with: difference (effect) in depression proportion or severity	Not reported					The effects of puberty blockers on depression are unknown

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				
Depression assessed with: mean change score in Beck Depression Inventory-II scale (0-63, higher scores represent more severe depression) (NICE, 2020a) Follow up: mean 1.9 years (range 0.4 to 5.1 years)	NA	-3.4 (-5.7 to -1.0)	NA	41 (1 study)	⨁⨁◯◯ LOW[1]	The mean depression score may decrease by 3.4 points after puberty blockers
Anxiety assessed with: difference (effect) in anxiety proportion or severity	Not reported					The effects of puberty blockers on anxiety are unknown
Anxiety assessed with: mean change score in STAI-Trait scale (0-80, higher scores represent more severe anxiety) (NICE, 2020a) Follow up: mean 1.9 years (range 0.4 to 5.1 years)	NA	-1.5 (-4.7 to 1.8)	NA	41 (1 study)	⨁⨁◯◯ LOW[1]	The mean anxiety score may decrease by 1.5 points after puberty blockers

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				
Quality of life assessed with: any measure	Not reported					The effects of puberty blockers on quality of life are unknown
Suicidal ideation difference (effect) in suicidal ideation (Rew, 2020) Follow-up: cross-sectional survey	The authors report that "compared to youth who did not receive pubertal suppression, those who did showed lower lifetime rates of suicidal ideation".			89 (1 study)	⨁◯◯◯ VERY LOW[2]	We are very uncertain about the effect of puberty blockers on suicidal ideation
Adverse effects assessed with: proportion of patients reporting adverse effects (NICE, 2020a) Follow up: mean 2.3 years (range 0.0 to 11.3 years)	NA	11%[3] (2% to 29%)	NA	27 (1 study)	⨁⨁◯◯ LOW[4]	The proportion of patients reporting adverse effects after treatment with puberty blockers may be 11%

STAI-Trait: Trait Anxiety Scale. Range: 0-80
CI: Confidence interval
NA: Not applicable

Table 1: Puberty blockers (gonadotrophin releasing hormone analogues) compared to no puberty blockers in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: puberty blockers (gonadotrophin releasing hormone analogues)
Comparison: no puberty blockers

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no puberty blockers	Risk / mean with puberty blockers				

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Mean change rated down due to risk of bias and imprecision. According to the systematic review authors, the study had poor methodological quality. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size).
2. The authors of Rew 2020 narratively summarized the outcome of Turban *et al.* 2020; a cross-sectional online survey study. According to the systematic review authors, Turban et al. did not describe the study participants and the setting in detail and it was unclear whether outcomes were measured in a valid and reliable way. We therefore, downgraded the certainty of evidence by one level from low to very low due to high risk of bias.
3. The authors reported 3/27 (11%) participants treated with GnRHa developed side effects: 1 participant developed sterile abscesses; they were switched from leuprolide acetate to triptorelin, 1 participant developed leg pains and headaches, which eventually resolved without treatment, 1 participant gained 19 kg within 9 months of initiating GnRH analogues.
4. Proportion of adverse effects rated down due to risk of bias and imprecision. According to the systematic review authors, the cohort study Khatchadourian *et al.* 2014 was assessed at high risk of bias due to incomplete reporting of its cohort. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size).

2. **Cross-sex hormones:** We found 9 systematic reviews assessing the effects of cross-sex hormones published between 2020 and 2022.[4-12] One of these, however, included both puberty blockers and cross-sex hormones combined in their evidence synthesis as was not prioritized.[5] From the 8 remaining reviews, we judged 1 as having high methodological quality, 2 as having moderate methodological quality, 2 as having low methodological quality, and 3 as having critically low methodological quality. Details of the assessment are provided in Figure 3. Because of its eligibility criteria related to study design, the systematic review judged at high methodological quality[7] did not include any studies and therefore we could not use it to inform any outcome.

   Table 2 summarizes the evidence about the effects of cross-sex hormones on the outcomes of interest. We used information from 4 systematic reviews.[6 9 11 12] For most outcomes (all except risk of breast cancer), there is no evidence about the effect of cross-sex hormones compared to not using cross-sex hormones. In other words, no studies compared the outcomes between a group of people with gender dysphoria using cross-sex hormones and another not using it. Therefore, it is unknown whether people with gender dysphoria who use cross-sex hormones experience more improvement in gender dysphoria, depression, anxiety, quality of life, and suicidality than those with gender dysphoria who do not use them. There is low certainty evidence suggesting that cross-sex hormones may not increase or decrease the risk of breast cancer (see details in Table 2).

   Studies, however, reported outcomes among a group of people with gender dysphoria after receiving cross-sex hormones. The findings are:
   - There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease gender dysphoria severity (mean change score in the Utrecht Gender Dysphoria scale, -42.4 points [95% CI, -44.1 to -40.1], range 12-60, with higher scores reflecting more severe gender dysphoria)
   - There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease depression (measured with different scales, see Table 4 for details) and the need for treatment for depression (change in percentage, -39%)
   - There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease anxiety (measured with different scales, see Table 4 for details) and the need for treatment for anxiety (change in percentage, -32%)
   - There is very low certainty about the change in quality of life after treatment with cross-sex hormones.
   - There is low certainty evidence suggesting that treatment with cross-sex hormones may decrease suicidality degree (mean change score in the Ask Suicide-Screening questions scale, -0.84 points [95% CI, -1.30 to -0.44], range 0-4, with higher scores reflecting more severe suicidality) and the percentage of patients with need for treatment due to suicidality/self-harm (change in percentage, -31%). There is very low certainty evidence about the percentage of people with suicidal ideation and suicide attempts after treatment with cross-sex hormones.

- There is low certainty evidence suggesting a low prevalence of venous thromboembolism after treatment with cross-sex hormones (see Table 2 for details)

Figure 3: AMSTAR assessment judgements for systematic reviews addressing cross-sex hormones

Review ID	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Methodological quality
AHRQ 2021																	MODERATE
Baker 2021																	MODERATE
Fledderus 2020																	CRITICALLY LOW
Haupt 2020																	HIGH
Karalexi 2020																	LOW
Kotamarti 2021																	CRITICALLY LOW
Mattawanon 2021																	CRITICALLY LOW
NICE 2021b																	MODERATE
Totaro 2021																	LOW

Figure legend:

Yes

Probably yes

Probably no

No

Not applicable

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	**Risk/ mean with cross-sex hormones**				
Gender dysphoria assessed with: difference (effect) in gender dysphoria percentage or severity	Not reported					The effects of cross-sex hormones on gender dysphoria are unknown
Gender dysphoria assessed with: mean change score in the Utrecht Gender Dysphoria Scale (12-60, higher scores reflect more gender dysphoria, 40 points or more indicate a diagnosis of gender dysphoria) (NICE, 2020b) Follow up: 1 year	NA	-42.4 (-44.1 to -40.1)	NA	23 (1 study)	⨁⨁◯◯ LOW[1]	The mean gender dysphoria score may decrease by 42 points after cross-sex hormones
Depression assessed with: difference (effect) in depression percentage or severity	Not reported					The effects of cross-sex hormones on depression are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	**Risk/ mean with cross-sex hormones**				
Depression assessed with: mean change score in depression scales (higher scores represent more severe depression) (NICE, 2020b) Follow up: 1 year	NA	The mean depression score reduction was 9.6 points when using the BDI-II scale (n=23) and 7.5 when using the CESD-R scale (n=50). The authors report that both reductions were statistically significant[2]	NA	73 (2 studies)	⨁⨁◯◯ LOW[1]	The mean depression score may decrease after cross-sex hormones
Depression assessed with: change in percentage of patients with need for treatment (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants requiring treatment was reduced by 39% (from 54% at baseline), which was statistically significant	NA	52 (1 study)	⨁⨁◯◯ LOW[1]	The percentage of participants requiring treatment may be reduced by 39% after cross-sex hormones
Anxiety assessed with: difference (effect) in anxiety percentage or severity	Not reported					The effects of cross-sex hormones on anxiety are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	**Risk/ mean with cross-sex hormones**				
Anxiety assessed with: mean change score in anxiety scales (higher scores represent more severe anxiety) (NICE, 2020b) Follow up: 1 year	NA	The mean anxiety score reduction was 16.5 points when using the STAI-State scale and 14.5 when using the STAI-Trait scale. The authors report that both reductions were statistically significant	NA	23 (1 study)	⨁⨁◯◯ LOW[1]	The mean anxiety score may decrease after cross-sex hormones
Anxiety assessed with: change in percentage of patients with need for treatment (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants requiring treatment was reduced by 32% (from 48% at baseline), which was statistically significant	NA	52 (1 study)	⨁⨁◯◯ LOW[1]	The percentage of participants requiring treatment may be reduced by 32% after cross-sex hormones
Quality of life assessed with: difference (effect) in quality of life improvement	Not reported					The effects of cross-sex hormones on quality of life are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	**Risk/ mean with cross-sex hormones**				
Quality of life assessed with: mean change score in QLES-Q-SF score (higher scores represent better quality of life) (NICE, 2020b) Follow up: 1 year	NA	The mean quality of life score improved, but the differences were not statistically significant. The magnitudes were not reported	NA	50 (1 study)	⨁◯◯◯ VERY LOW[3]	We are very uncertain about the quality of life change after cross-sex hormones
Suicide/ suicidal ideation assessed with: difference (effect) in suicide or suicidal ideation	Not reported					The effects of cross-sex hormones on suicide/ suicidal ideation are unknown
Suicidality assessed with: change in score from ASQ instrument (higher scores represent greater degree of suicidality) (NICE, 2020b) Mean follow up: 1 year	NA	-0.84 (-1.30 to -0.44)	NA	39 (1 study)	⨁⨁◯◯ LOW[1]	Suicidality scores may decrease by 0.84 points after cross-sex hormones

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	**Risk/ mean with cross-sex hormones**				
Suicidal ideation assessed with: percentage of participants with suicidal ideation measured with PHQ-9 (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants with suicidal ideation decreased by 6% (from 10% at baseline). The authors did not conduct a statistical analysis	NA	50 (1 study)	⨁◯◯◯ VERY LOW[3]	We are very uncertain about the change in percentage of patients in suicidal ideation after cross-sex hormones
Suicide attempts assessed with: not reported (NICE, 2020b) Follow up: not reported	NA	The percentage of people with lifetime suicide attempts was 15%, those with attempts 3 months before treatment was 2%, and those with attempts at follow up was 5%	NA	130 (1 study)	⨁◯◯◯ VERY LOW[3]	We are very uncertain about the percentage of people with suicide attempts after cross-sex hormones
Suicidality/ self-harm assessed with: change in percentage of patients with need for treatment (NICE, 2020b) Follow-up: 1 year	NA	The percentage of participants requiring treatment was reduced by 31% (from 35% at baseline), which was statistically significant	NA	52 (1 study)	⨁⨁◯◯ LOW[1]	The percentage of participants requiring treatment may be reduced by 31% after cross-sex hormones
Venous thromboembolism assessed with: Risk of VTE	Not reported					The effects of cross-sex hormones on the risk of VTE are unknown

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	**Risk/ mean with cross-sex hormones**				
Venous thromboembolism assessed with: Prevalence among assigned males at birth (Totaro, 2021) Mean follow up: 4.1 years	NA	**20 per 1,000** (10 to 30)	NA	11,542 (18 studies)	⨁⨁⨁◯ MODERATE[4]	The prevalence of VTE among assigned males at birth is probably 2% after cross-sex hormones
Venous thromboembolism assessed with: Prevalence among assigned females at birth (Kotamarti, 2021) Mean follow up: 5.7 years	NA	**6 per 1,000** (CI not reported)[5]	NA	4,218 (8 studies)	⨁⨁⨁◯ MODERATE[6]	The prevalence of VTE among assigned females at birth is probably 0.6% after cross-sex hormones
Breast cancer assessed with: Risk of breast cancer (Fledderus, 2020) Follow up: not reported	Two studies compare the risk of beast cancer between assigned females at birth using versus not using testosterone, and found no differences (0 vs 1 case [total n= 130], and 1 vs 6 [total n=1579]). A third study compared assigned females at birth with non transgender women and found a lower risk in the former (magnitude not reported)		NA	2,938 (3 studies)	⨁⨁◯◯ LOW[7]	The risk of breast cancer may not increase or decrease due to the use of cross-sex hormones

Table 2: Cross-sex hormones compared to no cross-sex hormones in youth (<21 years old) with gender dysphoria

Patient or population: youth (<21 years old) with gender dysphoria
Intervention: cross-sex hormones
Comparison: no cross-sex hormones

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no cross-sex hormones	Risk/ mean with cross-sex hormones				

ASQ: Ask Suicide-Screening Questions. Range 0-4
BDI-II: Beck Depression Inventory. Range: 0-63
CESD-R: Center for Epidemiological Studies Depression Scale. Range: 0-60
CI: Confidence interval
NA: Not applicable
PHQ-9: Patient Health Questionnaire (PHQ) Modified for Teens. For suicidal ideation, it is a single question (yes/no)
QLES-Q-SF: Quality of Life Enjoyment and Satisfaction Questionnaire. Range: 15-75
STAI: State-Trait Anxiety Inventory. Range: 0-80

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Mean change rated down due to risk of bias and imprecision. According to the systematic review authors, the studies had poor methodological quality. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size)
2. Similar results when this outcome was measured using the Patient Health Questionnaire (PHQ) Modified for Teens in one of the same studies
3. Rated down due to risk of bias, imprecision, and indirectness. According to the systematic review authors, the studies had poor methodological quality. In addition, there are too few participants included, which is not sufficient to make trustworthy inferences (does not meet the optimal information size). Finally, 30% of the participants did not have a diagnosis of gender dysphoria.
4. Prevalence rated down due to risk of bias. According to the systematic review authors, only 6 out of the 18 studies (representing 16.5% of the weight of the studies) were at low risk of bias.

