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TO: Amy Emerson, Rules Program Manager, Health Care Authority of Washington
FR: Danielle Askini, MSW, The Coalition For Inclusive Healthcare
RE: WAC 182-531-1675 – CR 102 – Treatment for Gender Dysphoria
DA: 5/05/2015

The 25 organizations of the Coalition for Inclusive Healthcare (“the Coalition”) appreciate this opportunity to provide public testimony for consideration by the Health Care Authority of Washington (“the Agency” or “HCA”) to address the proposed treatment for gender dysphoria within the Washington Apple Health (Medicaid) program.

First and foremost, we want to extend our incredible thanks and appreciation to the Health Care Authority for tackling this important issue and for being courageous in addressing what has been a long standing unmet need in the transgender community. We understand that coverage for the treatment of gender dysphoria can be controversial and is not without political risk and are thankful for the diligence and hard work the Health Care Authority has put into crafting these guidelines for the treatment of Gender Dysphoria. Over the last year it has been a great relief to see this process moving forward for the community.

The Coalition strongly supports a comprehensive patient and provider driven approach to Gender Dysphoria treatment that makes a range of care options available to patients in a manner consistent with the World Professional Association for Transgender Health (“WPATH”) Standards of Care. To this end, we believe that the Apple Health guidelines as proposed in the WAC 182-531-1675 CR-102 must be constructed to allow experienced medical and mental health professionals to provide the most evidence based Gender Dysphoria treatment for their patients.

As an illness, the distress felt for patients between their sex as assigned at birth and their psychological gender caused by Gender Dysphoria can be difficult to treat. As a result, treatment for Gender Dysphoria can vary greatly and must be based on the individual needs of patients. Treatment considerations include the extent to which Gender Dysphoria is experienced; the origins of that dysphoria; and the medical appropriateness of each type of treatment for a particular patient. Surgeons, therapists, and physicians who treat patients with Gender Dysphoria are highly skilled, and rules governing Apple Health programs should give deference to their determinations. Whenever possible, the

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regulations proposed by the Agency should preserve the ability of physicians treating individuals to best assess the type of care needed, the appropriateness of various treatment options, and the urgency with which those options are to be pursued. This approach is consistent with the WPATH standards of care, which are, in the organization's own words, "flexible guidelines."¹

Background on why these Guidelines are needed:
Why Washington Needs Transgender-Inclusive Public Health Programs

For many Transgender people, Gender Dysphoria is a serious illness that impacts many aspects of health and daily functioning. We appreciate that this is something the Health Care Authority recognizes. Numerous clinical studies have documented the severity of Gender Dysphoria, including large studies which have shown high levels of suicidality (Grant et. al 2011; Haas et. al 2014; Dhejne et al. 2010), a high prevalence of psychiatric problems (Hoshiai 2010), substance use (Nemoto 2010) , high risk sexual behavior leading to HIV (Clements-Nolle 2001), and adjustment disorder (Hoshiai 2010).

According to researcher Cohens-Kettenis "Applicants for sex reassignment indeed often experience their gender dysphoria as unbearable and as having a tremendous negative impact on their lives. Even if they have satisfying social and family contacts and are successful at work, the burden of their gender dysphoria may impede or even damage their functioning. A relationship between psychological or social impairment and [GD] is also suggested by reports on a relatively high prevalence of psychiatric problems among individuals with [GD]" (e.g., Bodlund, Kullgren, Sundblom, & Ho"jerback, 1993; De Cuypere, Janes,&Rubens, 1995; Hepp, Kraemer, Schnyder, Miller,& Delsignore, 2005) (Cohens-Kettenis 2010).

