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Literature Review

From: Noah Lewis, Transcend Legal

Re: Medical necessity of vaginoplasty to treat gender dysphoria in people under 18

Date: May 31, 2019

Cited articles are available upon request.

I. Vaginoplasty is clinically appropriate treatment for the illness or disease of gender dysphoria.

Gender reassignment surgeries are procedures that change male sex characteristics into female ones (or vice versa) for the purpose of treating gender dysphoria. Genital reassignment surgery (“GRS”), including vaginoplasty, has been shown to be highly effective in treating gender dysphoria.

A. Gender dysphoria is an illness or disease under the plan.

Gender dysphoria is a disease in which there is “incongruence between the individual’s own perception of his/her sex and their biological phenotype.”¹ Affected individuals have “a strong desire to undergo medical and surgical treatment . . . in order to alleviate physical incongruence and gender dysphoria.”² Gender dysphoria “is a clinical term used to describe the symptoms of excessive pain, anguish, agitation, restlessness, and malaise” that transgender people often experience. It “describes the psychological discomfort experienced with the physiological body . . . as well as a presence of clinical [symptoms] associated with emotional difficulties.”³ Gender dysphoria is “[o]ften experienced as depression, anxiety, irritation, and/or agitation, [it] describes the sense that something is very wrong”⁴ Before treatment, individuals with

¹ Ebba K. Lundqvist et al., *Quality of life improves early after gender reassignment surgery in transgender women*, 40 EUR. J. OF PLASTIC SURGERY 223 (2017).

² *Id.*

³ Arlene Istar Lev, *TRANSGENDER EMERGENCE: THERAPEUTIC GUIDELINES FOR WORKING WITH GENDER-VARIANT PEOPLE AND THEIR FAMILIES* 10 (2004).

⁴ Randi Kaufman, *Introduction to Transgender Identity and Health*, in *THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH* 331,

gender dysphoria “live in a dissociated state of mind and body.”⁵ Transsexualism—another term for gender dysphoria—is recognized under the International Classification of Diseases, Tenth Revision (ICD-10) as medical condition F.64.0.⁶

Gender dysphoria is thus a recognized “disease” under the plan. It is also an “illness” under the plan as a transgender woman with gender dysphoria has a female psychological sex, and the male sex characteristics of her body represent a pathological condition of the body.

B. A physician exercising prudent clinical judgment would perform vaginoplasty to treat gender dysphoria or its symptoms.

There is no dispute that vaginoplasty is a safe, effective, clinically appropriate treatment for gender dysphoria. This overwhelming medical consensus is reflected in the fact that all insurance companies with clinical policies on gender dysphoria treatments recognize vaginoplasty as medically necessary.⁷

337 (Harvey Makadon et al. eds., 2008).

⁵ David Seil, *The Diagnosis and Treatment of Transgendered Patients* in *TRANSGENDER SUBJECTIVES: A CLINICIAN’S GUIDE* 115 (eds. Ubaldo Leli & Jack Drescher) (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001).

⁶ World Health Organization, *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (2016), <http://apps.who.int/classifications/icd10/browse/2016/en#/F60-F69> (“A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex, and a wish to have surgery and hormonal treatment to make one’s body as congruent as possible with one’s preferred sex.”).

⁷ TRANSCEND LEGAL, *TRANSGENDER INSURANCE MEDICAL POLICIES*, <https://transcendlegal.org/health-insurance-medical-policies> (providing links to over 110 insurance company clinical guidelines on gender reassignment surgery and related treatments).

The safety of vaginoplasty is well-established.⁸ Vaginoplasty for transgender women has been performed since 1931, with modern vaginoplasty techniques emerging in the 1950's.⁹ There is a low rate of complications¹⁰ and a high rate of good clinical outcomes and patient satisfaction with the results.¹¹