5. A meta-analysis of independent studies reported in this systematic review suggested that the prevalence of VTE in non-transgender females at birth was 1.7% (based on 7 studies and 18,748 persons)
6. Prevalence rated down doe to risk of bias. According to the systematic review authors, all studies had at least one domain judged as problematic.
7. Risk rated down 2 levels because of risk of bias. The researchers did not account for confounding in any of the studies.

3. **Surgeries:** We found 15 systematic reviews assessing the effects of gender-affirming surgeries published between 2020 and 2022. We judged 8 as having low methodological quality and 7 as having critically low methodological quality. Details of the assessment are provided in Figure 4. We present the results regarding the effects of surgeries in three parts. First, we describe the effects of all surgeries on mental health outcomes in all patients. Second, we describe the effects of all surgeries on surgical outcomes in assigned females at birth (transgender males). Finally, we describe the effects of all surgeries on surgical outcomes in assigned males at birth (transgender females).

3.1 Effects of surgeries on mental health outcomes: Table 3 summarizes the evidence about the effects of all surgeries on mental health outcomes in all patients. We used information from 2 systematic reviews.[13 14] There were no systematic reviews and studies reporting on gender dysphoria, depression, anxiety, and suicidality. Therefore, the effects of surgeries on these outcomes (when compared to a group of patients with gender dysphoria who do not undergo surgery), or the changes in these outcomes (improvements or deterioration) among patients who undergo surgeries is unknown.

The systematic reviews addressed quality of life and depression, but none of the included studies included a comparison group. Thus, it is unknown whether people with gender dysphoria who undergo surgeries experience more improvement in quality of life or less regret than those with gender dysphoria who do not undergo surgeries.

Studies, however, reported the following outcomes among a group of people with gender dysphoria after undergoing surgeries. The findings are:

- There is low certainty evidence suggesting that the percentage of people who experience regret after surgery is low (1%)
- There is very low certainty evidence about how surgeries affect quality of life (see Table 3 for details)

Figure 4: AMSTAR assessment judgements for systematic reviews addressing gender-affirming surgery

Review ID	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Item 12	Item 13	Item 14	Item 15	Item 16	Methodological quality
Bustos SS 2021																	LOW
Bustos VP 2021																	LOW
Bustos VP 2021b																	LOW
Dunford 2021																	LOW
Eftekhar, 2020																	LOW
Falcone 2021																	CRITICALLY LOW
Hu, 2022																	CRITICALLY LOW
Huayllani 2021																	CRITICALLY LOW
Jolly 2021																	LOW
Nassiri 2020																	CRITICALLY LOW
Oles 2022																	LOW
Oles 2022b																	LOW
Salibian 2021																	CRITICALLY LOW
Sijben 2021																	CRITICALLY LOW
Tay 2021																	CRITICALLY LOW

Figure legend:

Yes

Probably yes

Probably no

No

Not applicable

Table 3: All surgeries compared to no surgeries in young people (<21 years old) with gender dysphoria

Patient or population: young people (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries
Outcomes: Mental health and regret

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Gender dysphoria assessed with: any measure	Not reported					The effects of surgery on gender dysphoria, the changes in gender dysphoria severity after surgery, and the prevalence of gender dysphoria after surgery are unknown
Depression assessed with: any measure	Not reported					The effects of surgery on depression, the changes in depression severity after surgery, and the prevalence of depression after surgery are unknown
Anxiety assessed with: any measure	Not reported					The effects of surgery on anxiety, the changes in anxiety severity after surgery, and the prevalence of anxiety after surgery are unknown
Suicidality assessed with: any measure	Not reported					The effects of surgery on suicidality, the changes in anxiety severity after surgery, and the prevalence of anxiety after surgery are unknown
Quality of life assessed with: difference (effect) in quality of life	Not reported					The effects of surgery on quality of life are unknown
Quality of life assessed with: change in quality of life	Not reported					The change in quality of life after surgery is unknown

Quality of life assessed with: mean score in the Short Form-36 Scale (0-100, higher scores reflect better quality of life) (Eftekhar Ardebili, 2020) Follow up: cross-sectional	NA	59.17 (48.59 to 69.74)[1]	NA	633 (5 studies)	⨁◯◯◯ VERY LOW[2]	We are very uncertain about the quality of life after surgeries
Regret assessed with: difference (effect) in percentage of people with regret	Not reported					The effects of surgery on regret are unknown
Regret assessed with: percentage of people with regret (Bustos, 2021) Mean follow up: 4 years	NA	1% (0 to 2%)[3]	NA	7928 (27 studies)	⨁⨁◯◯ LOW[4]	The percentage of people who experience regret is low

CI: Confidence interval
NA: Not applicable

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Similar scores for assigned males at birth and assigned females at birth.
2. Mean score rated down for risk of bias and inconsistency. According to the systematic review authors, all studies had concerns related to risk of bias. In addition, the smaller studies showed better quality of life than the larger study.
3. Similar percentage for assigned males at birth and assigned females at birth, and for different types of surgeries (all pooled percentages below 2%).
4. Percentage rated down due to risk of bias and indirectness. According to the authors, many of the studies had moderate or high risk of bias. The mean age of the participants at the time of surgery was higher than the target population. Because it was considered to not have an important effect on the pooled estimate, we did not rate down for statistical heterogeneity

3.2 **Effects of surgeries on assigned females at birth:** Table 4 summarizes the evidence about the effects of all surgeries on surgical outcomes among assigned at birth females. We used information from 3 systematic reviews.[13-17] Due to the nature of the outcomes (i.e. they can only be experienced by people who undergo surgeries), there cannot be studies comparing the outcomes between a group of people with gender dysphoria who undergo surgeries and another who does not.

Studies, therefore, assessed the outcomes among a group of people with gender dysphoria after surgery. The findings are:

- There is low certainty evidence suggesting that the percentage of people who are satisfied after chest surgery is high (92%)
- There is very low certainty evidence about the rate of surgical complications after chest surgery
- There is very low certainty evidence about the percentage of people who are satisfied, and the rate of surgical complications after bottom surgeries (see Table 4 for details)

Table 4: All surgeries compared to no surgeries in assigned females at birth (<21 years old) with gender dysphoria

Patient or population: assigned females at birth (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Chest surgery						
Satisfaction assessed with: percentage of people who reported being satisfied (Bustos VP, 2020b) Range of follow up: 6 weeks to 46 months[1]	NA	92% (88% to 96%)[2]	NA	733 (14 studies)	⨁⨁◯◯ LOW[3]	The percentage of people who reports being satisfied may be 92%
Surgical complications assessed with: rate of complications across patients (Oles, 2022) Range of follow up: 8 weeks to 1 year	NA	16.8% Range (5.5% to 80.0%)	NA	1255 (7 studies)	⨁◯◯◯ VERY LOW[4]	We are very uncertain about the rate of surgical complications
Reoperation assessed with: rate of reoperation across patients (Oles, 2022) Range of follow up: 8 weeks to 1 year	NA	6.2% Range (0.7% to 11.2%)	NA	1214 (6 studies)	⨁◯◯◯ VERY LOW[4]	We are very uncertain about the rate of reoperation
Bottom surgery						

Table 4: All surgeries compared to no surgeries in assigned females at birth (<21 years old) with gender dysphoria

Patient or population: assigned females at birth (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Satisfaction assessed with: percentage of people who reported being satisfied (Oles, 2022b) Range of follow up: 6 weeks to 46 months	NA	89.6% (45% to 100%)[5]	NA	1458 (27 studies)	⨁◯◯◯ VERY LOW[4]	We are very uncertain about the percentage of people who reports being satisfied
Surgical complications-Major assessed with: percentage of people experiencing major complications (Oles, 2022b) follow up: not reported	NA	The percentage was - 2.3% (range 0 to 20%) experiencing total flap loss - 19.5% (range 0 to 72%) experiencing prosthesis issues - 24.5% (range 0 to 86%) experiencing urethral issues	NA	3177 (42 studies)[6]	⨁◯◯◯ VERY LOW[4]	We are very uncertain about the percentage of people who experience major surgical complications
Surgical complications-Minor assessed with: percentage of people experiencing major complications (Oles, 2022b) follow up: not reported	NA	The percentage varied from 9.3% (range 0% to 45.5%) experiencing donor site issues, to 24% (range 10 to 93%) experiencing urethral issues[7]	NA	4466 (52 studies)[8]	⨁◯◯◯ VERY LOW[4]	We are very uncertain about the percentage of people who experience minor surgical complications

Table 4: All surgeries compared to no surgeries in assigned females at birth (<21 years old) with gender dysphoria

Patient or population: assigned females at birth (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Reoperation assessed with: rate of reoperation across patients (Oles, 2022b) follow up: not reported	NA	27.6% Range (2.5% to 40%)	NA	1624 (15 studies)	⨁◯◯◯ VERY LOW[4]	We are very uncertain about the percentage of people who undergo reoperations

CI: Confidence interval
NA: Not applicable

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Studies used different scales to assess satisfaction
2. The percentage was similar when the analysis was done by type of surgery and by follow up time (< 1 year vs 1 year or more). Another systematic review (Oles, 2022) also investigated this outcome, and reported a very similar percentage of satisfaction (91.8%, range 73% to 100%)
3. Percentage of patients satisfied rated down due to risk of bias and indirectness. According to the systematic review authors, several studies were judged at moderate and high risk of bias. In addition, the median of the mean age of patients included in the studies was 28 years
4. Rated down due to risk of bias, inconsistency/ imprecision, and indirectness. Even though the review authors did not assess risk of bias, these studies were included in other systematic reviews in which the authors judged several of them at high risk of bias. The studies report inconsistent results (some high and other low rates). The patients are older than the target population.
5. Results for phalloplasty. Similar results for metoidioplasty (91.3%).

6. People and studies for urethral complications. 2671 people (37 studies) for prosthesis issues, and 1548 people (22 studies) for total flap loss.
7. Percentage of wound dehiscence 9.8% (range, 2.9% to 75%), percentage of infection/ partial necrosis 10.3% (range, 0 to 45.8%), percentage of prosthesis issues 14.2% (range, 1.6 to 41.9%), percentage of incontinence 15.3% (range, 5.4% to 59.1%)
8. People and studies for infection/ partial necrosis. 2389 people (31 studies) for urethral issues, 1736 people (17 studies) for wound dehiscence, 1080 (10 studies) for prosthesis issues, 1053 people (8 studies) for donor site issues, 131 people (3 studies) for incontinence

3.3 **Effects of surgeries on assigned males at birth**: Table 5 summarizes the evidence about the effects of all surgeries on surgical outcomes among assigned at birth males. We used information from 3 systematic reviews.[16 18 19] Due to the nature of the outcomes (i.e. they can only be experienced by people who undergo surgeries), there cannot be studies comparing the outcomes between a group of people with gender dysphoria who undergo surgeries and another who does not.

