September 7, 2018

To: Director
Office of Regulation Policy and Management (00REG)
Department of Veterans Affairs
810 Vermont Ave., NW, Room 1063B
Washington, DC 20420

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On behalf of the American Academy of Nursing; the American College of Physicians; the American Medical Student Association; the American Nurses Association; GLMA: Health Professionals Advancing LGBT Equality; the Lesbian, Gay, Bisexual, and Transgender Caucus of Public Health Professionals; the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus of the American Academy of PAs, Inc.; and the World Professional Association for Transgender Health.

Re: Notice of Petition for Rulemaking and Request for Comments – Exclusion of Gender Alterations from the Medical Benefits Package

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I. Introduction

The Department of Veterans Affairs (VA) seeks comments to assist in determining whether to amend its medical regulations by removing a provision that excludes gender-affirming surgery, also referred to as ‘‘gender alteration surgery’’ or “sex reassignment surgery” (SRS), from the VA’s medical benefits package. The undersigned medical and mental health organizations submit the comments below in strong support of allowing veterans access to SRS, which for many patients is a clinically effective, medically necessary, and potentially life-saving treatment for gender dysphoria.

The VA's notice for comments references the Department of Defense's February 2018 Implementation Report (the "Implementation Report") which noted that uncertainty exists with respect to the effectiveness of SRS as a treatment for gender dysphoria. The undersigned medical and mental health organizations disagree that any uncertainty exists. These organizations have found, based on reasons set forth herein, that transition-related care is not only medically necessary, it is also effective in improving health outcomes for many individuals with gender dysphoria, especially patients for whom psychotherapy and hormone therapy are insufficient treatment for gender dysphoria.

The standards of care for gender dysphoria require individualized assessment and provision of medically necessary care to each patient. These standards are based on the fundamental principle that medical and mental health professionals must make a case-by-case assessment and treatment plan for each patient to identify the severity of, and to treat, each patient's condition or medical needs. If the VA continues to impose a blanket exclusion of medically necessary gender-affirming surgery from the VA's medical benefits package, the VA would deny patients with the most serious levels of gender dysphoria medically necessary care, placing them at substantially greater risk of serious physical and emotional trauma, including suicidal ideation, suicide attempts, and suicide.

In short, the internationally-recognized standards of care for gender dysphoria created by medical and mental health professional organizations across the globe compel the conclusion that providing care relating to gender transition, including gender-affirming surgery, is medically necessary and clinically effective for a significant portion of the VA's patient population experiencing gender dysphoria. The VA's ban on SRS denies veterans access to potentially life-saving care and must be put to an end.

II. These Comments Represent the Interests of Leading Medical and Mental Health Professionals Dedicated to Providing the Proper Health Care and Treatment for All Individuals in Need.

The following well-recognized medical and mental health organizations offer these comments to explain that the exclusion of medically necessary transition-related surgeries from the VA's medical benefits package impinges upon medical and mental health professionals' ability to provide medically necessary care to each veteran patient with gender dysphoria. These organizations promulgate the leading standards of care in the field and are comprised of medical professionals charged with ensuring proper treatment for their patients.

The American Academy of Nursing serves the public and nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy's more than 2,500 members, known as fellows, are nursing's most accomplished leaders in education management, practice, and research. The Academy is committed to ensuring dignified and respectful health care for all persons, regardless of sexual orientation or gender identity. The Academy supports initiatives to address the health needs of transgender individuals and supports policy initiatives which support transgender individuals' unique health concerns and reduce the health care barriers that transgender individuals encounter.

The American Nurses Association ("ANA") represents the interests of the Nation's four million registered nurses. With members in every State, ANA is comprised of state nurses associations and individual nurses. ANA is an advocate for social justice with particular attention to preserving the human rights of vulnerable groups, such as the poor, homeless, elderly, mentally ill, prisoners, refugees, women, children, and socially stigmatized groups.