⁸ See S. De Stefani et. al., *Microlaparoscopy in Sex Reassignment Surgery*, 4 THE SCIENTIFIC WORLD J. 100, 101 (2004) (Surgical techniques utilized for performing GRS on trans women are “well codified and relatively simple to perform.”); F. G. Bouman, *Sex Reassignment Surgery in Male to Female Transsexuals*, 21 ANNALS OF PLASTIC SURGERY, 526, 531 (1988) (“[v]aginal construction in male transsexuals . . . is a reliable technique”); Gennaro Selvaggi et al., *Gender Identity Disorder: General Overview and Surgical Treatment for Vaginoplasty in Male-to-Female Transsexuals*, 116 PLASTIC AND RECONSTRUCTIVE SURGERY 135e, 143e (2005) (describing the variety of modern techniques available and noting that the “penile-scrotal skin flap technique is considered the state of the art for vaginoplasty”). See also Cameron Bowman & Joshua M. Goldberg, *Care of the Patient Undergoing Sex Reassignment Surgery*, 9 INT’L J. OF TRANSGENDERISM 135, 142 (2006) (noting that it is safe to perform vaginoplasty and breast augmentation at the same time); Eric B. Gordon, *Transsexual Healing: Medicaid Funding of Sex Reassignment Surgery*, 20 ARCHIVES OF SEXUAL BEHAVIOR 61, 72 (1991) (noting that in 1991 GRS research was in the “‘refining’ stage”); Miroslav Djordjevic, *Rectosigmoid vaginoplasty: Clinical Experience and Outcomes in 86 Cases*, 8 J. OF SEXUAL MED. 3487, 3493 (2011) (“Rectosigmoid vaginoplasty presents a safe and reasonable choice with acceptable complications and satisfactory results” in both transgender and non-transgender women.).

⁹ See Jonathan Charles Goddard, et al., *Development of Feminizing Genitoplasty for Gender Dysphoria*, 4 J. OF SEXUAL MED. 981, 983-84 (2007).

¹⁰ See Ji-Xiang Wu et. al., *Laparoscopic Vaginal Reconstruction Using an Ileal Segment*, 107 INT’L J. OF GYNECOLOGY AND OBSTETRICS 258, 259 (2009) (finding no complications during surgery and only three post-operation complications, which were resolved, when vaginoplasties were performed on 80 trans and non-trans women); Ladislav Jarolim, *Gender Reassignment Surgery in Male-to-Female Transsexualism: A Retrospective 3-Month Follow-Up Study with Anatomical Remarks*, 6 J. OF SEXUAL MED. 1635, 1641 (2009) (reporting that for 128 trans women who underwent GRS, surgical complications were uncommon and were all successfully resolved); S. V. Perovic et al., *Vaginoplasty in Male Transsexuals Using Penile Skin and a Urethral Flap*, 86 BJU INT’L 843, 849 (2000) (reporting good results and only one major complication in a follow-up of eighty-nine vaginoplasties).

¹¹ See P.A. Sutcliffe et. al, *Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review*, 62 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 294, 299 (2009) (concluding results of vaginoplasty are generally satisfactory); Ciro Imbimbo et al., *A Report from a Single Institute’s 14-Year Experience in Treatment of Male-to-Female*

Peer-reviewed medical literature has conclusively demonstrated that GRS is effective and of material clinical benefit to individuals with gender dysphoria. GRS has been found to lead to a “virtual absence of gender dysphoria,”¹² and is proven to alleviate the psychological symptoms of gender dysphoria, including depression.¹³ GRS has also been found to lead to a decrease in suicide attempts and drug use in post-operative populations.¹⁴ Transgender women who transition as adults have a

Transsexuals, 6 J. OF SEXUAL MED. 2736, 2740 (2009) (reporting on the results of 139 patients over a 14-year period in which 94% of patients were satisfied and had no regrets); Anne A. Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 ARCHIVES OF SEXUAL BEHAVIOR 299, 309 (2003) (finding over 96% of transgender women participating in the study were happy with their GRS results); A. Michel et al., *The Transsexual: What About the Future?*, 17 EUROPEAN PSYCHIATRY 353, 354-55 (2002) (literature review finding that almost 90% of transgender people say they would make the decision to undergo GRS again); G. De Cuypere et al., *Long-term follow-up: psychosocial outcome of Belgian transsexuals after sex reassignment surgery*, 15 SEXOLOGIES 126, 131 (2006) (88% of transgender women “felt happy to very happy after surgery”); Jarolím, *supra* note 10, at 1635 (Czech study of 129 transgender women showed all were satisfied and the procedure was safe).