Several studies from the United States, Canada, Australia, and Europe have reported disproportionately high depression rates among transgender people, ranging from 8% to 66% (Asscheman, Gooren, & Eklund, 1989; Clements-Nolle, Marx, Guzman, & Katz, 2001;

¹ Coleman, E., Bockting, W, et. Al; "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7" International Journal of Transgenderism, 13:165-232, 2011

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Clements-Nolle, Marx, & Katz, 2006; Couch et al., 2007; Nemoto, Operario, Sevelius, et al., 2004; Nuttbrock, Rosenblum, & Blumenstein, 2002; Operario & Nemoto, 2005; Rotondi, Bauer, Scanlon, et al., 2011; Rotondi, Bauer, Travers, et al., 2011; Sugano, Nemoto, & Operario, 2006).

Suicide is a particularly critical concern. Two comprehensive studies of 6,450 Transgender people report that 41% of Transgender people have attempted suicide in their lifetimes (Grant 2011; Haas 2014), compared to 1.6% of the general population (McIntosh 2008; Grant 2011; Haas 2014). Further, a comprehensive 30-year analysis following Transsexual patients in Sweden by Dhejne et al. in 2011 shows that suicide remains the primary cause of mortality for Transgender and Transsexual people (Dhejne 2010).

These studies conclusively show that Gender Dysphoria is a serious illness that if left untreated results in impairment of daily life activities, employment, relationships, and social functioning. Furthermore, a lack of access to appropriate medical treatment greatly elevates the risk of suicide attempt and premature death by suicide (Dhejne et al. 2010; Grant 2011; Haas 2014).

Given the research on Gender Dysphoria and the established efficacy of treatment as supported by the American Medical Association in “Removing barriers to Care for Transgender Patients” (2008), the Agency’s Gender Dysphoria treatment program is vital for the health of Washington’s transgender population. To ensure that treatment is truly effective and in alignment with medical authority, the Coalition for Inclusive Healthcare urges the Agency to fully adopt an evidence based approach to the treatment of Gender Dysphoria that is tailored to each patient.

We continue to have serious concerns about the limitations on treatments under the current proposed rules for the Apple Health Gender Dysphoria treatment program. To bring the proposed program into alignment with best clinical practices and policy, we urge the Agency to consider the following recommendations:

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**The Coalition’s Suggested Changes to the Proposed Rules for the
the Apple Health Gender Dysphoria Treatment Program:**

Current Policy:

(5) (a) (i) *Be age eighteen years or older.*

Suggested Change:

(5)(a)(i) Have reached the age of medical consent or have parental or guardian permission as outlined in Washington State law or relevant jurisdiction’s law.

We all want the same thing for older teens experiencing gender dysphoria--for them to be safe and healthy. The Coalition for Inclusive Healthcare believes the age provision should be eliminated because it could endanger older teens who experience severe Gender Dysphoria with associated suicidality. In addition, we believe the Health Care Authority staff may have misinterpreted or misapplied the WPATH standard and Washington State Law in this matter.

Washington State Law clearly delineates the requirements for minors to receive medical care and our legislature and courts have extensively examined this issue. Washington laws: RCW 7.70.060, 7.70.050, t, 7.70.040 –RCW 26.28.010, RCW 7.70.065, and RCW 11.88. all clearly outline how age of medical consent, informed consent, and medical guardianship should work in Washington State for physicians, mental health care providers, and surgeons.

Furthermore, the Washington Supreme Court has clarified in *Smith v. Seibly*, 72 Wn.2d 16, 21, 431 P.2d719 (1967) that in some instances a “mature minor doctrine” applies for those under 18 to give informed consent to medical procedures if they are capable of understanding or appreciating the consequences of a medical procedure. In determining whether the patient is a mature minor, providers will evaluate the minor’s age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from control of parents.

“Both the law and the court precedents have clearly deliberated on this issue far beyond the capacity of the Health Care Authority to set a reasonable determination of age of medical consent.