GLMA: Health Professionals Advancing LGBT Equality ("GLMA") is the largest and oldest association of LGBT healthcare professionals. GLMA's mission is to ensure equality in

healthcare for LGBT individuals and healthcare professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 in part as a response to the call to advocate for policy and services to address the growing health crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health issues affecting LGBT people and GLMA has become a leader in public policy advocacy related to LGBT health. To advance its mission, GLMA provides cultural competency courses for medical providers, including in transgender health.

The HIV Medicine Association represents more than 5,000 HIV medical professionals who practice HIV medicine across the U.S. and in countries around the world. The Association was created by the Infectious Diseases Society of America in 2002 to represent the interests of HIV healthcare providers and researchers and their patients by promoting quality in HIV care and advocating for policies that ensure a comprehensive and humane response to the AIDS pandemic informed by science and social justice.

The Lesbian, Bisexual, Gay and Transgender ("LBGT") Physician Assistant ("PA") Caucus of the American Academy of PAs, Inc. is the national professional society for PAs and PA students who share a common interest in the art of LGBT health. It is an officially recognized constituent organization of the American Academy of PAs. Since 1979, the LBGT PA Caucus has been serving the PA profession on all aspects of sexual and gender minority diversity and inclusion in the PA workforce, PA education, and the health of the public. The LBGT PA Caucus endeavors toward a future where health outcomes will be independent of social determinants including age; sex; kinship networks; racial, ethnic, gender or sexual orientation identity groups;

religious affiliations; social classes; geographic regions; occupation; (dis)ability; and HIV or marital status. The LBGT PA Caucus joins these comments for reasons expressed in PA professional practice policies regarding non-discrimination in healthcare delivery on the basis of sex, gender identity, and gender expression, and the elimination of arbitrary condition-based exclusions that inhibit access to medically-necessary health care.

The World Professional Association for Transgender Health ("WPATH") is an interdisciplinary professional association committed to developing the best practices and supportive policies to promote health, research, education, respect, dignity, and equality for transgender people in all settings. WPATH was founded in 1979 and based on the principles of Dr. Harry Benjamin, one of the first physicians to work with transgender individuals. It is the only medical association devoted solely to the study and treatment of gender dysphoria, and maintains a leading role in setting medically-accepted standards for treatment. WPATH publishes *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* that articulate a professional consensus about the medical, psychiatric, psychological, and surgical management of gender dysphoria. The *Standards of Care* recognize the role of surgery to change sex characteristics in treating gender dysphoria. WPATH also offers training for healthcare providers in the management of transgender health.

III. Sex Reassignment Surgery Is A Clinically Effective, Medically Necessary Treatment For Certain Patients For Whom Psychotherapy And Hormone Therapy Are Not Sufficient To Treat Gender Dysphoria

a. Many Individuals With Gender Dysphoria Require Medical Treatment

Gender dysphoria is the medical term for the distress indicated by a strong, persistent cross-gender identification in which individuals "are cruelly imprisoned in a body incompatible with their subjective gender identity." *Merck Manual of Diagnosis and Therapy* 1568 (Robert S.

Porter et al. eds., 19th ed. 2011) (hereinafter *Merck Manual*). Most individuals' gender identities are congruent with their bodies. Individuals with gender dysphoria, in contrast, experience a degree of incongruence that is often severe, distressing, and long-standing. *Id.* When not properly treated, gender dysphoria can result in clinically significant psychological distress, dysfunction, debilitating depression, and, for some people, self-mutilation, thoughts of and attempts at suicide, and death. *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 454-55 (5th ed. 2013) (hereinafter DSM-5); George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. Transgenderism 31, 31-39 (2010).

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders recognizes the following diagnostic criteria for gender dysphoria in adolescents and adults:

> A) A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
>
> > (1) A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
> > (2) A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
> > (3) A strong desire for the primary and/or secondary sex characteristics of the other gender.
> > (4) A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
> > (5) A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
> > (6) A strong conviction that one has the typical feelings and reactions of the other gender…. and
>
> B) The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-5 at 452-53.