¹² Yolanda L. S. Smith, *Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals*, 35 PSYCHOLOGICAL MED. 94 (2005). *See also* Mohammad Hassan Murad, *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 CLINICAL ENDOCRINOLOGY 216 (2010) (“Male-to-female and FM individuals had the same psychological functioning level as measured by the Symptom Checklist inventory (SCL-90), which was also similar to the psychological functioning level of the normal population and better than that of untreated individuals with GID.”); Tiffany A. Ainsworth & Jeffrey H. Spiegel, *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 QUAL. LIFE RES. 1019, 1021 (2010) (“[T]ranswomen without surgical intervention had statistically significant ($P < 0.05$) lower mental health scores compared to the mental health scores for the general female population (mean 39.5 (SD 7.3) compared to mean 48.9). The mental health quality of life of transwomen without surgical intervention was significantly lower compared to the general population, while those transwomen who received FFS, GRS, or both had mental health quality of life scores not significantly different from the general female population.”).

¹³ *See* Murad, *supra* note 12, at 216 (“Pooling across studies shows that after sex reassignment, 78% of individuals with GID reported significant improvement in psychiatric symptoms.”).

¹⁴ *See* Jamil Rehman et al., *The Reported Sex and Surgery Satisfaction of 28 Postoperative Male-to-Female Transsexual Patients*, 28 ARCHIVES OF SEXUAL BEHAVIOR 71, 83

lower quality of life as compared to the general population, but GRS improves quality of life as compared to not having surgery.¹⁵

In the single controlled, randomized study available on GRS, one group of transsexual women received genital surgery early while another group remained on the ordinary waitlist. Those who had surgery showed significant improvement in psychiatric symptoms, and social and sexual function, while those who had not yet had surgery showed no improvement.¹⁶

In 1998, a comprehensive review of the literature on GRS outcomes was conducted, which compiled data spanning thirty years of follow-up studies, reporting on eighty studies from twelve countries.¹⁷ Treatment that included GRS was found to be effective in relieving gender dysphoria. Additionally, “[t]here were few negative consequences, and all aspects of the reassignment process contributed to overwhelmingly positive outcomes.”¹⁸

C. Being under 18 does not negate the effectiveness of vaginoplasty in alleviating gender dysphoria.

The insurer recognizes that GRS is medically appropriate to treat gender dysphoria in people over 18 and would cover the procedure if the patient were 18. Substantial evidence reveals that a person’s gender identity is fully formed in youth¹⁹ and that it is not possible to change

(1999).

¹⁵ Ebba K. Lundqvist et al., *Quality of life improves early after gender reassignment surgery in transgender women* 40 EUR. J. OF PLASTIC SURGERY 223 (2017).

¹⁶ See C. Mate-Kole et al., *A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals*, 157 BRITISH J. OF PSYCHIATRY 261, 264 (1990).

¹⁷ Stan Monstrey et al., *Surgery: General Principles*, in *Principles of Transgender Medicine and Surgery* 89, 95 (Stan Monstrey et al. eds., 2007).

¹⁸ *Id.*

¹⁹ See, e.g., Sarah M. Burke et al., *Hypothalamic Response to the Chemo-Signal Androstadienone in Gender Dysphoric Children and Adolescents*, 5 FRONTIERS IN ENDOCRINOLOGY 1 (2014) (demonstrating that adolescents with gender dysphoria have sex-linked olfactory responses congruent with their affirmed sex rather than their sex as-

gender identity.²⁰ The American Academy of Pediatrics notes that gender identity is stable by age four.²¹ Transgender children know and express their genders as clearly and consistently as non-transgender children express their genders.²²

While the exact biological root causes of gender dysphoria have not been identified, magnetic resonance imaging studies have shown that the brains of transgender children, adolescents and adults match the patterns associated with their affirmed sex rather than sex assigned at birth, even before any hormonal treatment.²³ The regions affected play a role in body perception and self-awareness.²⁴ Separately, family and twin studies indicate a strong genetic component.²⁵ This biological origin of brain sex is reflected in the forthcoming ICD-11, in which the re-named “gender incongruence” diagnosis has been moved from a mental health diagnosis to a physical one.²⁶

signed at birth indicating that their brain sex was formed during early brain development).