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The WPATH Standards of Care suggest “the legal age of majority to give consent for medical procedures in a given country” as an age floor for surgical care.² Although the general legal age of majority in the United States is 18, many state laws—including Washington’s, as discussed above—lower the age of consent for certain health care services. Special consent rules most commonly apply in the sexual and reproductive health context. Similarly, many providers who make up the leadership of WPATH practice in Europe and other countries where the age of majority is substantially lower than in the U.S.: only four out of 52 countries represented in WPATH membership set the age of majority above 16. Additionally, neighboring states such as Oregon regard the age of majority for medical consent to be 15. After hearing extensive expert testimony, the Health Evidence Review Commission who governs regulation of the Oregon Health Plan agreed that Oregon’s age of medical consent – 15 was appropriate for all treatments including surgeries for the treatment of Gender Dysphoria. Considering legal and policy perspectives within and beyond Washington, the proposed prohibition on surgery for patients under 18 without allowing any assessment by medical professionals on a case-by-case basis is too inflexible and fails to allow for sufficient physician judgment.

While surgical treatment for gender dysphoria in older teens will likely be rare, cases may arise in which it is the medically necessary approach to address Gender Dysphoria and suicidality.

Unfortunately, sometimes therapy, puberty suppression, and hormone treatment alone are not sufficient to address Gender Dysphoria, depression, or suicide in older teens. **Most surgical procedures for gender transition require extensive parental or familial support and involvement, both in the decision-making process as well as for care during recovery.** In a case where an older teen, along with his or her family and physician, decides that surgery before the age of 18 would be the best course of action, Apple Health should not explicitly prohibit access to care.

The Coalition for Inclusive Healthcare believes current laws and a treatment team’s best medical judgment about ability to make informed consent should be considered sufficient to ensure the health and wellbeing of older transgender teens seeking surgical treatment. Other surgical procedures for traumatic accidents or serious illnesses do not generally have age exclusions. It concerns us that

² SOC 7, 21.

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transgender patients—patients with gender dysphoria—would be singled out to be treated differently under Apple Health’s proposed rules. Older teens with any number of medical ailments are currently receiving surgical treatment with the support of their families, physicians, and treatment teams; it would be arbitrary and capricious to apply an age restriction on the treatment of Gender Dysphoria that runs contrary to Washington State law and court precedents.

Furthermore, the current proposed rules are already extensive, with multiple treatment stages; lengthy time periods for consideration (a minimum of 1 year); and group decision making by numerous health professionals highly trained in treating Gender Dysphoria in youth, including two mental health providers, a primary care physician, and a surgeon—all of whom must conduct independent assessments and concur before treatment is authorized **These guidelines provide sufficient safeguards to protect the best interests of older teens when applying for prior authorization for surgery.**

Given the high rate of suicide among older teenagers experiencing Gender Dysphoria—studies report approximately 31%³ ⁴ to 41.8%⁵ ⁶ of transgender youth attempt suicide—and given that the U.S. Centers for Disease Control and Prevention report suicide as the third leading cause of death among youth between the ages of 10 and 24⁷ generally, we believe that the proposed age requirement for surgery may preclude life-saving treatment for transgender teens. The age provision restricts physicians and psychiatrists who may seek surgical interventions as a last option to address severe cases of Gender Dysphoria. Seeing this exclusion may discourage otherwise competent care teams from

³ Brian S. Mustanski, PhD, Robert Garofalo, MD, MPH, and Erin M. Emerson, MA, “Mental Health Disorders, Psychological Distress, and Suicidality in a Diverse Sample of Lesbian, Gay, Bisexual, and Transgender Youths” *American Journal of Public Health*, December 2010, Vol 100, No. 12

⁴ Sari L. Reisner, Sc.D., M.A., et. Al “Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study”, *Journal of Adolescent Health* vol. 56 (2015) 274- 279

⁵ Dickey, L. M. (2011, September). Self-injury in the transgender community: A prevalence report. Paper presented at the 22nd Biennial Symposium of the World Professional Association for Transgender Health, Atlanta, GA.

⁶ Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2011). Injustice at every turn: A report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

⁷ http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf

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pursuing surgical care when it is medically indicated, or may communicate surgical treatment as an impossibility to suicidal clients.

Eliminating surgical options outright for older teens, regardless of individual circumstances, could lead to grave emotional, psychological, and physical harm for transgender youth. The prohibition on surgery for all minors is not an evidence based exclusion, a legally supported exclusion, or an exclusion that is in the best interest of older teens suffering from Gender Dysphoria.