Studies, therefore, assessed the outcomes among a group of people with gender dysphoria after surgery. The findings are:

- There is low certainty evidence suggesting that the percentage of people who are satisfied after vaginoplasty is high (91%)
- There is very low certainty evidence about the percentage of people who are satisfied, the rate of complications, and the rate of reoperations after chest surgery (see Table 5 for details)
- There is low certainty evidence suggesting that the percentage of people who have regret after vaginoplasty is low (2%)
- There is very low certainty evidence about the rate of complications and the rate of reoperations after vaginoplasty (see Table 5 for details)

Table 5: All surgeries compared to no surgeries in assigned males at birth (<21 years old) with gender dysphoria

Patient or population: assigned males at birth (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Chest surgery						
Satisfaction assessed with: percentage of people who reported being satisfied (Oles 2022) Range of follow up: 12 months to 17 years	NA	Range 75% (80/107) to 95% (33/35)[1]	NA	142 (2 studies)	⨁◯◯◯ VERY LOW[2]	We are very uncertain about the percentage of people who report being satisfied
Surgical complications assessed with: rate of complications across patients (Oles 2022) Range of follow up: 2 weeks to 16 years	NA	The complication rates were: - 3.8% (range 0% to 5.5%) of capsular contracture - 2.2% of major hematoma - 2.2% of implant extrusion[3]	NA	432 (5 studies)	⨁◯◯◯ VERY LOW[2]	We are very uncertain about the rate of surgical complications
Reoperation assessed with: rate of reoperation across patients (Oles 2022) Range of follow up: Not reported	NA	8.6% Range (4.4% to 10.4%)	NA	291 (2 studies)	⨁◯◯◯ VERY LOW[2]	We are very uncertain about the rate of reoperation
Bottom surgery						

Table 5: All surgeries compared to no surgeries in assigned males at birth (<21 years old) with gender dysphoria

Patient or population: assigned males at birth (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Satisfaction assessed with: percentage of people who reported being satisfied for overall outcomes (Bustos SS, 2021) Range of follow up: 1 week to 11.3 years	NA	91% (81% to 98%)[4]	NA	1230 (12 studies)	⨁⨁◯◯ LOW[5]	The percentage of people who report being satisfied with overall outcomes may be 91%
Regret assessed with: percentage of people who reported regret (Bustos SS, 2021) Range of follow up: 2 months to 24.1 years	NA	2% (1% to 3%)	NA	1137 (15 studies)	⨁⨁◯◯ LOW[6]	The percentage of people who report regret may be 2%
Surgical complications assessed with: rate of complications across patients (Bustos SS, 2021) Range of follow up: 3 weeks to 24.1 years	NA	The complication rates were: - 1% (95% CI, <0.1% to 2%) of fistula - 11% (95% CI, 8% to 14%) of stenosis and/or strictures - 4% (95% CI, 1% to 9%) of tissue necrosis - 3% (95% CI, 1% to 4%) of prolapse[7]	NA	4196 (42 studies)[3]	⨁◯◯◯ VERY LOW[8]	We are very uncertain about the rate of surgical complications

Table 5: All surgeries compared to no surgeries in assigned males at birth (<21 years old) with gender dysphoria

Patient or population: assigned males at birth (<21 years old) with gender dysphoria
Intervention: surgeries
Comparison: no surgeries

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	What happens
	Risk / mean with no surgery	Risk/ mean with surgery				
Reoperation assessed with: rate of reoperation across patients (Tay, 2021) Range of follow up: 6 weeks to 14.8 months	NA	One study reported a surgical revision rate of 9% (1/11 patients), and a second study reported that 13% (19/145) patients required repeat surgery due to complications.	NA	156 (2 studies)	⨁◯◯◯ VERY LOW[9]	We are very uncertain about the percentage of people who undergo reoperations

CI: Confidence interval
NA: Not applicable

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

1. Another systematic review, Sijben 2021, reported satisfaction from 3 additional studies: 82% (113/138) were satisfied or very satisfied, 93% (32/34) were happier and more satisfied with their chest, and 79% (28/36) were very satisfied with the overall cosmetic result (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
2. Rated down due to risk of bias, indirectness (the included studies were not restricted to youth or young adults), and imprecision (too few participants included, not meeting optimal information size).

3. Another systematic review, Sijben 2021, reported similar ranges for rates of complication requiring reoperation from 7 studies (835 patients): capsular contraction (range 0.0-5.6%), asymmetry (3.6%), hematoma (range 0.0-2.9%), infection (range 0.0-0.9%), striae distensae (0.7%), implant rupture (0.7%), abscess (0.4%), scarring (0.0%), hypersensitivity (0.0%), and numbness (0.0%) (very low certainty of evidence due to risk of bias, imprecision, and indirectness)
4. Bustos SS *et al.* 2021 additionally reported on satisfaction for functional (87%, 95% CI 77% to 94%) and aesthetic (90%, 95% CI 84% to 94%) outcomes. Another systematic review and meta-analysis, Oles 2022b, similarly reported that 92.3% (range 23.1% to 100%) of patients (2410/2601) were satisfied after vaginoplasty (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
5. Rated down due to risk of bias (the systematic review authors reported the quality of the included studies to be low to moderate using the New Castle Ottawa scale), and indirectness as the included studies were not restricted to youth or young adults. We did not rate down for imprecision or inconsistency despite high I^2 values as a satisfaction rate of 80% or above was deemed as a minimum threshold for clinical importance.
6. Rated down due to risk of bias (the systematic review authors reported the quality of the included studies to be low to moderate using the New Castle Ottawa scale), and indirectness as the included studies were not restricted to youth or young adults.
7. Another systematic review, Oles 2022b, similarly reported the percentage of patients experiencing complications from 51 studies, ranging from 2.4% to 12.0% (range 0% to 88%) for minor complications (intraoperative injury, wound dehiscence, superficial necrosis, infection, urinary issues, vaginal prolapse, stenosis, and bleeding) and 1.6% to 2.1% (range 0% to 31%) for major complications (flap/graft necrosis and infection) after genitoplasty (very low certainty of evidence due to risk of bias, imprecision, and indirectness).
8. Rated down due to risk of bias (the systematic review authors reported the quality of the included studies to be low to moderate using the New Castle Ottawa scale), imprecision and inconsistency, with wide confidence intervals and I^2 values ranging from 65.8% to 94.3%, and indirectness as the included studies were not restricted to youth or young adults.
9. Rated down due to risk of bias, indirectness (the age range of patients in the included studies was 24 to 39 years; the studies included were restricted to those that investigated the use of peritoneum in neovagina construction), and imprecision (too few participants included, not meeting optimal information size).

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Results; May 16, 2022

Results from search for studies not included in the systematic reviews: After screening 1854 records found through our searches, we found 10 eligible studies (figure 5). From these, 8 were comparative observational studies[20-27] and 2 were non- comparative[28 29]. We provide reasons for excluding studies in appendix 2.

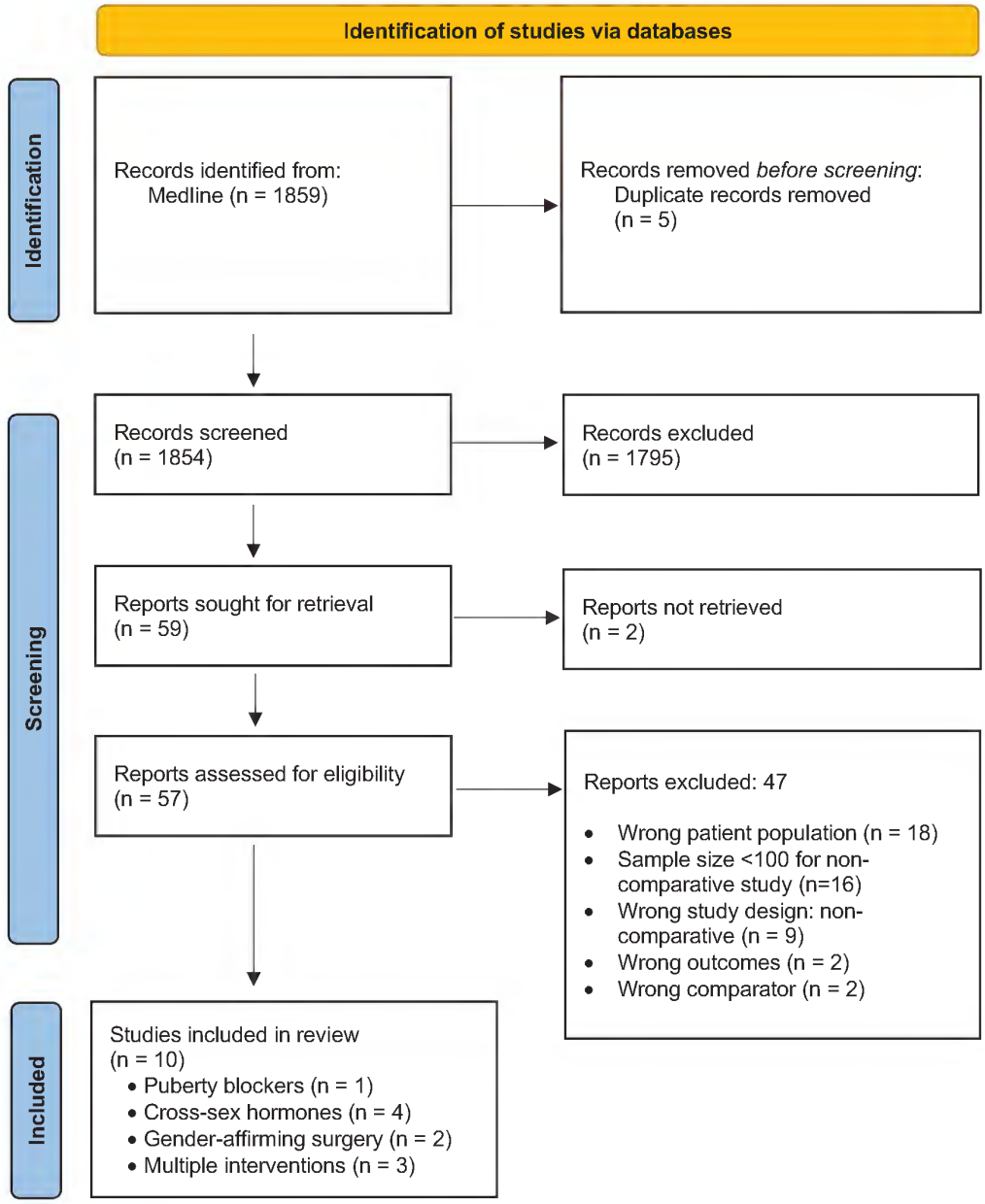


Figure 5: PRISMA flow diagram for the selection of primary studies. *From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/

None of the studies were judged as likely to importantly change the conclusions obtained from the systematic reviews (Tables 6 and 7). The main limitations of the comparative studies were risk of bias concerns (Figures 6 and 7) due to confounding, classification of intervention, and missing data; as well as small sample sizes. Although non-comparative studies were at lower risk of bias, because their results were consistent with those of the included evidence, they were also judged as unlikely to change the conclusions importantly.

Table 6: Characteristics of eligible comparative observational studies

Study ID	Sample size*	Study design	Intervention	Comparator	Outcomes measured	Likely to change conclusions	Reasons
VanDerMiesen, 2020	450	Retrospective cohort study	Puberty blockers	Waiting for puberty blockers	Self-harm/ suicidality, internalizing behaviors	No	Reports a small benefit on suicidality and moderate on internalizing behaviours, but high risk of bias
Becker-Hebly, 2021	75	Prospective cohort study	1. Puberty blockers 2. Cross-sex hormones 3. Surgery	No medical intervention yet; psychosocial intervention only	Health-related quality of life	No	Critical risk of bias (missing data due to low response rate, and confounding). Reports small benefit in mean change score for mental and physical dimension QoL as compared to no medical treatment. Imprecision; the 95% CIs for mean change scores are wide.
Green, 2021	3235	Cross-sectional study	Cross-sex hormones	Would like to take cross-sex hormones	Depression, suicidality	No	Critical risk of bias, no follow up of patients (measurement of current outcomes and not adjusting for baseline)
Tordoff, 2022	84	Prospective cohort study	1. Puberty blockers 2. Cross-sex hormones	No intervention	Depression, anxiety, suicidal thoughts	No	Moderate risk of bias, small sample size
Turban, 2022	9341	Cross-sectional study	Cross-sex hormones	Desired but never accessed gender affirming hormones	Suicidal ideation, suicidal attempt	No	Critical risk of bias, no follow up of patients (measurement of current outcomes and not adjusting for baseline)
Grannis, 2021	47	Cross-sectional study	Cross-sex hormones	No intervention yet	Anxiety, depression	No	Critical risk of bias, no follow up of patients, small sample size
Fontanari, 2020	350	Cross-sectional study	1. Cross-sex hormones 2. Cross-sex hormones or surgery	1. Waiting for cross-sex hormones 2. No intervention	Anxiety, depression, gender distress	No	Critical risk of bias (confounding, self-reported classification of interventions). Online cross-sectional survery reported small benefit in anxiety and depression mean scores, and little to no effect on gender distress with cross-sex hormones and/or surgery. Non-randomized comparative study provides very low certainty evidence due to

							very serious risk of bias and serious imprecision (95% CIs include little to no effect)
Castelo-Branco, 2021	205	Cross-sectional study	Cross-sex hormones	No intervention	Anxiety, depression	No	Critical risk of bias due to confounding (non-adjusted analysis). Reported no difference observed in anxiety and depression mean scores (Symptom Checklist-90-Revised scale) between groups. Non-randomized comparative study provides low certainty evidence.