²⁰ See generally Milton Diamond & H. Keith Sigmudson, *Sex Reassignment at Birth: Long-term Review and Clinical Implications*, 151 ARCH. PEDIATRIC MED. 298 (1997) (arguing that gender identity is formed at an early age and cannot be changed through therapy).

²¹ David A. Levine and the Committee on Adolescence, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132 PEDIATRICS e297, e299 (2013).

²² Kristina R. Olson et al., *Gender cognition in transgender children*, 26 PSYCHOLOGICAL SCIENCE, 467–474 (2015).

²³ Elyse Pine-Twaddle, *Medical Management Updates for Gender Minority Youth and Difficult Cases*, 29 ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS 97, 98 (2018) (compiling the literature).

²⁴ *Id.*

²⁵ *Id.*; Tinca J. C. Polderman et al., *The Biological Contributions to Gender Identity and Gender Diversity: Bringing Data to the Table*, 48 BEHAVIOR GENETICS 95-108 (2018).

²⁶ World Health Organization, *ICD-11: Classifying disease to map the way we live and die* (2018), <http://www.who.int/health-topics/international-classification-of-diseases> (“Gender incongruence, meanwhile, has also been moved out of mental disorders in the ICD, into sexual health conditions. The rationale being that while evidence is now

The widespread endorsement of and insurance coverage of gonadotropin-releasing hormone (GnRH) analog treatment at the start of puberty²⁷ is based on this stability of gender dysphoria that exists at the time of puberty. There is no clinical or medical basis for the implicit concern that in the remaining interval before her 18th birthday that the patient's need for surgery will abate or that her long-standing female identity will change to male. Indeed, the widespread acceptance for initiating cross-sex hormone therapy by age 16 is based on the fact that most individuals of that age have sufficient mental capacity to give informed consent.²⁸

The symptoms of gender dysphoria are consistent whether an individual is over 18 or under 18 and stem from the physical condition of having a penis. While interventions such as talk therapy, GnRH analogs, and hormones may be sufficient to relieve some symptoms of gender dysphoria, the only way to permanently treat dysphoria caused by having a penis is genital reassignment surgery. The fact that the patient is under 18 does not make gender reassignment surgery any less effective or any less medically necessary in resolving those symptoms.²⁹ (Ex. A). As one researcher puts it, “transgender adults started as transgender children. This concept is finally starting to translate into an affirmative practice model across the domains of law, ethics, advocacy, and health

clear that it is not a mental disorder, and indeed classifying it in this can cause enormous stigma for people who are transgender, there remain significant health care needs that can best be met if the condition is coded under the ICD.”).

²⁷ TRANSCEND LEGAL, MEDICAL POLICIES ON YOUTH SERVICES, <https://transcendlegal.org/health-insurance-medical-policies/youth-services> (linking to dozens of policies covering GnRH analogs for treating gender dysphoria).

²⁸ Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 3, 15, 17 (2017).

²⁹ See generally Johanna Olson-Kennedy et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults*, 172 JAMA PEDIATRICS 431-436 (2018).

care.”³⁰ At issue should be the provider’s assessment of whether the individual has gender dysphoria, is ready for treatment, and can provide informed consent—not the patient’s chronological age.³¹

The medical evidence establishes that surgery is effective regardless of chronological age. The insurer bears the burden of demonstrating why the legal age of majority is an appropriate medical criterion for this treatment. There is no medically relevant event that occurs when a person turns 18, and the legal age of majority is not a relevant criterion for any other medical treatment where the patient and the parents have provided informed consent.

II. This surgery is provided in accordance with applicable medical standards.

A. Medical opinions of professional societies recognize vaginoplasty as appropriate treatment.

1. The American Academy of Pediatrics recognizes a case-by-case approach to genital surgery for minors.

The American Academy of Pediatrics (AAP) is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.³² The AAP has published a policy statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse* endorsing medical treatment for transgender minors.³³ (**Ex. B**). The policy statement, issued on October

³⁰ Johanna Olson-Kennedy, *Hot Topics and Fresh Paradigms in Gender, Diversity, and Care*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* 85, 85 (2018).

³¹ *Id.* at 436.