Current policy:

(5)(c)(vii) *A statement about the client's adherence to the medical and mental health treatment plan, including keeping scheduled appointments.*

Suggested:

(5)(c)(vii) Delete provision.

We believe that the adverse consequences of this provision are two-fold. First, it will create a negative perception of mental health and primary care providers as “gate keepers” who are scrutinizing their client’s willingness to comply with provider demands. This may reduce a patient’s willingness to participate fully in the treatment plan, disclose other health or risk factors such as unsafe sex, substance use, or life circumstances that might lead to negative long term health outcomes, and create an adversarial relationship between clients and providers. Such provisions will also remove the agency of clients to select practitioners who are may be more culturally competent for fear of impacting their ability to access surgical benefits or for being seen to “not comply” with a treatment plan that has unrealistic, inappropriate, or unscientific requirements. Past approaches to treat gender dysphoria often required transgender women to “prove” seriousness by demonstrating excessive femininity, presenting themselves in a “visually appealing way to the opposite sex”^{8 9 10}– a requirement that no longer is appropriate – but some clinicians still attempt to enforce. Given the history of inappropriate “clinical” requirements – transgender patients should be allowed agency to determine if treatment plans and the clinicians who write them are “a good fit”. Secondly, this provision will

⁸ Richard Green, “Psychiatric management of special problems in transsexualism,” in *Transsexualism and Sex Reassignment*, p. 287.

⁹ Namaste, Vivianne “Invisible Lives: The Erasure of Transgender and Transsexual Lives” 2000, The University of Chicago Press

¹⁰ Serano, Julia “Whipping Girl: A transsexual woman on sexism and the scapegoating of Femininity” 2007, Seal Press

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disproportionately penalize against low income clients, who may have more difficulty making appointments if they depend upon transportation systems beyond their control or lack flexibility in their work schedule. **These are NOT factors as outlined by the World Professional Association for Transgender Health in the assessment of readiness for surgery.** We believe that such provisions are unnecessarily coercive and adversarial and are not supported by clinical best practices guidelines in determining successful treatment of Gender Dysphoria.

Current policy:

(5)(c)(viii) *A description of the outcome of the client's hormonal therapy.*

Suggested:

(5)(c)(vii) Delete provision unless directly indicated for treatment plan.

WPATH does not include the outcome of hormonal treatment as a requirement of surgery. Furthermore, HIPPA sections 45 CFR 164.502(b), 164.514(d) requires the Health Care Authority to request the minimum medical information necessary to make an assessment for treatment. We believe that this information unnecessarily violates the protected health privacy of patients and is not related to the prior approval process for additional forms of care. The Health Care Authority has an obligation to avoid overly intrusive details about client's genitals, secondary sex characteristics, or other highly sensitive medical information if it is not justified by a legitimate medical need in assessing approval for further treatment. Only in the instance of breast reconstruction are the outcomes of hormonal treatment indicated as important to health outcomes by WPATH Standards of Care. Requiring this information for all patients is unnecessarily invasive.

Current policy:

(6)(e) The agency does not cover the following surgical procedures in stage four:

(i) Abdominoplasty; (ii) Blepharoplasty; (iii) Breast augmentation; (iv) Brow lift; (v) Calf implants; (vi) Cheek/malar implants; (vii) Chin/nose implants; (viii) Collagen injections; (ix) Drugs for hair loss or growth; (x) Electrolysis; (xi) Facial feminization; (xii) Face lift; (xiii) Forehead lift; (xiv) Hair transplantation; (xv) Jaw shortening; (xvi) Laryngoplasty; (xvii) Lip reduction; (xviii) Liposuction; (xix) Mastopexy; (xx) Neck tightening; (xxi) Pectoral implants; (xxii) Reduction thyroid chondroplasty; (xxiii) Removal of redundant skin; (xxiv) Rhinoplasty; (xxv) Suction-assisted lipoplasty of the waist; (xxvi) Trachea shave; (xxvii) Voice modification

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surgery; and (xxviii) Voice therapy.