*Considered the number of participants relevant to the questions of this report, not all people included in the studies

Table 7: Characteristics of eligible non- comparative observational studies

Study ID	Sample size	Intervention	Outcomes measured	Likely to change conclusions	Reasons
Bordas, 2021	813	FtM bottom surgery	Surgical complications, satisfaction	No	Reports rate of complications (10.5%) and satisfaction (79% totally satisfied, 20% mainly satisfied) within range of effects reported by studies already included in systematic reviews. Unlikely to reduce imprecision and inconsistency within body of evidence (3177 and 1458 people, respectively) of non-comparative studies (42 and 27, respectively) to increase certainty of evidence
Elias, 2022	110	FtM top surgery	Complications	No	Reports rate of complications (16%) and revision surgery (5%), which is consistent with the rates reported in the studies included. Unlikely to increase the certainty of evidence

Figure 6: Risk of bias judgements for comparative studies

Study ID	Intervention	Confounding	Classification of the intervention	Deviations from intended interventions	Missing data	Measurement of outcome	Overall
Becker-Hebly, 2021	Puberty blockers, cross-sex hormones, or surgery						CRITICAL
Castelo-Branco, 2021	Cross-sex hormones						CRITICAL
Fontanari, 2020	Cross-sex hormones, cross-sex hormones or surgery						CRITICAL
Grannis, 2021	Cross-sex hormones						CRITICAL
Green, 2021	Cross-sex hormones						CRITICAL
Tordoff, 2022	Puberty blockers, cross-sex hormones						MODERATE
Turban, 2022	Cross-sex hormones						CRITICAL
Van Der Miesen, 2020	Puberty blockers						SERIOUS

Figure legend:

Low

Moderate

Serious

Critical

Unclear

Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence. Dr. Romina Brignardello-Petersen and Dr. Wojtek Wiercioch; Results; May 16, 2022

Figure 7: Risk of bias judgements for non-comparative studies

Study ID	Intervention	Representativeness of sample	Classification of intervention	Deviation from intended interventions	Missing data	Measurement of outcome	Overall
Bordas, 2021	FtM bottom surgery						LOW
Elias, 2022	FtM top surgery						MODERATE

Figure legend:

Low

Moderate

High

References

1. Ramos GGF, Mengai ACS, Daltro CAT, et al. Systematic Review: Puberty suppression with GnRH analogues in adolescents with gender incongruity. *Journal of endocrinological investigation* 2021;44(6):1151-58. doi: https://dx.doi.org/10.1007/s40618-020-01449-5
2. Rew L, Young CC, Monge M, et al. Review: Puberty blockers for transgender and gender diverse youth-a critical review of the literature. *Child and adolescent mental health* 2021;26(1):3-14. doi: https://dx.doi.org/10.1111/camh.12437
3. Excellence NIfHaC. Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria, 2020.
4. Quality AfHRa. Topic Brief: Treatments for Gender Dysphoria in Transgender Youth, 2021.
5. Baker KE, Wilson LM, Sharma R, et al. Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. *Journal of the Endocrine Society* 2021;5(4):bvab011. doi: 10.1210/jendso/bvab011
6. Fledderus AC, Gout HA, Ogilvie AC, et al. Breast malignancy in female-to-male transsexuals: systematic review, case report, and recommendations for screening. *Breast (Edinburgh, Scotland)* 2020;53(9213011):92-100. doi: https://dx.doi.org/10.1016/j.breast.2020.06.008
7. Haupt C, Henke M, Kutschmar A, et al. Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *The Cochrane database of systematic reviews* 2020;11:CD013138. doi: 10.1002/14651858.CD013138.pub2
8. Karalexi MA, Georgakis MK, Dimitriou NG, et al. Gender-affirming hormone treatment and cognitive function in transgender young adults: a systematic review and meta-analysis. *Psychoneuroendocrinology* 2020;119:104721. doi: 10.1016/j.psyneuen.2020.104721
9. Kotamarti VS, Greige N, Heiman AJ, et al. Risk for Venous Thromboembolism in Transgender Patients Undergoing Cross-Sex Hormone Treatment: A Systematic Review. *The journal of sexual medicine* 2021 doi: 10.1016/j.jsxm.2021.04.006
10. Mattawanon N, Charoenkwan K, Tangpricha V. Sexual Dysfunction in Transgender People: A Systematic Review. *The Urologic clinics of North America* 2021;48(4):437-60. doi: 10.1016/j.ucl.2021.06.004
11. Totaro M, Palazzi S, Castellini C, et al. Risk of Venous Thromboembolism in Transgender People Undergoing Hormone Feminizing Therapy: A Prevalence Meta-Analysis and Meta-Regression Study. *Frontiers in endocrinology* 2021;12:741866. doi: 10.3389/fendo.2021.741866
12. Excellence NIfHaC. Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria., 2020.
13. Eftekhar Ardebili M, Janani L, Khazaei Z, et al. Quality of life in people with transsexuality after surgery: a systematic review and meta-analysis. *Health and quality of life outcomes* 2020;18(1):264. doi: 10.1186/s12955-020-01510-0
14. Bustos VP, Bustos SS, Mascaro A, et al. Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. *Plastic and reconstructive surgery Global open* 2021;9(3):e3477. doi: 10.1097/GOX.0000000000003477
15. Oles N, Darrach H, Landford W, et al. Gender Affirming Surgery: A Comprehensive, Systematic Review of All Peer-reviewed Literature and Methods of Assessing Patient-centered Outcomes (Part 2: Genital Reconstruction). *Annals of surgery* 2022;275(1):e67-e74. doi: 10.1097/SLA.0000000000004717
16. Oles N, Darrach H, Landford W, et al. Gender Affirming Surgery: A Comprehensive, Systematic Review of All Peer-Reviewed Literature and Methods of Assessing Patient-Centered Outcomes (Part 1: Breast/Chest, Face, and Voice). *Annals of surgery* 2022 doi: 10.1097/SLA.0000000000004728
17. Bustos VP, Bustos SS, Mascaro A, et al. Transgender and Gender-nonbinary Patient Satisfaction after Transmasculine Chest Surgery. *Plastic and reconstructive surgery Global open* 2021;9(3):e3479. doi: 10.1097/GOX.0000000000003479
18. Bustos SS, Bustos VP, Mascaro A, et al. Complications and Patient-reported Outcomes in Transfemale Vaginoplasty: An Updated Systematic Review and Meta-analysis. *Plastic and reconstructive surgery Global open* 2021;9(3):e3510. doi: 10.1097/GOX.0000000000003510
19. Tay YT, Lo CH. Use of peritoneum in neovagina construction in gender-affirming surgery: A systematic review. *ANZ journal of surgery* 2021 doi: 10.1111/ans.17147

20. Becker-Hebly I, Fahrenkrug S, Campion F, et al. Psychosocial health in adolescents and young adults with gender dysphoria before and after gender-affirming medical interventions: a descriptive study from the Hamburg Gender Identity Service. *European child & adolescent psychiatry* 2021;30(11):1755-67. doi: https://dx.doi.org/10.1007/s00787-020-01640-2
21. Castelo-Branco C, RiberaTorres L, Gomez-Gil E, et al. Psychopathological symptoms in Spanish subjects with gender dysphoria. A cross-sectional study. *Gynecological endocrinology : the official journal of the International Society of Gynecological Endocrinology* 2021;37(6):534-40. doi: https://dx.doi.org/10.1080/09513590.2021.1913113
22. Fontanari AMV, Vilanova F, Schneider MA, et al. Gender Affirmation Is Associated with Transgender and Gender Nonbinary Youth Mental Health Improvement. *LGBT health* 2020;7(5):237-47. doi: https://dx.doi.org/10.1089/lgbt.2019.0046
23. Grannis C, Leibowitz SF, Gahn S, et al. Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys. *Psychoneuroendocrinology* 2021;132(7612148, qgc):105358. doi: https://dx.doi.org/10.1016/j.psyneuen.2021.105358
24. Green AE, DeChants JP, Price MN, et al. Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine* 2022;70(4):643-49. doi: https://dx.doi.org/10.1016/j.jadohealth.2021.10.036
25. Tordoff DM, Wanta JW, Collin A, et al. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA network open* 2022;5(2):e220978. doi: https://dx.doi.org/10.1001/jamanetworkopen.2022.0978
26. Turban JL, King D, Kobe J, et al. Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PloS one* 2022;17(1):e0261039. doi: https://dx.doi.org/10.1371/journal.pone.0261039
27. van der Miesen AIR, Steensma TD, de Vries ALC, et al. Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine* 2020;66(6):699-704. doi: https://dx.doi.org/10.1016/j.jadohealth.2019.12.018
28. Bordas N, Stojanovic B, Bizic M, et al. Metoidioplasty: Surgical Options and Outcomes in 813 Cases. *Frontiers in endocrinology* 2021;12(101555782):760284. doi: https://dx.doi.org/10.3389/fendo.2021.760284
29. Elias N, Rysin R, Kwartin S, et al. Breaking the Binary: The Approach to Chest Masculinizing Gender-Affirming Surgery in Trangender Men. *The Israel Medical Association journal : IMAJ* 2022;24(1):20-24.

ID	Study	Reason
#534	Abu-Ghname 2020	Wrong population: non transgender men
#434	Aires 2022	Wrong interventions: Other type of surgery: glottoplasty
#514	Angus 2021	Wrong outcomes: It does not include any outcome of interest. Includes: serum total testosterone concentration, body fat redistribution, breast development, and facial/body hair reduction
#318	Baddredine 2022	Wrong intervention. Continuing vs stopping estrogen during perioperative period of vaginoplasty
#40	Baram 2019	Wrong outcomes: only clinical outcomes are sperm count, testicular histology, hormone levels, etc.
#145	Barcelos 2022	Wrong outcomes: sexual satisfaction, desire, and function outcomes only
#60	Boczar 2021	No outcome data
#386	Bouman 2014	Wrong population: unclear that more than 80% are transgender
#208	Bustos 2021	Wrong intervention: niple areola reconstruction
#54	Connelly 2021	Wrong outcomes: Blood pressure
#43	Coon 2022	Wrong intervention: facial gender surgery
#34	D'Angelo 2018	Wrong design: narrative review
#165	Delgado-Ruiz 2019	Wrong outcomes: bone density
#355	Escandon 2022	Other type of surgery: facial surgery
#129	Fighera 2019	Wrong outcomes: bone mass
#597	Hembree 2017	Practice guideline, does not report the methods/ results of the systematic review in details
#120	Kakadekar 2021	Wrong outcomes: histological findings
#451	Kennedy 2021	Wrong intervention: self administered hormones
#375	Kloer 2021	Wrong outcomes: sexual health and satisfaction outcomes only
#439	Kovar 2019	More than 20% participants did not have gender dysphoria
#297	Kristensen 2021	Wrong outcomes: agression and hostility
#637	Leclere 2015	Wrong design: commentary of a systematic review
#293	Miranda 2021	Published in abstract format only
#624	Morrison 2016	Wrong intervention: facial feminization surgery
#270	Narayan 2021	Wrong design: narrative review
#119	Nolan 2019	Wrong intervention: phonosurgery
#167	Patel 2021	Wrong intervention: facial hair transplantation
#287	Ray 2020	Wrong population: cisgender is the population of interest, transgender included as indirect evidence and not in a systematic manner
#518	Rozga 2020	Published in abstract format only
#265	Sariyaka 2017	Wrong population: More than 20% participants did not have gender dysphoria
#35	Sayegh 2019	Wrong intervention: facial masculinization surgery
#124	Schwarz 2017	Wrong intervention: laryngeal surgery

#97	Siringo 2021	Wrong intervention: facial feminization surgery
#253	Song 2016	Wrong intervention: phonosurgery
#250	Song 2017	Wrong intervention: phonosurgery
#104	Spanos 2020	Wrong outcomes: lean mass, fat mass or insulin resistance
#257	Therattil 2017	Wrong intervention: thyroid chartilage reduction surgery
#328	Tirrell 2022	Wrong intervention: facial feminization surgery
#676	Traish 2010	Wrong design: narrative review
#279	VanDamme 2017	Wrong intervention: voice pitch raising surgery
#171	Vellho 2017	Wrong outcomes: BMI, blood pressure, hematocrit, hemoglobin, lipid profile, and liver enzymes
#112	Wilson 2020	Wrong outcomes: prolactine related outcomes (levels, hyperprolactinemia, prolactinoma)
#245	Worth 2018	Unable to access full text
#122	Ziegler 2018	Wrong outcomes: voice parameters and satisfaction with voice
#499	Zucker 2021	Unable to access full text