³² American Academy of Pediatrics, *AAP Policy Statement Urges Support and Care of Transgender and Gender-Diverse Children and Adolescents* (Sept. 17, 2018), <https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Policy-Statement-Urges-Support-and-Care-of-Transgender-and-Gender-Diverse-Children-and-Adolescents.aspx>.

³³ Jason Rafferty, American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, and AAP Section on Lesbian, Gay, Bisexual, And Transgender Health and Wellness, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*.

4, 2018, is the most recent statement from a professional society on treatment for transgender youth. Accordingly, it reflects current best practices in this area more than earlier position statements.

The statement notes that surgeries to treat gender dysphoria, including surgery on genitals or reproductive organs, are performed on adolescents on a case-by-case basis. The AAP speaks to the lack of clarity in existing protocols noting: “Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.”³⁴ The AAP continues: “Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent’s overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.”³⁵

Finally, specifically as to insurance coverage for surgery, the AAP recommends “that insurance plans offer coverage for health care that is specific to the needs of youth who identify as [transgender and gender diverse], including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions.”³⁶

2. Surgery is in accordance with the WPATH Standards of Care, which emphasize an individualized approach.

The World Professional Association for Transgender Health publishes the *Standards of Care for the Health of Transsexual, Transgender, and*

142 PEDIATRICS, e20182162 (2018).

³⁴ *Id.* at 6.

³⁵ *Id.* at 7.

³⁶ *Id.* at 10.

Gender Nonconforming People,³⁷ (“SOC”) to help guide clinicians about decision-making on behalf of their transgender patients. The SOC endorse vaginoplasty as an appropriate treatment for gender dysphoria.³⁸ WPATH also released a statement on medically necessary therapy and treatment for trans people that specifically listed vaginoplasty as a medically necessary surgery.³⁹

WPATH supports social and medical transition for transgender youth, including puberty suppression, hormones, and surgeries where appropriate.⁴⁰ While the SOC explicitly endorse chest surgeries for people under 18, the criteria for genital surgery includes reaching the legal age of majority.⁴¹ While WPATH recommends that patients wait until the age of majority, the SOC as a whole emphasize individualized care, meaning that providers must do what is clinically appropriate for a given patient, not rigidly follow the SOC.

In the opening section on “Purpose and Use of the Standards of Care,” WPATH emphasizes that the “Standards of Care Are Flexible Clinical Guidelines[.] The SOC are intended to be flexible in order to meet the

³⁷ WPATH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE (7th ed.) (2011) [hereinafter WPATH STANDARDS OF CARE] https://amo_hub_content.s3.amazonaws.com/Association140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf.

³⁸ *Id.* at 57.

³⁹ WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, POSITION STATEMENT ON MEDICAL NECESSITY OF TREATMENT, SEX RE-ASSIGNMENT, AND INSURANCE COVERAGE IN THE U.S.A. (Dec. 21, 2016), https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf.

⁴⁰ WPATH STANDARDS OF CARE *supra* note 37, at 10-21. Chest surgery in affirmed males under 18 is explicitly endorsed. *Id.* at 21 (“Chest surgery in FtM patients could be carried out earlier [than the age of majority].”). For mastectomy and breast augmentation, the SOC for children and adolescents are to be followed. *Id.* at 59.

⁴¹ *Id.* at 60.

diverse health care needs of transsexual, transgender, and gender non-conforming people.”⁴²

The SOC criteria are “clinical guidelines; individual health professionals and programs *may modify them*. Clinical departures from the SOC may come about because of a patient’s unique anatomic, social, or psychological situation; an experienced health professional’s evolving method of handling a common situation; ... or the need for specific harm reduction strategies.”⁴³ Relevant factors necessitating surgery before age 18 include needing to undergo surgery during high school so as to not delay college, the evolving trend toward surgeries in younger patients, and the need to reduce suffering and reduce the risk of suicidality caused by delaying surgery.

The SOC explicitly recognize and expect that departures from the SOC will be necessary. These “departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care—and the SOC—to evolve.”⁴⁴

Finally, the SOC “articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches.”⁴⁵

3. There have been significant advances in the field since the *Standards of Care* were published 7 years ago.

Clinical decisions made now must reflect current clinical practice and not be beholden to outdated standards. The most recent SOC were released in 2011, but the field of transgender youth care has exponentially grown over the past five years. The age of people seeking care has steadily fallen.⁴⁶ (Ex. C). Historically, few parents supported children

⁴² *Id.* at 2.