Suggested:

(6)(e)(i)-(xxvi) Delete these provisions; consider all surgical and non-surgical services on a case-by-case basis as recommended in the treatment plan presented by the treatment team as outlined in Section 3 of this policy, through the prior approval process and in accordance with the WPATH Standards of Care.

Medically necessary treatments for transgender people are distinct from cosmetic treatments sought by non-transgender people to improve a person's appearance.

Many treatments included in the excluded list when used to treat Gender Dysphoria meet the WAC 182-500-0070 definition of Medically Necessary:

Medically Necessary: a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

These exclusionary prohibitions posit that these treatments are considered "cosmetic" – however this disregards the medical purpose of the treatments at issue – the treatment of Gender Dysphoria, and inappropriately focuses instead on the results of the treatment, considering in isolation from the underlying diagnosis and overall therapeutic goals of treating Gender Dysphoria. By its very nature – Gender Dysphoria arises when a crisis develops between psychological sex and a patient's primary and secondary sex characteristics; treatment of this condition necessitates an evaluation and treatment of those characteristics to address the Gender Dysphoria. **As such – treatments should be considered "reconstructive surgery" when those surgeries are performed to correct or repair abnormal structures of the body caused by congenital defects or disease. Gender Dysphoria fits the classification of a disease according to the ICD-11 and DSM-V and the presence of secondary sex characteristics not in alignment with the gender identity of a person with Gender**

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Dysphoria are the effects of this disease. As such, reconstructive surgeries and other procedures that ameliorate these effects should be covered as treatment for Gender Dysphoria.

Gender Dysphoria is experienced differently for each client, and there is no “cookie cutter” model for treating Gender Dysphoria.

Some clients may elect to have less expensive procedures such as hair removal only, rather than opting for far more expensive surgical interventions. Hair removal may be sufficient in achieving treatment of Gender Dysphoria. Decisions about what treatments will best address Gender Dysphoria – including services that are listed here as “cosmetic” is best left to the treatment team to submit in their treatment plan. The Health Care Authority should evaluate each treatment plan based on the best medical evidence, research, and clinical judgements submitted to it.

The goal of gender transition related treatment whether genital reconstruction, hormone therapy, breast or chest reconstruction, or any other gender-confirming procedures is to treat Gender Dysphoria – not to improve a person’s appearance. Put simply, the purpose of transition-related treatment is to resolve Gender Dysphoria and help the individual function socially and be accepted as their adopted gender. In order to evaluate what is considered reconstructive and medically necessary – we applaud the Health Care Authority’s approach to a treatment team-based model based on the WPATH standards of care.

The evaluation of Medical Necessity must be individualized and take into account the totality of the patient’s Gender Dysphoria, their appearance, and transition-related needs.

Up until this portion of the policy the Health Care Authority has outlined an extensive, and honestly quite complicated set of requirements, including a comprehensive team of experts to evaluate each patient for Gender Dysphoria and set forth a treatment plan. We believe that these exclusions remove options for clinicians that may result in the best health outcomes for clients and consequently will lead to poor treatment for the underlying Gender Dysphoria.

Health Care Authority should evaluate each client’s request for these services in alignment with the overall treatment plan and through the prior authorization process.

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Specifically we will call out the following examples which are important to consider above and beyond the above arguments:

(iii) *Breast reconstruction for transgender women is medically necessary*

Extensive research has shown that breasts are an essential part of women’s identities. Furthermore, under a parity argument The Health Care Authority currently covers breast reconstruction, we have included a literature review as an attachment evaluating this question. Some key highlights from meta-analysis’s include:

“Current evidence suggests that final breast size appears insufficient in the perception of the majority of trans women as 60–70% seeks surgical augmentation.¹¹”

Under current rules, the health care authority covers breast reconstruction for women with congenital, illness, physical trauma, or cancer related causes. We believe that consistent treatment for Gender Dysphoria is the most appropriate course of action as well as the action required by the Affordable Care Act Section 1557 and the Washington Law Against Discrimination.