Similarly, the World Health Organization's International Classification of Diseases recognizes that gender dysphoria is "characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex." World Health Organization ("WHO"), *International Classification of Diseases-10* F64.2 (2015 ed.), http://apps.who.int/classifications/ icd10/browse/2015/en#/F64.2. One court recently held that gender dysphoria is a disability within the meaning of the Americans with Disabilities Act. *Blatt v. Cabela's Retail, Inc.*, No. 5:14-cv-04822, 2017 WL 2178123, at *4 (E.D. Pa. May 18, 2017).

At the core of the assessment of gender dysphoria are the persistent cross-gender identification and discomfort and distress that result from gender incongruence. The World Health Organization has recognized that gender dysphoria involves a "profound disturbance" with an individual's gender identity and "a persistent preoccupation with the dress and/or activities of the opposite sex and/or repudiation of the patient's own sex." WHO, *supra* p. 10, F64.2. Before treatment begins, individuals with gender dysphoria "live in a dissociated state of mind and body." David Seil, *The Diagnosis and Treatment of Transgendered Patients*, 8 J. Gay & Lesbian Psychotherapy 99, 115 (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001). In these individuals, "[t]he mind is of one gender, and the body is of the other." *Id.*

As a result of the gender dysphoria, some male-to-female individuals resort to self-treatment with hormones or, in some cases, attempt their own castration or penectomy. DSM-5 at 454; Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment*, at 33. In these cases, individuals with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicide. *Id.* The literature in the field is replete with accounts of individuals who have taken their own lives or attempted to do so because their

gender dysphoria was not properly assessed and treated, with some studies finding as many as one in four male-to-female individuals and one in five female-to-male-individuals attempted suicide before treatment. *See, e.g.*, Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment*, at 31-39; Bram Kuiper & Peggy Cohen-Kettenis, *Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals*, 17 Archives Sexual Behav. 439, 451 (1988).

b. Sex Reassignment Surgery Is A Widely-Accepted Treatment For Many Individuals With Gender Dysphoria

The medical and mental health communities have well-established protocols for assessing and treating gender dysphoria, which specifically recognize the medical necessity and therapeutic importance of sex reassignment surgery, or SRS. First published in 1979 by *amicus curiae* the World Professional Association for Transgender Health (WPATH), the WPATH *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* are the internationally-recognized professional standards of care regarding the treatment of individuals with gender dysphoria. *See* WPATH, *Standards of Care*, at 8-9 (7th ed. 2011), https://www.wpath.org/publications/soc; *see also Merck Manual*, at 1570 (recognizing that WPATH's Standards of Care are "the internationally accepted standards of care for the treatment of gender identity disorders"). Informed by current consensus in medical research and clinical practice, the WPATH Standards of Care emphasize that treatment must consider each patient's unique anatomic, social, and psychological situation. WPATH, *Standards of Care*, at 2. "Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person." *Id.* at 5. "While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria." *Id.* at 54. Studies have shown that SRS is a safe and effective treatment for

gender dysphoria. *See id.* at 55 ("Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes.").

The decision to undergo SRS "is not taken lightly." Hilary Daniel & Renee Butkus, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians*, 163 Annals of Internal Med. 135 (2015), http://annals.org/aim/article/2292051/lesbian-gay-bisexual-transgender-health-disparities-executive-summary-policy-position. "Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs." *Id.* In other words, "[g]enital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures." *See* WPATH, *Standards of Care*, at 55. They are medically necessary treatments for gender dysphoria to be undertaken only after "assessment of the patient by qualified mental health professionals" to determine that the patient has "met the criteria for a specific surgical treatment." *Id.*

c. Some Individuals With Severe Gender Dysphoria Cannot Manage Their Gender Dysphoria With Psychotherapy And Hormone Therapy

Medical and mental health professionals widely recognize that for some individuals, especially those with severe gender dysphoria, it is impossible to manage their distress with psychotherapy and/or hormone therapy alone. Seil, *The Diagnosis and Treatment of Transgendered Patients* at 114-16; Yolanda L.S. Smith, *et al*., *Adolescents With Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study*, 40 J. Am. Academy Child Adolescent Psychiatry 472, 473 (2001); Walter O. Bockting & Eli Coleman, *A Comprehensive Approach to the Treatment of Gender Dysphoria*, 5 J. Psychol. & Human Sexuality, vol. 4 1993, at 131, 150. For these patients, "relief from gender dysphoria

cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity." WPATH, *Standards of Care*, at 54-55.