⁴³ *Id.* (emphasis added).

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Christine Milrod, *How Young Is Too Young: Ethical Concerns in Genital Surgery of the*

and adolescents who expressed that they were a different sex, but that has rapidly changed with wider societal awareness of and acceptance of transgender people.⁴⁷ (Ex. D, E). The increase in information available about gender dysphoria has led to a dramatic increase in recent years in the number of children and adolescents who, with parental support, are seeking treatment for their gender dysphoria.⁴⁸ Increased physician awareness due to the publication of clinical guidelines, such as the publication of the 2009 Endocrine Society guidelines⁴⁹ and the 2011 version of the SOC itself also likely contributed to the increase in referrals to gender clinics.⁵⁰ A final factor is the increased number of clinical care

Transgender MTF Adolescent, 11 J. SEXUAL MED. 338 (2014).

⁴⁷ Britt Colebunders et al., *New Criteria for Sex Reassignment Surgery: WPATH Standards of Care, Version 7, Revisited*, 16 INT’L J. OF TRANSGENDERISM 222, 228 (2015); Marta R. Bizic et al., *Gender Dysphoria: Bioethical Aspects of Medical Treatment*, BIOMED RESEARCH INT’L, vol. 2018, Article ID 9652305, <https://doi.org/10.1155/2018/9652305> (“Presence of public figures who are openly transgender, their appearance in mainstream media, and political and social climate lead to more individuals coming out in the open as to their state.”).

⁴⁸ Melinda Chen et al., *Characteristics of Referrals for Gender Dysphoria Over a 13-Year Period*, 58 J. ADOLESC. HEALTH (2016) (74% of patients at the Pediatric Endocrinology, Riley Hospital for Children, Indiana University School of Medicine were referred during the last 3 years); Norman P. Spack, et al. *Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center*, 129 Pediatrics 418, 4210 (2012) (reporting a fourfold increase following the 2007 establishment of the Gender Management Service clinic at Children’s Hospital Boston); Karine Khatchadourian et al., *Clinical management of youth with gender dysphoria in Vancouver*, 164 J. OF PEDIATRICS 906, 907 (2014) (reporting a dramatic increase in new patients at British Columbia Children’s Hospital in 2011); Madison Aitken et al., *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, 12 J. SEX. MED. 756 (2015) (showing an increase in patients at a Toronto clinic starting in 2004 and rising dramatically after 2010); Hayley Wood et al., *Patterns of Referral to a Gender Identity Service for Children and Adolescents (1976–2011): Age, Sex Ratio, and Sexual Orientation*, 39 J. OF SEX & MARITAL THERAPY 1-6 (2013) (showing a sharp increase in adolescent referrals to a Toronto clinic from 2008–2011); Ehrensaft, *supra* note 59, at 255.

⁴⁹ Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: Endocrine Society Clinical Practice Guideline*, 94 J. OF CLINICAL ENDOCRINOLOGY & METABOLISM 3132–3154 (2009).

⁵⁰ See Karine Khatchadourian et al. *Clinical management of youth with gender dysphoria*

options, including youth-specific clinics.⁵¹ Indeed, centers specializing in the care of transgender youth have experienced profound growth in the numbers of youth seeking care related to physical gender transition.⁵² (Ex. F).

The SOC recognize that the field of gender care evolves rapidly.⁵³ Youth care has come very far since 2011. In 2011, researchers at the Amsterdam Gender Clinic noted an increase from 3% to 30% of youth who were socially transitioned at the time of entry into care.⁵⁴ When Version 7 of the SOC were released in 2011, the practice of suppressing puberty and induction of an exogenous puberty in adolescence was quite recent in the U.S. Indeed, “[b]efore 2006, medical intervention for transgender youth was almost non-existent in the United States.”⁵⁵

This increased time between the initiation of hormone therapy at younger ages and the delay of surgery until 18 “increases the gap between the two medical procedures and postpones the desired outcome of the transition.”⁵⁶ The increasing use of puberty suppression treatment made it “only a matter of time” before the issue of vaginoplasty in

in Vancouver, 164 J. OF PEDIATRICS 906, 909 (2014).