WAC 182-531-0100

“(1)(x) Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects (e.g., congenital or as a result of illness or physical trauma), or for mastectomy reconstruction for post cancer treatment;”

Medical Evidence Demonstrates Significant Improvement in Gender Dysphoria and Patient Well-Being for Transgender Women who undergo Chest Reconstruction

Furthermore, in “Patient Satisfaction with Breasts and Psychosocial, Sexual, and Physical Well-Being after Breast Augmentation in Male-to-Female Transsexuals” Romain Weigert, et. al found that there was a huge improvement in satisfaction with breasts, psychosocial well-being,

¹¹ Katrien Wierckx, MD, Louis Gooren, MD, PhD, and Guy T’Sjoen, MD, PhD; “Clinical Review: Breast Development in Trans Women Receiving Cross-Sex Hormones” Journal of Sexual Medicine 2014;11:1240–1247.

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and sexual well-being after breast reconstruction for transgender women. Such evidence is echoed in numerous other studies. We have included this evidence with our testimony –and strongly urge the Health Care Authority to reevaluate the evidence in support of this treatment¹².

(x) Facial electrolysis for transgender women is medically necessary

For many transgender women, the presence of a full beard is a deep and serious source of gender dysphoria. Transgender men benefit from the growth of a beard simply from the administration of testosterone. Of particular concern for many clinicians and transgender patients is a question of how Apple Health will ensure access to adequately address the medical necessity of facial hair removal. Research has shown that facial electrolysis is safe, effective, and medically necessary for transgender women to address gender dysphoria^{13 14}. Coverage of hair removal has been offered by insurers for other forms of hirsutism such as those arising from Polycystic Ovarian Syndrome – recognizing that extensive hirsutism can be extremely damaging to the daily functioning and employability of women. Clinicians and researchers have widely noted that transgender women who are unable to conceal or hide their facial hair face widespread discrimination in the workplace, medical settings, and in performing daily tasks¹⁵. We believe coverage for electrolysis and other forms of facial hair removal should be considered on a case-by-case basis as a part of the treatment plan and should not be categorically excluded, particularly if the treatment team deems this a medically necessary procedure. Several courts around the country – including the South Carolina Supreme Court in *Abernathy v. The Prudential Insurance Company of America*, found that when prescribed by a physician to treat an illness, electrolysis is medically necessary. We believe that this also is true for the treatment of Gender Dysphoria.

¹² Romain Weigert, M.D. Eric Frison, M.D. Quentin Sessiecq, M.D. Khalid Al Mutairi, M.D.& Vincent Casoli, M.D., Ph.D; " Patient Satisfaction with Breasts and Psychosocial, Sexual, and Physical Well-Being after Breast Augmentation in Male-to-Female Transsexuals". December 2013. *Journal of Plastic and Reconstructive Surgery*

¹³ Dallas Denny & Ahoova Mischael. (1998). Electrolysis in transsexual women: A retrospective look at frequency of treatment in four cases. In D. Denny (Ed.), *Current concepts in transgender identity*, 1998, 335-352 and *Journal of Electrolysis*, 1997, V. 12, No. 2, pp. 2-16.

¹⁵ Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

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(xxviii) Voice therapy.

(WAC 182-531-0375) “The agency may pay for speech/audiology program services for conditions that are the result of medically recognized diseases and defects. See specific guidance on CPT 92507 and 92508 “treatment of speech, language, voice, communication and/or auditory processing disorder; individual” (Apple Health Contract 16.7.3.11)

Speech Therapy: 6 units (total of 6 untimed visits)

(per Molina under 'Physical Therapy')

http://www.molinahealthcare.com/providers/wa/medicaid/manual/PDF/manual_wa_14_BeneIndex_Apple_Health_Final_01-2014.pdf

We believe that a strong parity argument exists for vocal training which is available at low cost at University of Washington Medical Center.