ID	Study	Reason
#1458	Al-Tamimi 2019	Wrong patient population
#287	Al-Tamimi 2020	Wrong study design: non comparative
#403	Alcon 2021	Wrong study design: non comparative
#214	Aldridge 2021	Wrong study design: non comparative
#54	Almazan 2021	Wrong patient population
#1387	Boas 2019	Wrong patient population
#1323	Branstrom 2020	Wrong patient population
#1447	Breidenstein 2019	Wrong study design: non comparative
#114	Briles 2022	Insufficient Sample Size <100
#1804	Butler 2019	Wrong patient population
#716	Carmichael 2021	Wrong study design: non comparative
#622	Cocchetti 2021	Wrong outcomes
#1067	Coon 2020	Wrong patient population
#1835	Cristofari 2019	Wrong patient population
#1486	Cuccolo 2019	Wrong patient population
#1276	deBlok 2020	Wrong patient population
#577	deRooij 2021	Wrong patient population
#1625	DeWolf 2019	Wrong patient population
#1759	Djordjevic 2019	Wrong patient population
#244	Falcone 2020	Insufficient Sample Size <100
#258	FosterSkewis 2021	Wrong comparator
#1583	Gallagher 2019	Wrong patient population
#139	Gumussoy 2022	Wrong study design: non comparative
#515	Hisle-Gorman 2021	Wrong study design: non comparative
#350	Hougen 2021	Insufficient Sample Size <100
#1007	Meyer 2020	Wrong study design: non comparative
#499	Miller 2021	Wrong patient population
#621	Mullins 2021	Wrong study design: non comparative
#1653	Naeimi 2019	Insufficient Sample Size <100
#1691	Namba 2019	Insufficient Sample Size <100
#1770	Neuville 2019	Insufficient Sample Size <100
#623	Neuville 2021	Insufficient Sample Size <100
#644	Nieder 2021	Insufficient Sample Size <100
#1624	Nikkels 2019	Wrong patient population
#353	Opsomer 2021	Wrong patient population
#1306	Papadopulos 2020	Wrong comparator
#640	Papadopulos 2021	Insufficient Sample Size <100
#1472	Pigot 2019	Wrong patient population
#899	Pigot 2020	Insufficient Sample Size <100
#1212	Segev-Becker 2020	Insufficient Sample Size <100
#1351	Staples 2020	Wrong outcomes
#645	Staud 2021	Insufficient Sample Size <100
#864	Terrier 2020	Insufficient Sample Size <100
#1083	vanderSluis 2020	Insufficient Sample Size <100

#1204	Veerman 2020	Insufficient Sample Size <100
#1409	Watanabe 2019	Wrong patient population
#512	Waterschoot 2021	Insufficient Sample Size <100

ATTACHMENT D

THE SCIENCE OF GENDER DYSPHORIA AND TRANSSEXUALISM

REPORT SUBMITTED TO THE

FLORIDA AGENCY FOR HEALTHCARE ADMINISTRATION

JAMES M. CANTOR, PHD

17 MAY 2022

TABLE OF CONTENTS

I. Background & Credentials

1. I am a research scientist and clinical psychologist and am currently the Director of the Toronto Sexuality Centre in Canada. For my education and training, I received my Bachelor of Science degree from Rensselaer Polytechnic Institute, where I studied mathematics, physics, and computer science. I received my Master of Arts degree in psychology from Boston University, where I studied neuropsychology. I earned my Doctoral degree in psychology from McGill University, which included successfully defending my doctoral dissertation studying the effects of psychiatric medication and neurochemical changes on sexual behavior, and included a clinical internship assessing and treating people with a wide range of sexual and gender identity issues.

2. Over my academic career, my posts have included Senior Scientist and Psychologist at the Centre for Addiction and Mental Health (CAMH), Head of Research for CAMH's Sexual Behaviour Clinic, Associate Professor of Psychiatry on the University of Toronto Faculty of Medicine, and Editor-in-Chief of the peer reviewed journal, *Sexual Abuse*. That journal is one of the top-impact, peer-reviewed journals in sexual behavior science and is the official journal of the Association for the Treatment of Sexual Abusers. In that appointment, I was charged to be the final arbiter for impartially deciding which contributions from other scientists in my field merited publication. I believe that appointment indicates not only my extensive experience evaluating scientific claims and methods, but also the faith put in me by the other scientists in my field. I have also served on the Editorial Boards of the *Journal of Sex Research*, the *Archives of Sexual Behavior*, and *Journal of Sexual Aggression*. Thus, although I cannot speak for other scientists, I regularly interact with and am routinely exposed to the views and opinions of most of the scientists active in our field today, within the United States and throughout the world.

3. My scientific expertise spans the biological and non-biological development

of human sexuality, the classification of sexual interest patterns, the assessment and treatment of atypical sexualities, and the application of statistics and research methodology in sex research. I am the author of over 50 peer-reviewed articles in my field, spanning the development of sexual orientation, gender identity, hypersexuality, and atypical sexualities collectively referred to as *paraphilias*. I am the author of the past three editions of the gender identity and atypical sexualities chapter of the *Oxford Textbook of Psychopathology*. These works are now routinely cited in the field and are included in numerous other textbooks of sex research.

4. I began providing clinical services to people with gender dysphoria in 1998. I trained under Dr. Ray Blanchard of CAMH and have participated in the assessment and treatment of over one hundred individuals at various stages of considering and enacting both transition and detransition, including its legal, social, and medical (both cross-hormonal and surgical) aspects. My clinical experience includes the assessment and treatment of several thousand individuals experiencing other atypical sexuality issues. I am regularly called upon to provide objective assessment of the science of human sexuality by the courts (prosecution and defense), professional media, and mental health care providers.

5. A substantial proportion of the existing research on gender dysphoria comes from two clinics, one in Canada and one in the Netherlands. The CAMH gender clinic (previously, Clarke Institute of Psychiatry) was in operation for several decades, and its research was directed by Dr. Kenneth Zucker. I was employed by CAMH between 1998 and 2018. Although I was a member of the hospital's adult forensic program, I remained in regular contact with members of the CAMH child psychiatry program (of which Dr. Zucker was a member), and we collaborated on multiple research projects.

II. Summary of Conclusions

- The scientific research consistently demonstrates that there is more than one distinct phenomenon that can lead to gender dysphoria. These types are distinguished by differing epidemiological and demographic patterns, unique psychological and behavioral profiles, and differing responses to the treatment options.
- Studies show that otherwise mentally healthy adults—undergoing thorough assessment (1–2 year Real Life Experience) and supervised by clinics engaged in gate-keeping roles—adjust well to life as the opposite sex.
- Regarding pre-pubescent children with gender dysphoria, there have been 11 outcomes studies. All 11 reported the majority of children to cease to feel dysphoric by puberty. They typically report being gay or lesbian instead.
- Regarding pubescent and adolescent age minors, there have been (also) 11 follow-up studies of puberty blockers and cross-sex hormones. In four, mental health failed to improve at all. In five, mental health improved, but because psychotherapy and medical interventions were both provided, which one caused the improvement could not be identified. The two remaining studies employed methods that did permit psychotherapy effects to be distinguished from medical effects, and neither found medical intervention to be superior to psychotherapy-only.
- The research importantly distinguishes completed suicides—which occur primarily in biological males and involve the intent to die—from suicidal ideation, gestures, and attempts—which occur primarily in biological females and represent psychological distress and cries for help. The evidence is minimally consistent with transphobia being the predominant cause of suicidality. The evidence is very strongly consistent with the hypothesis that other mental health issues, such as Borderline Personality Disorder (BPD), cause suicidality and unstable identities, including gender identity confusion.
- The international consensus of public health care services is that there remains no evidence to support medicalized transition for youth. The responses in the U.S. stand in stark contrast with Sweden, Finland, France, and the United Kingdom, which are issuing increasingly restrictive statements and policies, including bans on all medical transition of minors.

III. Science of Gender Dysphoria and Transsexualism

6. One of the most widespread public misunderstandings about transsexualism and people with gender dysphoria is that all cases of gender dysphoria represent the same phenomenon; however, the clinical science has long and consistently demonstrated that gender dysphoric children (cases of *early-onset* gender dysphoria) do not represent the same phenomenon as adult gender dysphoria

(cases of *late-onset* gender dysphoria),[1] merely attending clinics at younger ages. That is, gender dysphoric children are not simply younger versions of gender dysphoric adults. They differ in every known regard, from sexual interest patterns, to responses to treatments. A third presentation has recently become increasingly observed among people presenting to gender clinics: These cases appear to have an onset in adolescence in the absence of any childhood history of gender dysphoria. Such cases have been called adolescent-onset or "rapid-onset" gender dysphoria (ROGD). Very many public misunderstandings and expert misstatements come from misattributing evidence or personal experience from one of these types to another.

A. Adult-Onset Gender Dysphoria

7. People with adult-onset gender dysphoria typically attend clinics requesting transition services in mid-adulthood, usually in their 30s or 40s. Such individuals are nearly exclusively biological males.[2] They typically report being sexually attracted to women and sometimes to both men and women. Some cases profess asexuality, but very few indicate any sexual interest in or behavior involving men.[3] Cases of adult-onset gender dysphoria are typically associated with a sexual interest pattern (medically, a *paraphilia*) involving themselves in female form.[4]

1. Outcome Studies of Transition in Adult-Onset Gender Dysphoria

8. Clinical research facilities studying gender dysphoria have repeatedly reported low rates of regret (less than 3%) among adult-onset patients who underwent complete transition (*i.e.*, social, plus hormonal, plus surgical transition). This has been widely reported by clinics in Canada,[5] Sweden,[6] and the Netherlands.[7]

9. Importantly, each of the Canadian, Swedish, and Dutch clinics for adults

---

1 Blanchard, 1985.
2 Blanchard, 1990, 1991.
3 Blanchard, 1988.
4 Blanchard 1989a, 1989b, 1991.
5 Blanchard, *et al.*, 1989.
6 Dhejneberg, *et al.*, 2014.
7 Wiepjes, *et al.*, 2018.

with gender dysphoria all performed "gate-keeping" procedures, disqualifying from medical services people with mental health or other contraindications. One would not expect the same results to emerge in the absence of such gate-keeping or when gate-keepers apply only minimal standards or cursory assessment.

10. An important caution applies to interpreting these results: The side-effect of removing these people from the samples of transitioners is that if a researcher compared the average mental health of individuals coming into the clinic with the average mental health of individuals going through medical transition, then the post-transition group would appear to show a substantial improvement, even though transition had *no effect at all*: The removal of people with poorer mental health created the statistical illusion of improvement among the remaining people.

2. Mental Health Issues in Adult-Onset Gender Dysphoria

11. The research evidence on mental health issues in gender dysphoria indicates it to be different between adult-onset versus adolescent-onset versus prepubescent-onset types. The co-occurrence of mental illness with gender dysphoria in adults is widely recognized and widely documented.[8] A research team in 2016 published a comprehensive and systematic review of all studies examining rates of mental health issues in transgender adults.[9] There were 38 studies in total. The review indicated that many studies were methodologically weak, but nonetheless demonstrated (1) that rates of mental health issues among people are highly elevated both before *and after* transition, (2) but that rates were less elevated among those who completed transition. Analyses were not conducted in a way so as to compare the elevation in mental health issues observed among people newly attending clinics to improvement after transition. Also, several studies showed more than 40% of patients to become "lost to follow-up." With attrition rates that high, it is unclear to what

[8] *See, e.g.*, Hepp, *et al.*, 2005.
[9] Dhejne, *et al.*, 2016.

extent the information from the remaining participants would accurately reflect the whole population. The very high rate of "lost to follow-up" leaves open the possibility of considerably more negative results overall.

12. The long-standing and consistent finding that gender dysphoric adults continue to show high rates of mental health issues after transition indicates a critical point: To the extent that gender dysphoric children resemble adults, we should not expect mental health to improve as a result of transition—that is, transition does not appear to be what causes mental health improvement. Rather, mental health issues should be resolved before any transition, as has been noted in multiple standards of care documents, as detailed in their own section of this report.