As medical and mental health professionals have recognized, gender identity cannot be changed through psychotherapy, "[h]owever, the body can be changed, and when a proper transition to the other gender has been completed, the dissociation" of gender dysphoria may be lessened. Seil, *The Diagnosis and Treatment of Transgendered Patients*, at 115. Research has shown that many of those seeking treatment for gender dysphoria regard their genitals and sexual features with repugnance. *Merck Manual*, at 1570. As a result, some individuals with gender dysphoria prioritize "obtain[ing] hormones and genital surgery that will make their physical appearance approximate their felt gender identity." *Id.* It is the combination of psychotherapy, hormone therapy, and SRS that "is often curative when the disorder is appropriately diagnosed and clinicians follow the internationally accepted standards of care." *Id.* Empirical studies reflect the importance of the interplay among treatments, finding hormone therapy in conjunction with psychotherapy and, for some, SRS, to be necessary elements of treating severe levels of gender dysphoria. *See* Gianna E. Israel & Donald E. Tarver II, *Transgender Care: Recommended Guidelines, Practical Information & Personal Accounts* 56-73 (1997).

Treatment utilizing SRS for individuals with severe gender dysphoria may be vital to a patient's health. *See* Smith, 40 J. Am. Academy Child & Adolescent Psychiatry, at 473. In a study of outcomes of sex reassignment surgery, including SRS in adolescents, sex reassignment surgery significantly improved anxiety, depression, and hostility. *Id.* at 475-77.

Many transgender veterans "have experienced and continue to experience extreme and sometimes life-threatening hardships because they cannot obtain coverage" for medically-necessary healthcare services to complete their transition. *See* Attachment 1 (Affidavit of Evan

Young, May 5, 2016, filed in *Fulcher v. Secretary of Veterans Affairs*, Federal Circuit, No. 17-1460, Dkt. 126 at 114). For example, in June 2015 a transgender veteran, a retired Sergeant, took her own life, referencing in her suicide note her inability to have "medical procedures covered as a reason for her desperation and hopelessness." *See id*. Thus, "[i]f the VA were to amend its regulations to include coverage of sex reassignment surgery, such an amendment would significantly improve the physical and mental health of . . . transgender veterans with gender dysphoria." *See id*. In short, SRS is an effective and medically necessary treatment for certain patients for whom psychotherapy and hormone therapy are insufficient treatment for gender dysphoria.

IV. Case-By-Case Assessment And Appropriate Treatment Of Veterans With Gender Dysphoria Is Necessary To Prevent Physical And Emotional Harm

a. Medical And Mental Health Organizations, Courts, And The Federal Government Have All Recognized The Importance Of Individualized Care

Because not all patients require the same therapeutic care, medical and mental health professionals must make treatment decisions on a case-by-case basis. This is a fundamental principle of the WPATH Standards of Care, which state: "While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria." *See* WPATH, *Standards of Care*, at 54.

Recognizing the importance of individualized care for transgender patients, major medical and mental health organizations have called for an end to blanket exclusions in health insurance coverage for treatment of gender dysphoria:

- "The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered

services to transgender persons as they would all other beneficiaries." Daniel & Butkus, 163 Annals of Internal Med. 135, 136.

- In its Standards of Care, WPATH "urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria." WPATH, *Standards of Care*, at 33.
- The American Medical Association ("AMA") "supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician." AMA Policy H-185.950, https://policysearch.ama-assn.org/policyfinder/detail/H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml.
- "The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder." American College of Obstetricians & Gynecologists, Committee Opinion of the Committee on Healthcare for Underserved Women, No. 512, *Health Care for Transgender Individuals* (Dec. 2011).
- The American Psychiatric Association "[a]dvocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment" and "[o]pposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician." Am. Psychiatric Ass'n, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012), https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-transgender-gender-variant-access-care.pdf.
- The American Psychological Association "recognizes the efficacy, benefit, and necessity of gender transition treatments for appropriately evaluated individuals and calls upon

public and private insurers to cover these medically necessary treatments." Am. Psychol. Ass'n, *Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination* (Aug. 2008), http://www.apa.org/about/policy/transgender.pdf.