⁵¹ Agnieszka Janicka, *Mental Health and Well-Being of Transgender Youth: Clinical Considerations*, 29 ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS 20 (2018).

⁵² Christine Milrod, *Age Is Just a Number: WPATH-Affiliated Surgeons’ Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, 14 J. OF SEXUAL MEDICINE 624, 626 (2017).

⁵³ WPATH STANDARDS OF CARE *supra* note 37, at 41 (“Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues.”).

⁵⁴ Thomas D. Steensma & Peggy T. Cohen-Kettenis, *Gender Transitioning before Puberty*, 40 ARCH. SEX. BEHAV. 649, 649 (2011).

⁵⁵ Johanna Olson-Kennedy, *Hot Topics and Fresh Paradigms in Gender, Diversity, and Care*, 29 ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS 85, 85 (2018).

⁵⁶ Bizic, *supra* note 47, at 3.

minors would arise.⁵⁷ It is “only logical that if social transitioning and administration of hormones are being sought at younger ages, the request for surgical procedures among younger individuals will follow.”⁵⁸ Indeed, “the members of the working committee preparing the standards of care (SOC) could not have foreseen the explosion in gender care that was about to transpire.”⁵⁹ (Ex. G). The SOC simply did not discuss the developmental trajectory of transgender young women who would eventually be struggling to navigate late adolescence and early adulthood with peri-pubescent genitals that function neither as adult female nor adult male genitalia. Today, however, “the concept of living full-time as an early teen in the affirmed gender is no longer considered rare or unusual.”⁶⁰

The SOC are undergoing changes in order to reflect the rapidly evolving field of transgender care, and a Revision Committee is reassessing the minimum age for genital surgery.⁶¹ Practitioners recommended that the next revision endorse genital surgery before age 18.⁶² The new SOC will likely suggest an even greater need to help patients make decisions on a case-by-case basis, so that sweeping recommendations do not overlook the needs of each individual. Tellingly, the most recent document issued by WPATH is its June 2018 list of services—based on the SOC—that it recommends should be covered by insurance plans.⁶³ The

⁵⁷ *Id.*

⁵⁸ Colebunders, *supra* note 47, at 229.

⁵⁹ Diane Ehrensaft et al., *Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens*, 19 INT’L J. OF TRANSGENDERISM 251 (2018).

⁶⁰ Milrod, *How Young Is Too Young*, *supra* note 46, at 340; Colebunders, *supra* note 47, at 222.

⁶¹ Colebunders, *supra* note 47, at 231.

⁶² *Id.*

⁶³ WPATH, *Transgender Medical Benefits* (2018), https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/6_June/Transgender%20Medical%20Benefits.pdf.

document lists prior approval requirements, including that informed consent has been provided, but it does not list any age requirements.

4. The Endocrine Society recommends a case-by-case approach rather than a strict age requirement.

Although the Endocrine Society suggests that genital surgery be delayed until 18, that recommendation “itself is acknowledged by the Endocrine Society as ‘weak’ and the quality of evidence as ‘very low,’” meaning that what is required is “a deeper evaluation of the transitioning individual’s circumstances and preferences in order to make a decision.”⁶⁴

5. Guidelines published by the Center of Excellence for Transgender Health at the University of California San Francisco endorse surgery in people under 18.

The *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* published by the Center of Excellence for Transgender Health at the University of California San Francisco⁶⁵ specifically note that any insurance policy requirement that the patient be 18 is an “arbitrary barrier[] to surgery” and recommend that providers appeal denials to ensure that their minor patients can undergo chest surgery.⁶⁶ The *Guidelines* note that “care for transgender youth is a young and rapidly evolving field. In the absence of solid evidence, providers must often rely on the expert opinions of innovators and thought leaders in the field; many of these expert opinions are expressed in this

⁶⁴ Hembree, *supra* note 28, at 26; Colebunders, *supra* note 47, at 229.

⁶⁵ Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco, GUIDELINES FOR THE PRIMARY AND GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PEOPLE, (Madeline B. Deutsch, ed., 2nd ed. 2016), <http://transhealth.ucsf.edu/trans?page=guidelines-home>.