**With Thanks for your hard work on this policy,
On Behalf of The Coalition for Inclusive Healthcare,**

**Danielle Askini, MSW
Gender Justice League**

**Marsha Botzer, MA
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Professional Association Statements on Transgender Health

“Position Statement on Access to Care for Transgender and Gender Variant Individuals,” Official Position of the American Psychiatric Association, 2012:
“The American Psychiatric Association: 1. Recognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments. 2. Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment. 3. Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.”

“Health Care for Transgender Individuals,” Committee Opinion of the Committee on Health Care for Underserved Women, The American College of Obstetricians and Gynecologists, 2011:
“Obstetrician–gynecologists should be prepared to assist or refer transgender individuals. Physicians are urged to eliminate barriers to access to care for this population through their own individual efforts... The American College of Obstetricians and Gynecologists urges health care providers to foster nondiscriminatory practices and policies to increase identification and to facilitate quality health care for transgender individuals, both in assisting with the transition if desired as well as providing long-term preventive health care.”

“Removing Barriers to Care for Transgender Patients,” American Medical Association House of Delegates, 2008: ***“RESOLVED, That our American Medical Association support public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient’s physician.”***

“An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy, and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID.”

“Transgender, Gender Identity & Gender Expression Nondiscrimination,” adopted by the American Psychological Association Council of Representatives, 2008.
“APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments.”

Additionally notes that, ***“transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender transition treatments.”***

National Association of Social Workers Policy Statement on Transgender and Gender Identity Issues, in Social Work Speaks, 2009:
“NASW supports the rights of all individuals to receive health insurance and other health coverage without discrimination on the basis of gender identity, and specifically without exclusion of services related to transgender or transsexual transition (or ‘sex change’), in order to receive medical and mental health services

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[...] which may include hormone replacement therapy, surgical interventions, prosthetic devices, and other medical procedures.”

World Professional Association for Transgender Health Clarification Statement, 2008
urges ***“health insurance carriers and healthcare providers in the U.S. to eliminate transgender or trans-sex exclusions and to provide coverage for transgender patients and the medically prescribed sex reassignment services necessary for their treatment and well-being.”***

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WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide

The World Professional Association for Transgender Health (WPATH) is an international association devoted to the understanding and treatment of individuals with gender identity disorders. Founded in 1979, and currently with over 600 physician, psychologist, social scientist, and legal professional members, all of whom are engaged in research and/or clinical practice that affects the lives of transgender and transsexual people, WPATH is the oldest interdisciplinary professional association in the world concerned with this specialty.

Gender Identity Disorder (GID), more commonly known as transsexualism, is a condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV, 1994, and DSM-IV-TR, 2000), published by the American Psychiatric Association. Transsexualism is also recognized in the ICD Classification of Mental and Behavioural Disorders, tenth revision, as endorsed by the Forty-third World Health Assembly in May 1990, and came into use in WHO Member States as of 1994.

The criteria listed for Gender Identity Disorders (GID) (at F.64) including transsexualism (at F.64.0) are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity, which is developed in early childhood and understood to be firmly established by age 4,[1] though for some transgender individuals, gender identity may remain somewhat fluid for many years. The ICD 10 descriptive criteria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment known as gender dysphoria that is often associated with transsexualism.

The WPATH Standards of Care for Gender Identity Disorders were first issued in 1979, and articulate the "professional consensus about the psychiatric, psychological, medical and surgical management of GID." Periodically revised to reflect the latest clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary. Medical necessity is a term common to health care coverage and insurance policies in the United States, and a common definition among insurers is:

"[H]ealth care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. [2]

"Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally

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recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors."