- The American Nurses Association "is committed to the elimination of health disparities and discrimination based on sexual orientation, gender identity, and/or expression within health care. LGBTQ+ populations face significant obstacles accessing care such as stigma, discrimination, inequity in health insurance, and denial of care because of an individual's sexual orientation or gender identity." American Nurses Association, *Position Statement on Nursing Advocacy for LGBTQ+ Populations* (2018), https://www.nursingworld.org/~49866e/globalassets/practiceandpolicy/ethics/nursing-advocacy-for-lgbtq-populations.pdf.

Moreover, courts have recognized the importance of individualized assessment and treatment and the harm that can result from blanket prohibitions. For example, in *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011), the Seventh Circuit affirmed the district court's decision striking down on Eighth Amendment grounds a Wisconsin statute that prohibited the Wisconsin Department of Corrections from providing transgender inmates with hormone therapy and SRS. *Id*. at 559. The Seventh Circuit held that such a blanket policy is unacceptable: because "[t]he feelings of dysphoria can vary in intensity . . . . [t]he accepted standards of care dictate a gradual approach to treatment." *Id.* at 553-54. Thus, "[f]or some number of patients," psychotherapy "will be effective in controlling feelings of dysphoria," but for others, "a doctor can prescribe hormones, which have the effect of relieving the psychological distress." *Id.* at 554. Following this individualized course of treatment depending on an individual's needs, "[i]n the most severe cases, sexual reassignment surgery may be appropriate." *Id.*; *see also Fields v. Smith*, *Amicus*

Br. of Medical and Mental Health Professionals 12-16 (arguing case-by-case assessment is necessary for prisoners with gender dysphoria).

Similarly, in *De'lonta v. Johnson*, 708 F.3d 520 (4th Cir. 2013), the Fourth Circuit reversed the district court's dismissal of a transgender prisoner's Eighth Amendment claim based on the prison's refusal to refer the plaintiff for assessment for SRS because she was already receiving counseling and hormone therapy to treat her gender dysphoria. In so ruling, the Fourth Circuit observed that "the [WPATH] Standards of Care . . . indicate that [SRS] may be necessary for individuals who continue to present with severe [gender dysphoria] after one year of hormone therapy." *Id.* at 525; *see also Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1118 (N.D. Cal. 2015) (plaintiff, who was an inmate, stated an Eighth Amendment claim for denial of SRS, characterizing it as "necessary medical treatment" for this inmate); *cf. O'Donnabhain v. Commissioner*, 134 T.C. 34, 65-70 & n.45 (2010) (SRS is "well-recognized and accepted treatment[] for severe" gender dysphoria).

Adding to the weight of authority, the U.S. Department of Health and Human Services ("HHS") has recognized the need for individualized assessment and treatment: HHS recently overturned a blanket ban on providing Medicare coverage for SRS. *See In re NCD 140.3, Transsexual Surgery*, DAB Dec. No. 2576, Docket No. A-13-87 (HHS, Appeals Bd., May 30, 2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf. In May 2014, the HHS Appeals Board determined that the blanket denial of "Medicare coverage of all transsexual surgery as a treatment for transsexualism" failed the Board's "reasonableness standard." *Id.* at 1. The Board found that SRS "is an effective treatment option in appropriate cases," *id.* at 15, and that the WPATH Standards of Care, which

have "attained widespread acceptance," *id.* at 23, include "criteria for the use of" SRS, *id.* at 15 n.22.

Empirical studies of individuals who have undergone the full treatment prescribed by medical and mental health professionals for their diagnosis further demonstrate that gender dysphoria "is not a homogenous phenomenon," and that it requires "a more varied treatment approach." P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 J. Psychosomatic Res. 315, 328 (1999) (reviewing empirical studies on those with gender dysphoria).