B. Childhood Onset (Pre-Puberty) Gender Dysphoria

1. Follow-up Studies Show Most Children Desist by Puberty

13. Prepubescent children (and their parents) have been approaching mental health professionals for help with their unhappiness with their sex and belief they would be happier living as the other for many decades. The large majority of childhood onset cases of gender dysphoria occur in biological males, with clinics reporting 2–6 biological male children to each female.[10]

14. In total, there have been 11 outcomes studies of these children, listed in Appendix 1. In sum, despite coming from a variety of countries, conducted by a variety of labs, using a variety of methods, all spanning four decades, every study without exception has come to the identical conclusion: Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty—ranging from 61–88% desistance across the large, prospective studies. Such cases are often referred to as "desisters," whereas children who continue to feel gender dysphoric are often called "persisters."

15. Notably, in most cases, these children were receiving professional

[10] Cohen-Kettenis, *et al.*, 2003; Steensma, *et al.*, 2018; Wood, *et al.*, 2013.

psychosocial support across the study period aimed, not at affirming cross-gender identification, but at resolving stressors and issues potentially interfering with desistance. While beneficial to these children and their families, the inclusion of therapy in the study protocol represents a complication for the interpretation of the results: It is not possible to know to what extent the outcomes were influenced by the psychosocial support or would have emerged regardless. In science, this is referred to as a confound.

16. While the absolute number of those who present as prepubescent children with gender dysphoria and "persist" through adolescence is very small in relation to the total population, persistence in some subjects was observed in each of these studies. Thus, a clinician cannot take either outcome for granted.

17. It is because of this long-established and unanimous research finding of desistance being probable but not inevitable, that the "watchful waiting" method became the standard approach for assisting gender dysphoric children. The balance of potential risks to potential benefits is very different for groups likely to desist versus groups unlikely to desist: If a child is very likely to persist, then taking on the risks of medical transition might be more worthwhile than if that child is very likely to desist in transgender feelings.

18. The consistent observation of high rates of desistance among pre-pubertal children who present with gender dysphoria demonstrates a pivotally important—yet often overlooked—feature: because gender dysphoria so often desists on its own, clinical researchers cannot assume that therapeutic intervention cannot facilitate or speed desistance for at least some patients. That is, gender identity is not the same as sexual orientation, and it cannot be assumed that gender identity is as unchangeable as is sexual orientation. Such is an empirical question, and there has not yet been any such study.

19. It is also important to note that research has not yet identified any reliable

procedure for discerning which children who present with gender dysphoria will persist, as against the majority who will desist, absent transition and "affirmation." Such a method would be valuable, as the more accurately that potential persisters can be distinguished from desisters, the better the risks and benefits of options can be weighted. Such "risk prediction" and "test construction" are standard components of applied statistics in the behavioral sciences. Multiple research teams have reported that, on average, groups of persisters are somewhat more gender non-conforming than desisters, but not so different as to usefully predict the course of a particular child.[11]

20. In contrast, one research team (the aforementioned Olson group) claimed the opposite, asserting that they developed a method of distinguishing persisters from desisters, using a single composite score representing a combination of children's "peer preference, toy preference, clothing preference, gender similarity, and gender identity."[12] They reported a statistical association (mathematically equivalent to a correlation) between that composite score and the probability of persistence. As they indicated, "Our model predicted that a child with a gender-nonconformity score of .50 would have roughly a .30 probability . . . of socially transitioning. By contrast, a child with gender-nonconformity score of .75 would have roughly a .48 probability."[13] Although the Olson team declared that "social transitions may be predictable from gender identification and preferences,"[14] their actual results suggest the opposite: The gender-nonconforming group who went on to transition (socially) had a mean composite score of .73 (which is less than .75), and the gender-nonconforming group who did not transition had a mean composite score of .61, also less than .75.[15] Both of those are lower than the value of .75, so both of those would be more likely than not

---

11 Singh, *et al.* (2021); Steensma *et al.*, 2013.
12 Rae, *et al.*, 2019, at 671.
13 Rae, *et al.*, 2019, at 673.
14 Rae, *et al.*, 2019, at 669.
15 Rae, *et al.*, 2019, Supplemental Material at 6, Table S1, bottom line.

to desist, rather than to proceed to transition. That is, Olson's model does not distinguish likely from unlikely to transition; rather, it distinguishes unlikely from even less likely to transition.

21. Although it remains possible for some future discovery to yield a method to identify with sufficient accuracy which gender dysphoric children will persist, there does not exist such a method at the present time. Moreover, in the absence of long-term follow-up, it cannot be known what proportions come to regret having transitioned and then *de*transition. Because only a minority of gender dysphoric children persist in feeling gender dysphoric in the first place, "transition-on-demand" increases the probability of unnecessary transition and unnecessary medical risks.

2. "Watchful Waiting" and "The Dutch Protocol"

22. It was this state of the science—that the majority of prepubescent children will desist in their feelings of gender dysphoria and that we lack an accurate method of identifying which children will persist—that led to the development of a clinical approach, The Dutch Protocol,[16] including its "Watchful Waiting" period. Internationally, the Dutch Protocol remains the most empirically supported protocol for the treatment of children with gender dysphoria.

23. The purpose of the protocol was to compromise the conflicting needs among: clients' initial wishes upon assessment, the long-established and repeated observation that those wishes will change in the majority of (but not in all) childhood cases, and that cosmetic aspects of medical transition are perceived to be better when they occur earlier rather than later.

24. The Dutch Protocol was developed over many years by the Netherlands' child gender identity clinic, incorporating the accumulating findings from their own research as well as those reported by other clinics working with gender dysphoric

[16] Delemarre-van de Waal & Cohen-Kettenis (2006).

children. They summarized and explicated the approach in their peer-reviewed report, *Clinical management of gender dysphoria in children and adolescents: The Dutch Approach*.[17] The components of the Dutch Approach are:

- no social transition at all considered before age 12 (watchful waiting period),
- no puberty blockers considered before age 12,
- cross-sex hormones considered only after age 16, and
- resolution of mental health issues before any transition.

25. For youth under age 12, "the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty."[18]

26. The age cut-offs of the Dutch Approach were not based on any research demonstrating their superiority over other potential age cut-off's. Rather, they were chosen to correspond to the ages of consent to medical procedures under Dutch law. Nevertheless, whatever the original rationale, the data from this clinic simply contain no information about the safety or efficacy of employing these measures at younger ages.

27. The authors of the Dutch Approach repeatedly and consistently emphasize the need for extensive mental health assessment, including clinical interviews, formal psychological testing with validated psychometric instruments, and multiple sessions with the child and the child's parents.

28. Within the Dutch approach, there is no social transition before age twelve. That is, social affirmation of the new gender may not begin until age 12—as desistance is less likely to occur past that age. "Watchful Waiting" refers to a child's developmental period up to that age. Watchful waiting does not mean do nothing but passively observe the child. Rather, such children and families typically present with substantial distress involving both gender and non-gender issues, and it is during the watchful waiting period that a child (and other family members as appropriate) would

---

17 de Vries & Cohen-Kettenis, 2012
18 de Vries & Cohen-Kettenis, 2012, at 301.

undergo therapy, resolving other issues which may be exacerbating psychological stress or dysphoria. As noted by the Dutch clinic, "[T]he adolescents in this study received extensive family or other social support . . . [and they] were all regularly seen by one of the clinic's psychologists or psychiatrists."[19] One is actively treating the person, while carefully "watching" the dysphoria.

3. Follow-Up Studies of Puberty Blockers and Cross-Sex Hormones

29. Very many strong claims have appeared in the media and on social media asserting that transition results in improved mental health or, contradictorily, in decreased mental health. In the highly politicized context of gender and transgender research, many outlets have cited only the findings which appear to support one side, cherry-picking from the complete set of research reports. It total, there have been 11 prospective outcomes studies following up gender dysphoric children undergoing medically induced suppression of puberty or cross-sex hormone treatment. Four studies failed to find evidence of improvement in mental health functioning at all, and some groups deteriorated on some variables.[20] Five studies successfully identified evidence of improvement, but because patients received psychotherapy along with medical services, which of those treatments caused the improvement is unknowable.[21] In the remaining two studies, both psychotherapy and medical interventions were provided, but the studies were designed in such a way as to allow the effects of psychotherapy to be separated from the effects of the puberty-blocking medications.[22] As detailed in the following, neither identified benefits of medication over psychotherapy alone.

a. Four studies found no mental health improvement

30. Carmichael, *et al.* (2021) recently released its findings from the Tavistock

---

19 de Vries, *et al.*, 2011, at 2280-2281.
20 Carmichael, *et al.*, 2021; Hisle-Gorman, *et al.*, 2021; Kaltiala, *et al.*, 2020; Kuper, *et al.*, 2020.
21 de Vries, *et al.*, 2011; Tordoff, *et al.*, 2022; van der Miesen, *et al.*, 2020.
22 Achille, *et al.*, 2020; Costa, *et al.*, 2015.

and Portman clinic in the U.K.[23] Study participants were ages 12–15 (Tanner stage 3 for natal males, Tanner stage 2 for natal females) and were repeatedly tested before beginning puberty-blocking medications and then every six months thereafter. Cases exhibiting serious mental illnesses (*e.g.*, psychosis, bipolar disorder, anorexia nervosa, severe body-dysmorphic disorder unrelated to gender dysphoria) were excluded. Relative to the time point before beginning puberty suppression, there were *no* significant changes in any psychological measure, from either the patients' or their parents' perspective.

31. In Kuper, *et al.* (2020), a multidisciplinary team from Dallas published a prospective follow-up study which included 25 youths as they began puberty suppression.[24] (The other 123 study participants were undergoing cross-sex hormone treatment.) Interventions were administered according to practice guidelines from the Endocrine Society.[25] Their analyses found *no statistically significant changes* in the group undergoing puberty suppression on any of the nine measures of wellbeing measured, spanning tests of body satisfaction, depressive symptoms, or anxiety symptoms.[26] Notably, whereas the Dutch Protocol includes age 12 as a minimum for puberty suppression treatment, this team provided such treatment beginning at age 9.8 years (full range: 9.8–14.9 years).[27]

32. Hisle-Gorman, *et al.* (2021) analyzed military families' healthcare data to compare 963 transgender and gender-diverse youth before versus after hormonal treatment, with their non-gender dysphoric siblings as controls. The study participants included youth undergoing puberty-blocking as well as those undergoing cross-sex hormone treatment, but these subgroups did not differ from each other. Study participants had a mean age of 18 years when beginning the study, but their

---

[23] Carmichael, *et al.*, 2021.
[24] Kuper, *et al.*, 2020, at 5.
[25] Kuper, *et al.*, 2020, at 3, referring to Hembree, *et al.*, 2017.
[26] Kuper, *et al.*, 2020, at Table 2.
[27] Kuper, *et al.*, 2020, at 4.

initial clinical contacts and diagnoses occurred at a mean age of 10 years. According to the study, "mental health care visits overall did not significantly change following gender-affirming pharmaceutical care,"[28] yet, "psychotropic medication use *increased,*"[29] indicating *deteriorating* mental health.

33. Kaltiala et al. (2020) similarly reported that after cross-sex hormone treatment, "Those who had psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems during real-life."[30] They concluded, "Medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities among adolescents with gender dysphoria. Appropriate interventions are warranted for psychiatric comorbidities and problems in adolescent development."[31]

b. Five studies confounded psychotherapy and medical treatment

34. The initial enthusiasm for medical blocking of puberty followed largely from early reports from the Dutch clinical research team suggesting at least some mental health improvement.[32] It was when subsequent research studies failed to replicate those successes that it became apparent that the successes were due, not to the medical interventions, but to the psychotherapy that accompanied such interventions in most clinics, including the Dutch clinic.