The current Board of Directors of the WPATH herewith expresses its conviction that sex (gender) reassignment, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or gender dysphoria. Sex reassignment plays an undisputed role in contributing toward favorable outcomes, and comprises Real Life Experience, legal name and sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures. Genital reconstruction is not required for social gender recognition, and such surgery should not be a prerequisite for document or record changes; the Real Life Experience component of the transition process is crucial to psychological adjustment, and is usually completed prior to any genital reconstruction, when appropriate for the patient, according to the WPATH Standards of Care. Changes to documentation are important aids to social functioning, and are a necessary component of the pre-surgical process; delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

Medically necessary sex reassignment procedures also include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient (including breast prostheses if necessary), genital reconstruction (by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, penile and testicular prostheses, as necessary), facial hair removal, and certain facial plastic reconstruction as appropriate to the patient.

"Non-genital surgical procedures are routinely performed... notably, subcutaneous mastectomy in female-to-male transsexuals, and facial feminization surgery, and/or breast augmentation in male-to-female transsexuals. These surgical interventions are often of greater practical significance in the patient's daily life than reconstruction of the genitals." [3]

Furthermore, not every patient will have a medical need for identical procedures; clinically appropriate treatments must be determined on an individualized basis with the patient's physician.

The medical procedures attendant to sex reassignment are not "cosmetic" or "elective" or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition. [4] Further, the WPATH Standards consider it unethical to deny eligibility for sex reassignment surgeries or hormonal therapies solely on the basis of blood seropositivity for infections such as HIV or hepatitis.

These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient. For example, a recent study of female-to-male transsexuals found significantly improved quality of life following cross-gender hormonal therapy. Moreover,

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those who had also undergone chest reconstruction had significantly higher scores for general health, social functioning, as well as mental health. [5]

"In over 80 qualitatively different case studies and reviews from 12 countries, it has been demonstrated during the last 30 years that the treatment that includes the whole process of gender reassignment is effective." [6]

Available routinely in Europe and in many other countries, these treatments are cost effective rather than cost prohibitive. In Europe, , numerous state health service providers have negotiated contracts with their insurance carriers to enable medically necessary treatment for transsexualism and/or GID to be provided to covered individuals. The European Court has also upheld gender reassignment as a valid health treatment to be provided by European States (L v Lithuania [2007] ECHR (case no. 27527/03)). All states in Europe now provide treatment routeways for transsexual people. Increasingly, insurers are being obliged to realize the validity and effectiveness of treatment , and coverage is being offered, increasingly at no additional premium cost.

"Professionals who provide services to patients with gender conditions understand the necessity of SRS, and concur that it is reconstructive, and as such should be reimbursed, as would any other medically necessary treatment." [7]

The WPATH Board of Directors urges state healthcare providers and insurers throughout the world to eliminate transgender or trans-sex exclusions and to provide coverage for transgender patients including the medically prescribed sex reassignment services necessary for their treatment and well-being, and to ensure that their ongoing healthcare (both routine and specialized) is readily accessible.

This clarification constitutes the professional opinion of the signatories below, comprised of all members of the WPATH Board of Directors and Executive Officers as of this date, June 17, 2008.

Stephen Whittle, Ph.D., O.B.E. (UK) President
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Beatrice "Bean" E. Robinson, Ph.D. (USA) Executive Director

[1] American Academy of Pediatrics, 1999

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[2] Definition taken from 2007 Blue Cross Blue Shield Settlement available at www.hmosettlements.com

[3] Monstrey S, De Cuypere G, Ettner R, (2007) . Surgery: General Principles. In Ettner R et al (eds) Principles of Transgender Medicine and Surgery. New York:Haworth Press:2007.p.90.

[4] Victoria L. Davidson v. Aetna Life & Casualty Insurance Co. 101 Misc.2d 1, 420 N.Y.S.2d 450 (Sup. Ct., 1979). Judges found that "...the treatment and surgery...is of a medical nature and is feasible and required for the health and well-being of the patient."

[5] Newfield E, et al (2006). Female-to-male quality of life. In Quality of Life Research. Springer.

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[7] Monstrey S, De Cuypere G, Ettner R, (2007) . Surgery: General Principles. In Ettner R et al (eds) Principles of Transgender Medicine and Surgery. New York: Haworth Press:2007.p.94.