Further, despite actuarial fears of over-utilization and a potentially expensive benefit, programs that have expanded to include coverage of SRS have found the economic costs to be minimal compared to other insurance costs. *See* Jody L. Herman, The Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings From a Survey of Employers* 2, 11, 15, 16 (Sept. 2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf; Human Rights Campaign, *San Francisco Transgender Benefit: Actual Cost & Utilization (2001-2006)*, http://www.hrc.org/resources/entry/san-francisco-transgender-benefit-actual-cost-utilization-2001-2006 (last visited June 19, 2017).

b. The VA's Blanket Ban On Sex Reassignment Surgery Denies Individualized Care And Disrupts Continuity Of Patient Care

Blanket bans on SRS—such as the VA's ban—disrupt continuity of patient care. Continuity of care for transgender patients is an important principle in the WPATH Standards of Care. The Standards of Care advise that "[h]ealth professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care." *See* WPATH,

Standards of Care, at 3, 65. In conflict with this important standard of care, the VA covers all medically necessary care for transgender veterans *except* for SRS:

> It is VHA policy that medically necessary care is provided to enrolled or otherwise eligible intersex and transgender Veterans, including hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following sex reassignment surgery. Sex reassignment surgery cannot be performed or funded by the VA.

see VHA Directive 2013-003, *Providing Health Care for Transgender and Intersex Veterans*, Feb. 8, 2013, *revised* Jan. 9, 2017, https://www.birmingham.va.gov/docs/LGBT_Healthcare.pdf, at § 3; *see also* Department of Veterans Affairs, *Presidential Transition Briefing Book*, Nov. 1, 2016, https://www.oprm.va.gov/docs/foia/2016PresidentialTransitionUserGuide.pdf, at 88 ("VA currently provides many services for transgender Veterans to include hormone therapy, mental health care, preoperative evaluation, and long-term care following sex reassignment surgery."). Transgender veterans may receive a bundle of pre- and post-operative care from their VA providers but must obtain—and pay for—the critical operative care on their own.

This disruption of continuity of care runs contrary to the healthcare needs of transgender veterans, which the VA well understands. The VA has been providing some transition-related care for veterans since 2011 and, since 2015, the VA has opened clinics in Cleveland, Ohio and Tucson, Arizona that specialize in providing medical care to transgender veterans. *See* Brian Albrecht, *All Things Considered: VA Transgender Clinic Opens in Cleveland*, Cleveland.com (Nov. 12, 2015, 4:07 PM), http://www.cleveland.com/metro/index.ssf/2015/11/vas_first_transgender_clinic_o.html; Jimmy Jenkins, *New VA Clinic Opens for Transgender Vets*, NPR (Dec. 29, 2015), http://www.npr.org/2015/12/29/460955296/new-va-clinic-opens-for-transgender-vets. But although veterans are able to receive comprehensive pre- and post-operative care from the

VA, they must seek out their medically-necessary surgeries elsewhere. Jenkins, *New VA Clinic Opens for Transgender Vets*.

This can lead to terrible and absurd results. For example, when one transgender veteran was denied coverage of her medically-necessary SRS, she went to Tijuana, Mexico to obtain that surgery. She did this because the VA's denial of coverage required her to pay for the surgery out-of-pocket and had she obtained the surgery in the U.S. it would have been three times as expensive. After the Mexican doctor botched her surgery, she was forced to undergo years of post-operative care, including corrective surgeries, through the VA. *See, e.g.*, Nicole Comstock, California Veteran Shares Story of Gender Transition, FOX40 (May 11, 2015), http://fox40.com/2015/05/11/california-veteran-shares-story-of-gender-transition/. Had the VA provided coverage of the veteran's surgery at the outset, her operation would have been conducted correctly, sparing the patient years of pain and, likely, saving taxpayers money.