35. The Dutch clinical research team followed up a cohort of youth at their clinic undergoing puberty suppression[33] and later cross-hormone treatment and surgical sex reassignment.[34] The youth improved on several variables upon follow-up as compared to pre-suppression measurement, including depressive symptoms and

---

28 Hisle-Gorman, et al., 2021, at 1448.
29 Hisle-Gorman, et al., 2021, at 1448, emphasis added.
30 Kaltiala et al., 2020, at 213.
31 Kaltiala et al., 2020, at 213.
32 de Vries, *et al.*, 2011; de Vries, *et al.*, 2014
33 de Vries, *et al.*, 2011.
34 de Vries, *et al.*, 2014.

general functioning. No changes were detected in feelings of anxiety or anger or in gender dysphoria as a result of puberty suppression; however, natal females using puberty suppression suffered *increased* body dissatisfaction both with their secondary sex characteristics and with nonsexual characteristics.[35]

36. As the report authors noted, while it is possible that the improvement on some variables was due to the puberty-blockers, it is also possible that the improvement was due to the mental health support, and it is possible that the improvement occurred only on its own with natural maturation. So any conclusion that puberty blockers improved the mental health of the treated children is not justified by the data. Because this study did not include a control group (another group of adolescents matching the first group, but *not* receiving medical or social support), these possibilities cannot be distinguished from each other. The authors of the study were explicit in noting this themselves: "All these factors may have contributed to the psychological well-being of these gender dysphoric adolescents."[36]

37. In a 2020 update, the Dutch clinic reported continuing to find improvement in transgender adolescents' psychological functioning, reaching age-typical levels, "after the start of specialized transgender care involving puberty suppression."[37] Unfortunately, because the transgender care method of that clinic involves both psychosocial support and puberty suppression, it again cannot be known which of those (or their combination) is driving the improvement. Also, the authors indicate that the changing demographic and other features among gender dysphoric youth might have caused the treated group to differ from the control group in unknown ways. As the study authors noted again, "The present study can, therefore, not provide evidence about the direct benefits of puberty suppression over time and long-

[35] Biggs, 2020.
[36] de Vries, *et al.* 2011, at 2281.
[37] van der Miesen, *et al.*, 2020, at 699.

term mental health outcomes."[38]

38. Allen, *et al.* (2019) reported on a sample of 47 youth, ages 13–20, undergoing cross-sex hormone treatment. They reported observing increases in measures of well-being and decreases in measures of suicidality; however, as the authors also noted, "whether a patient is actively receiving psychotherapy" may have been a confounding variable.[39]

39. Tordoff, *et al.* (2022) reported on a sample of youth, ages 13–20 years, treated with either puberty blockers or cross-sex hormones. There were improvements in mental health functioning; however, 62.5% of the sample was again receiving mental health therapy.[40]

c. Two studies showed no superiority of medical intervention above psychotherapy

40. Costa, *et al.* (2015) reported on preliminary outcomes from the Tavistock and Portman NHS Foundation Trust clinic in the UK. They compared the psychological functioning of one group of youth receiving psychological support with a second group receiving both psychological support as well as puberty blocking medication. Both groups improved in psychological functioning over the course of the study, but no statistically significant differences between the groups was detected at any point.[41] As those authors concluded, "Psychological support and puberty suppression were both associated with an improved global psychosocial functioning in GD adolescence. Both these interventions may be considered effective in the clinical management of psychosocial functioning difficulties in GD adolescence."[42] Because psychological support does not pose the physical health risks that hormonal interventions or surgery does (such as loss of reproductive function) however, one

---

38 van der Miesen, *et al.*, 2020, at 703.
39 Allen, *et al.*, 2019.
40 Tordoff, et al., 2022, Table 1.
41 Costa, *et al.*, at 2212 Table 2.
42 Costa, *et al.*, at 2206.

cannot justify taking on the greater risks of social transition, puberty blockers or surgery without evidence of such treatment producing superior results. Such evidence does not exist. Moreover, this clinical team subsequently released the final version of this preliminary report, finding that neither group actually experienced significant improvement,[43] making moot any discussion of the source any improvement.

41. Achille, *et al.* (2020) at Stony Brook Children's Hospital in New York treated a sample of 95 youth with gender dysphoria, providing follow-up data on 50 of them. (The report did not indicate how these 50 were selected from the 95.) As well as receiving puberty blocking medications, "Most subjects were followed by mental health professionals. Those that were not were encouraged to see a mental health professional."[44] The puberty blockers themselves "were introduced in accordance with the Endocrine Society and the WPATH guidelines."[45] Upon follow-up, some incremental improvements were noted; however, after statistically adjusting for psychiatric medication and engagement in counselling, "*most predictors did not reach statistical significance*."[46] That is, puberty blockers did not improve mental health any more than did mental health care on its own.

d. Conclusions

42. The authors of the original Dutch studies were careful not to overstate the implications of their results, "We *cautiously* conclude that puberty suppression *may be* a valuable *element* in clinical management of adolescent gender dysphoria."[47] Nonetheless, many other clinics and clinicians intrepidly proceeded on the basis of only the perceived positives, broadened the range of people beyond those represented in the research findings, and removed the protections applied in the procedures that

---

43 Carmichael, et al., 2021.
44 Achille, *et al.*, 2020, at 2.
45 Achille, *et al.*, 2020, at 2.
46 Achille, *et al.*, 2020, at 3 (italics added).
47 de Vries, *et al.* 2011, at 2282, italics added.

led to those outcomes. Many clinics and individual clinicians have reduced the minimum age for transition to 10 instead of 12. While the Dutch Protocol involves interdisciplinary teams of clinicians, many clinics now rely on a single assessor, in some cases one without adequate professional training in childhood and adolescent mental health. Comprehensive, longitudinal assessments (*e.g.*, 1 to 2 *years*[48]) became approvals after one or two assessment sessions. Validated, objective measures of youths' psychological functioning were replaced with clinicians' subjective (and first) opinions, often reflecting only the clients' own self-report. Systematic recordings of outcomes, so as to allow for detection and correction of clinical deficiencies, were eliminated.

43. Notably, Dr. Thomas Steensma, central researcher of the Dutch clinic, has decried other clinics for "blindly adopting our research" despite the indications that those results may not actually apply: "We don't know whether studies we have done in the past are still applicable to today. Many more children are registering, and also a different type."[49] Steensma opined that "every doctor or psychologist who is involved in transgender care should feel the obligation to do a good pre- and post-test." But few if any are doing so.

4. Mental Health Issues in Childhood-Onset Gender Dysphoria

44. As shown by the outcomes studies, there is little evidence that transition improves the mental well-being of children. As shown repeatedly by clinical guidelines from multiple professional associations, mental health issues are expected or required to be resolved *before* undergoing transition. The reasoning behind these conclusions is that children may be expressing gender dysphoria, not because they are experiencing what gender dysphoric adults report, but because they mistake what their experiences indicate or to what they might lead. For example, a child

48 de Vries, *et al.*, 2011.
49 Tetelepta, 2021.

experiencing depression from social isolation might develop the hope—and the unrealistic expectation—that transition will help them fit in, this time as and with the other sex.

45. If a child undergoes transition, discovering only then that their mental health or social situations will not in fact change, the medical risks and side-effects (such as sterilization) will have been borne for no reason. If, however, a child resolves the mental health issues first, with the gender dysphoria resolving with it (which the research literature shows to be the case in the large majority), then the child need not undergo transition at all, but retains the opportunity to do so later.

46. Elevated rates of multiple mental health issues among gender dysphoric children are reported throughout the research literature. A formal analysis of children (ages 4–11) undergoing assessment at the Dutch child gender clinic showed 52% fulfilled criteria for a DSM axis-I disorder.[50] A comparison of the children attending the Canadian versus Dutch child gender dysphoria clinic showed only few differences between them, but a large proportion in both groups were diagnosable with clinically significant mental health issues. Results of standard assessment instruments (Child Behavior Check List, or CBCL) demonstrated that the average score was in the clinical rather than healthy range, among children in both clinics.[51] When expressed as percentages, among 6–11-year-olds, 61.7% of the Canadian and 62.1% of the Dutch sample were in the clinical range.

47. A systematic, comprehensive review of all studies of Autism Spectrum Disorders (ASDs) and Attention-Deficit Hyperactivity Disorder (ADHD) among children diagnosed with gender dysphoria was recently conducted. It was able to identify a total of 22 studies examining the prevalence of ASD or ADHD I youth with gender dysphoria. Studies reviewing medical records of children and adolescents

[50] Wallien, *et al.*, 2007.
[51] Cohen-Kettenis, *et al.*, 2003, at 46.

referred to gender clinics showed 5–26% to have been diagnosed with ASD.[52] Moreover, those authors gave specific caution on the "considerable overlap between symptoms of ASD and symptoms of gender variance, exemplified by the subthreshold group which may display symptoms which could be interpreted as either ASD or gender variance. Overlap between symptoms of ASD and symptoms of GD may well confound results."[53] As noted elsewhere herein, when two or more issues are present at the same time, researchers cannot distinguish when a result is associated with or caused by the issue of interest or one of the side issues.[54] The rate of ADHD among children with GD was 8.3–11%. Conversely, in data from children (ages 6–18) with Autism Spectrum Disorders (ASDs) show they are more than seven times more likely to have parent-reported "gender variance."[55]

C. Adolescent-Onset Gender Dysphoria

1. Features of Adolescent-Onset Gender Dysphoria

48. In the social media age, a third profile has recently begun to present clinically or socially, characteristically distinct from the two previously identified profiles.[56] Unlike adult-onset or childhood-onset gender dysphoria, this group is predominately biologically female. This group typically presents in adolescence, but lacks the history of cross-gender behavior in childhood like the childhood-onset cases have. It is that feature which led to the term Rapid Onset Gender Dysphoria (ROGD).[57] The majority of cases appear to occur within clusters of peers and in association with increased social media use[58] and especially among people with autism or other neurodevelopmental or mental health issues.[59]

49. It cannot be easily determined whether the self-reported gender dysphoria

---

52 Thrower, *et al.*, 2020.
53 Thrower, *et al.*, 2020, at 703.
54 Cohen-Kettenis *et al.*, 2003, at 51; Skelly *et al.*, 2012.
55 Janssen, *et al.*, 2016.
56 Kaltiala-Heino, *et al.*, 2015; Littman, 2018.
57 Littman, 2018.
58 Littman, 2018.
59 Kaltiala-Heino, *et al.*, 2015; Littman, 2018; Warrier, *et al.*, 2020.

is a result of other underlying issues or if those mental health issues are the result of the stresses of being a sexual minority, as some writers are quick to assume.[60] (The science of the *Minority Stress Hypothesis* appears in its own section.) Importantly, and unlike other presentations of gender dysphoria, people with rapid-onset gender dysphoria often (47.2%) experienced *declines* rather than improvements in mental health when they publicly acknowledged their gender status.[61] Although long-term outcomes have not yet been reported, these distinctions demonstrate that one cannot apply findings from the other types of gender dysphoria to this type. That is, in the absence of evidence, researchers cannot assume that the pattern found in childhood-onset or adult-onset gender dysphoria also applies to adolescent-onset gender dysphoria. The multiple differences already observed between these groups argue against predicting that features present in one type would generalize to be present in all types of gender dysphoria.

2. Social Transition and Puberty Blockers with Adolescent Onset

50. There do not yet exist prospective outcomes studies either for social transition or for medical interventions for people whose gender dysphoria began in adolescence. That is, instead of taking a sample of individuals and following them forward over time (thus permitting researchers to account for people dropping out of the study, people misremembering the order of events, etc.), all studies have thus far been *retrospective*. It is not possible for such studies to identify what factors caused what outcomes. No study has yet been organized in such a way as to allow for an analysis of the adolescent-onset group, as distinct from childhood-onset or adult-onset cases. Many of the newer clinics (not the original clinics which systematically tracked and reported on their cases' results) fail to distinguish between people who had childhood-onset gender dysphoria and have aged into adolescence versus people

[60] Boivin, *et al.*, 2020.
[61] Biggs, 2020; Littman, 2018.

whose onset was not until adolescence. (Analogously, there are reports failing to distinguish people who had adolescent-onset gender dysphoria and aged into adulthood from adult-onset gender dysphoria.) Studies selecting groups according to their current age instead of their ages of onset produces confounded results, representing unclear mixes according to how many of each type of case wound up in the final sample.

3. Mental Illness in Adolescent-Onset Gender Dysphoria

51. In 2019, a Special Section appeared in the *Archives of Sexual Behavior* titled, "Clinical Approaches to Adolescents with Gender Dysphoria." It included this brief yet thorough summary of rates of mental health issues among adolescents expressing gender dysphoria, by Dr. Aron Janssen of the Department of Child and Adolescent Psychiatry of New York University:[62] The literature varies in the range of percentages of adolescents with co-occurring disorders. The range for depressive symptoms ranges was 6–42%,[63] with suicide attempts ranging 10 to 45%.[64] Self-injurious thoughts and behaviors range 14–39%.[65] Anxiety disorders and disruptive behavior difficulties including Attention Deficit/Hyperactivity Disorder are also prevalent.[66] Gender dysphoria also overlaps with Autism Spectrum Disorder.[67]

52. Of particular concern in the context of adolescent onset gender dysphoria is Borderline Personality Disorder (BPD; diagnostic criteria to follow). It is increasingly hypothesized that very many cases appearing to be adolescent-onset gender dysphoria actually represent cases of BPD.[68] That is, some people may be misinterpreting their experiencing of the broader "identity disturbance" of symptom Criterion 3 to represent a gender identity issue specifically. Like adolescent-onset

---

62 Janssen, *et al.*, 2019.
63 Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013; Wallien, *et al.*, 2007.
64 Reisner, *et al.*, 2015.
65 Holt, *et al.*, 2016; Skagerberg, *et al.*, 2013.
66 de Vries, *et al.*, 2011; Mustanski, *et al.*, 2010; Wallien, *et al.*, 2007.
67 de Vries, *et al.*, 2010; Jacobs, *et al.*, 2014; Janssen, *et al.*, 2016; May, *et al.*, 2016; Strang, *et al.*, 2014, 2016.
68 *E.g.*, Anzani, *et al.*, 2020; Zucker, 2019.

gender dysphoria, BPD begins to manifest in adolescence, is three times more common in biological females than males, and occurs in 2–3% of the population, rather than 1-in-5,000 people. (Thus, if even only a portion of people with BPD experienced an identity disturbance that focused on gender identity and were mistaken for transgender, they could easily overwhelm the number of genuine cases of gender dysphoria.)