The VA's refusal to cover such care has no basis in medicine. In fact, the VA has repeatedly recognized that surgical care is medically necessary. In letters to a number of Members of Congress, the VA's former Under Secretary for Health unequivocally stated that "[i]ncreased understanding of both gender dysphoria and surgical techniques in this area has improved significantly and is now widely accepted as medically necessary treatment." *See* Attachment 2 (Letter from David J. Shulkin, M.D., Former Under Secretary for Health, Department of Veterans Affairs to Sen. Elizabeth Warren, Nov. 10, 2016); *see also* Department of Veterans Affairs, 38 CFR Part 17, Proposed Rule, Removing Gender Alterations Restriction from the Medical Benefits Package (Spring 2016), https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201604&RIN=2900-AP69 (making same statement).

In addition, the VA provides these very surgeries to other veterans. The VA's Directive is clear that its ban on SRS does not apply to intersex veterans. *See* VHA Directive 2013-003, *Providing Health Care for Transgender and Intersex Veterans*, Feb. 8, 2013, *revised* Jan. 9, 2017, § 3. Moreover, the VA provides the same kind of surgical benefits to non-transgender veterans with other medical needs, whether because of cancer or a genital injury during service. *Id*; *see also*, Mimi Leong *et al., Effective Breast Reconstruction in Female Veterans*, 198 Am. J. Surg. 658 (2009) (addressing outcomes of breast reconstruction performed at VA hospitals); *Shimansky v. West*, 17 Vet. App. 90, 90, 1999 WL 757054 (1999) (unpublished table decision) (patient received a penile prosthesis at the Wilmington, Delaware VA Medical Center); *Brewer v. Nicholson*, 21 Vet. App. 420, 420, 2006 WL 3007323 (2006) (unpublished table decision) (patient received a penile prosthesis at the Jackson, Mississippi VA Medical Center); Board of Veteran's Appeals, Docket No. 96-07-121 (Sept. 26, 1997), https://www.va.gov/vetapp97/files4/9732876.txt (stating patient received a "testicular prosthetic implantation" at a VA hospital); Carolyn Gardella et al., *Prevalence of Hysterectomy and Associated Factors in Women Veterans Affairs Patients*, 50 J. Reprod. Med. 166, 167-72 (2005) (estimating prevalence of hysterectomies provided by the VA Puget Sound Health Care System); Denise Hynes et al., *Breast Cancer Surgery Trends and Outcomes: Results from a National Department of Veterans Affairs Study*, 198 J. Am. College of Surgeons, 707, 707-16 (2004) (examining trends in breast cancer surgery performed at VA hospitals); *Norvell v. Peake*, 22 Vet. App. 194, 195 (2008) (noting that the patient underwent a bilateral orchiectomy at Lexington, Kentucky, VA Medical Center), *aff'd sub nom*. *Norvell v. Shinseki*, 333 F. App'x 571 (Fed. Cir. 2009); J.M. Corman *et al.*, *Fournier's Gangrene in a Modern Surgical Setting: Improved Survival with Aggressive Management*, 84 BJU Int'l, 85, 85-88 (July 1999) (noting that all patients covered in the survey

had received scrotectomies for Fournier's Gangrene and that some of the patients had been treated at West Los Angeles Veterans Administration Hospital); Board of Veterans Appeals, Docket No. 05-31 519 (Oct. 25, 2007), https://www.va.gov/vetapp07/files4/0733550.txt (noting that the patient had undergone a total penectomy at a VA hospital due to cancer).

In sum, because of the individual nature of gender dysphoria and its treatment, medical and mental health professionals must evaluate each patient with gender dysphoria on a case-by-case basis to prescribe the proper therapeutic treatment. Some transgender veterans require SRS, and the VA's blanket policy of denying SRS precludes case-by-case assessment and treatment of individuals with gender dysphoria. Thus, this blanket ban prevents medical and mental health professionals from prescribing the proper treatment and places veterans at substantially greater risk of physical and emotional harm.

Regards,

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CC: The American Academy of Nursing; the American College of Physicians; the American Medical Student Association; the American Nurses Association; GLMA: Health Professionals Advancing LGBT Equality; the Lesbian, Gay, Bisexual, and Transgender Caucus of Public Health Professionals; the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus of the American Academy of PAs, Inc.; and the World Professional Association for Transgender Health.