53. DSM-5-TR Diagnostic Criteria for Borderline Personality Disorder:

> A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.)
> 2. A pattern of unstable and intense interpersonal relationship characterized by alternating between extremes of idealization and devaluation.
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behavior.*
> 6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
> 7. Chronic feelings of emptiness.
> 8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
> 9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Italics added.)

54. Mistaking cases of BPD for cases of Gender Dysphoria may prevent such youth from receiving the correct mental health services for their condition, and a primary cause for concern is symptom Criterion 5: Recurrent suicidality. (The research on suicide and suicidality are detailed in their own section herein.)

Regarding the provision of mental health care, the distinction between these conditions is crucial: A person with BPD going undiagnosed will not receive the appropriate treatments (the currently most effective of which is Dialectical Behavior Therapy). A person with a cross-gender identity would be expected to feel relief from medical transition, but someone with BPD would not: The problem was not about *gender* identity, but about having an *unstable* identity. Moreover, after a failure of medical transition to provide relief, one would predict for these people increased levels of hopelessness and increased risk of suicidality.

55. Regarding research, there have now been several attempts to document rates of suicidality among gender dysphoric adolescents. The scientific concern presented by BPD is that it poses a potential confound: Samples of gender dysphoric adolescents could appear to have elevated rates of suicidality, not because of the gender dysphoria (or transphobia in society), but because of the number of people with BPD in the sample.

IV. Other Scientific Claims Assessed

A. Suicide and Suicidality

56. Social media increasingly circulate demands for transition accompanied by hyperbolic warnings of suicide should there be delay or obstacle. Claims accompany admissions that "I'd rather have a trans daughter than a dead son," and such threats are treated as the justification for referring to affirming gender transitions as 'life-saving' or 'medically necessary'. Such claims convey only grossly misleading misrepresentations of the research literature, however, deploying terms for their shock value rather than accuracy, and exploiting common public misperceptions about suicide. Indeed, suicide prevention research and public health campaigns repeatedly warn against circulating such exaggerations, due to the risk of copy-cat

behavior they encourage.[69]

57. Despite that the media treat them as near synonyms, suicide and suicidality are distinct phenomena. They represent different behaviors with different motivations, with different mental health issues, and with different clinical needs. *Suicide* refers to completed suicides and the sincere intent to die. It is substantially associated with impulsivity, using more lethal means, and being a biological male.[70] *Suicidality* refers to parasuicidal behaviors, including suicidal ideation, threats, and gestures. These typically represent cries for help rather than an intent to die and are more common among biological females. Suicidal threats can indicate any of many problems or represent emotional blackmail, as typified by "If you leave me, I will kill myself." Professing suicidality is also used for attention-seeking or for the support or sympathy it evokes from others, denoting distress much more frequently than an intent to die.

58. Notwithstanding public misconceptions about the frequency of suicide and related behaviors, the highest rates of suicide are among middle-aged and elderly men in high income countries.[71] Biological males are at three times greater risk of death by suicide than are biological females, whereas suicidal ideation, plans, and attempts are three times more common among biological females.[72] In contrast with completed suicides, the frequency of suicidal ideation, plans, and attempts is highest during adolescence and young adulthood, with reported ideation rates spanning 12.1–33%.[73] Relative to other countries, Americans report elevated rates of each of suicidal ideation (15.6%), plans (5.4%), and attempts (5.0%).[74] Suicide attempts occur up to 30

---

69 Gould & Lake, 2013.
70 Freeman, *et al.*, 2017.
71 Turecki & Brent, 2016
72 Klonsky et al., 2016; Turecki & Brent, 2016
73 Borges et a., 2010; Nock et al., 2008
74 Klonsky, et al., 2016.

times more frequently than completed suicides.[75] The rate of completed suicides in the U.S. population is 14.5 per 100,000 people.[76] The widely discrepant numbers representing completed suicides versus transient suicidal ideation has left those statistics open to substantial abuse in the media and social media. Despite public media guidelines urging "Avoid dramatic headlines and strong terms such as 'suicide epidemic'," [77] that is exactly what mainstream outlets have done.[78]

59. There is substantial research associating sexual orientation with suicidality, but much less so with completed suicide.[79] More specifically, there is some evidence suggesting gay adult men are more likely to die by suicide than are heterosexual men, but there is less evidence of an analogous pattern among lesbian women. Regarding suicidality, surveys of self-identified LGB Americans repeatedly report rates of suicidal ideation and suicide attempts 2–7 times higher than their heterosexual counterparts. Because of this association of suicidality with sexual orientation, one must apply caution in interpreting findings allegedly about gender identity: Because of the overlap between people who self-identify as non-heterosexual and as non-cis-gendered, correlations detected between suicidality and gender dysphoria may instead reflect (be confounded by) homosexuality. Indeed, other authors have made explicit their surprise that so many studies, purportedly of gender identity, entirely omitted measurement or consideration of sexual orientation, creating the situation where features that seem to be associated with gender identity instead reflect the sexual orientation of the members of the sample.[80]

60. Among post-transition transsexuals, completed suicide rates are elevated,

---

75 Bachman, 2018.
76 World Health Organization, 2022.
77 Samaritans, 2020.
78 E.g., MSNBC, 2015, *Trans youth and suicide: An epidemic.*
79 Haas, *et al.*, 2011.
80 McNeil, *et al.* (2017)

but are nonetheless rare.[81] Regarding suicidality, there have been three recent, systematic reviews of the research literature.[82] All three included specific methods to minimize any potential effects of cherry-picking findings from within the research literature. Compiling the results of 108 articles reported from 64 research projects, Adams and Vincent (2019) found an overall average rate of 46.55% for suicidal ideation (ranging 18.18%–95.5%) and an overall average rate of 27.19% for suicidal attempts (ranging 8.57%–52.4%). These findings confirmed those reported by McNeil, *et al.* (2017), whose review of 30 articles revealed a range of 37%–83% for suicidal ideation and 9.8%–43% for suicidal attempts. Thus, on the one hand, these ranges are greater than those reported for the mainstream population—They instead approximate the rates reported among sexual orientation minorities. On the other hand, with measures so lacking in reliability that they produce every result from 'rare' to 'almost everyone', it is unclear which, if any of them, represents a valid conclusion.

61. McNeil *et al.* (2017) observed also the research to reveal rates of suicidal ideation and suicidal attempts to be related—not to transition status—but to the social support received: The studies reviewed showed support to decrease suicidality, but transition not to. Indeed, in some situations, social support was associated with *increased* suicide attempts, suggesting the reported suicidality may represent attempts to evoke more support.[83]

62. Marshall et al. (2016) identified and examined 31 studies, again finding rates of suicidal ideation and suicide attempts to be elevated, particularly among biological females, indicating that suicidality patterns correspond to biological sex rather than self-identified gender.[84]

---

81 Wiepjes, *et al.*, 2020.
82 Adams & Vincent, 2019; Marshall, *et al.*, 2016; McNeil, *et al.* (2017).
83 Bauer, *et al.*, 2015; Canetto, et al., 2021.
84 Marshall, et al., 2016.

63. Despite that mental health issues, including suicidality, are repeatedly required by clinical standards of care to be resolved before transition, threats of suicide are instead oftentimes used as the very justification for labelling transition a 'medical necessity'. However plausible it might seem that failing to affirm transition causes suicidality, the epidemiological evidence indicates that hypothesis to be incorrect: Suicide rates remains elevated even after complete transition, as shown by a comprehensive review of 17 studies of suicidality in gender dysphoria.[85]

64. The scientific study of suicide is inextricably linked to that of mental illness, and Borderline Personality Disorder is repeatedly documented to be greatly elevated among sexual minorities[86].

B. Conversion Therapy

65. Activists and social media increasingly, but erroneously, apply the term "conversion therapy" moving farther and farther from what the research has reported. "Conversion therapy" (or "reparative therapy" and other names) was the attempt to change a person's sexual orientation; however, with the public more frequently accustomed to "LGB" being expanded to "LGBTQ+", the claims relevant only to sexual orientation are being misapplied to gender identity. The research has repeatedly demonstrated that once one explicitly acknowledges being gay or lesbian, this is only very rarely are mistaken. That is entirely unlike gender identity, wherein the great majority of children who declare cross-gender identity cease to do so by puberty, as already shown unanimously by all follow-up studies. As the field grows increasingly polarized, any therapy failing to provide affirmation-on-demand is mislabeled "conversion therapy."[87] Indeed, even actions of non-therapists, unrelated

---

85 McNeil, *et al.*, 2017.
86 Reuter, *et al.*, 2016; Rodriguez-Seiljas, *et al.*, 2021; Zanarni, *et al.*, 2021.
87 D'Angelo, *et al.*, 2021.

to any therapy, have been labelled conversion therapy, including the prohibition of biological males competing on female teams.[88]

C. Assessing Demands for Social Transition and Affirmation-Only or Affirmation-on-Demand Treatment in Pre-Pubertal Children.

66. Colloquially, affirmation refers broadly to any actions that treat the person as belonging to a new gender. In different contexts, that could apply to social actions (use of a new name and pronouns), legal actions (changes to birth certificates), or medical actions (hormonal and surgical interventions). That is, social transition, legal transition, and medical transition (and subparts thereof) need not, and rarely do, occur at the same time. In practice, there are cases in which a child has socially only partially transitioned, such as presenting as one gender at home and another at school or presenting as one gender with one custodial parent and another gender with the other parent.

67. Referring to "affirmation" as a treatment approach is ambiguous: Although often used in public discourse to take advantage of the positive connotations of the term, it obfuscates what exactly is being affirmed. This often leads to confusion, such as quoting a study of the benefits and risks of social affirmation in a discussion of medical affirmation, where the appearance of the isolated word "affirmation" refers to entirely different actions.

68. It is also an error to divide treatment approaches into affirmative versus non-affirmative. As noted already, the widely adopted Dutch Approach (and the guidelines of the multiple professional associations based on it) cannot be said to be either: It is a staged set of interventions, wherein social transition (and puberty blocking) may not begin until age 12 and cross-sex hormonal and other medical interventions, later.

69. Formal clinical approaches to helping children expressing gender dysphoria

[88] Turban, 2021, March 16.

employ a gate-keeper model, with decision trees to help clinicians decide when and if the potential benefits of affirmation of the new gender would outweigh the potential risks of doing so. Because the gate-keepers and decision-trees generally include the possibility of affirmation in at least some cases, it is misleading to refer to any one approach as "the affirmation approach." The most extreme decision-tree would be accurately called affirmation-*on-demand,* involving little or no opportunity for children to explore at all whether the distress they feel is due to some other, less obvious, factor, whereas more moderate gate-keeping would endorse transition only in select situations, when the likelihood of regretting transition is minimized.

70. Many outcomes studies have been published examining the results of gate-keeper models, but no such studies have been published regarding affirmation-on-demand with children. Although there have been claims that affirmation-on-demand causes mental health or other improvement, these have been the result only of "retrospective" rather than "prospective" studies. That is, such studies did not take a sample of children and follow them up over time, to see how many dropped out altogether, how many transitioned successfully, and how many transitioned and regretted it or detransitioned. Rather, such studies took a sample of successfully transitioned adults and asked them retrospective questions about their past. In such studies, it is not possible to know how many other people dropped out or regretted transition, and it is not possible to infer causality from any of the correlations detected, despite authors implying and inferring causality.

D. Assessing the "Minority Stress Hypothesis"

71. The elevated levels of mental health problems among lesbian, gay, and bisexual populations is a well-documented phenomenon, and the idea that it is caused by living within a socially hostile environment is called the *Minority Stress Hypothesis*.[89] The association is not entirely straight-forward, however. For example,

[89] Meyer, 2003.