⁶⁶ Johanna Olson-Kennedy, MD, Stephen M. Rosenthal, MD, Jennifer Hastings, MD and Linda Wesp, MSN, NP-C, *Health considerations for gender non-conforming children and transgender adolescents* in GUIDELINES FOR THE PRIMARY AND GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PEOPLE, (Madeline B. Deutsch, ed., 2nd ed. 2016), <http://www.transhealth.ucsf.edu/trans?page=guidelines-youth>.

youth guideline. The four primary authors for this youth protocol represent many years of expertise in clinical care and research, in both academic and community practice settings, and within the disciplines of adolescent medicine, pediatric endocrinology, family medicine, and advanced practice nursing.”⁶⁷

6. “Age 18” is not in accordance with the SOC.

To the extent that the insurer attempts to assert that their bar on coverage for surgery for people under 18 is based on the SOC, such an assertion is incorrect. The SOC do not say “age 18,” but rather “age of majority.”⁶⁸ The age of majority is 19 in Nebraska.⁶⁹ In other states, the age of majority for medical treatment—including surgery—without parental consent is under 18. It is 15 in Oregon⁷⁰ and 14 in Alabama.⁷¹ Many other states allow minors to consent to medical treatment in a variety of circumstances, such as being emancipated or being deemed a “mature minor.”⁷² In New York, a mature minor—a minor who is emotionally and intellectually mature enough to give informed consent and who lives under the supervision of a parent or guardian—may be allowed to make health care decisions without parental consent.⁷³ In New York, a

⁶⁷ *Id.*

⁶⁸ WPATH STANDARDS OF CARE *supra* note 37, at 21.

⁶⁹ Nebraska Revised Statute 43-2101.

⁷⁰ Oregon Revised Statutes § 109.640(2) (“A minor 15 years of age or older may give consent, without the consent of a parent or guardian of the minor, to: (a) Hospital care, medical or surgical diagnosis or treatment by a physician licensed by the Oregon Medical Board...”).

⁷¹ Ala. Code § 22-8-4 (“Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary.”).

⁷² Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS 786 (2013).

⁷³ Jessica Feirman et al., *Teenagers, Health Care & the Law: A Guide to the Law on Minors’ Rights in New York State* 22 (2018), <https://www.nyclu.org/sites/default/files/thl.pdf>.

minor who has married or had a child is also able to consent to medical procedures.⁷⁴ So are minors who are emancipated.⁷⁵ A policy of requiring age 18 is thus out of alignment with the SOC. This also highlights that the SOC “age of majority” requirement is based on legal concerns, not ability to knowingly consent to surgery.

Under the mature minor doctrine, the patient could establish that she is a mature minor who is capable of consenting to her own medical treatment even without parental consent—she is thus of the age of majority for SOC purposes.

B. Peer-reviewed medical literature and clinical practitioners hold vaginoplasty in transgender minors to be clinically appropriate on a case-by-case basis.

Existing evidence supports vaginoplasty in people under 18. Two studies following the same population of girls who underwent vaginoplasty during adolescence report improved psychological functioning and decreased gender dysphoria at 1 and 5 years follow-up.⁷⁶ And a longitudinal study of surgery in people ages 18-22 showed gender dysphoria was alleviated and psychological functioning improved.⁷⁷

Practicing clinicians and specialists in treating gender dysphoria agree on the necessity of vaginoplasty for transgender patients, including people under 18. Although formal guidelines continue to recommend surgery at or after age 18, practitioners acknowledge individual readiness,

⁷⁴ *Id.* at 19.

⁷⁵ *Id.* at 20.

⁷⁶ Peggy T. Cohen-Kettenis & Stephanie H.M. van Goozen, *Sex Reassignment of Adolescent Transsexuals: A Follow-up Study*, 36 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 263–271 (1997); Yolanda L.S. Smith, Stephanie H.M. van Goozen & Peggy T. Cohen-Kettenis, *Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study*, 40 J. of the Am. Academy of Child and Adolescent Psychiatry 472–481 (2001); Simone Mahfouda et al. *Gender-affirming Hormones and Surgery in Transgender Children and Adolescents* [published online ahead of print December 6, 2018]. LANCET DIABETES ENDOCRINOL. doi:10.1016/S22138587(18)30305-X

⁷⁷ Annelou L.C. De Vries et al., *Young Adult Psychological Outcome after Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS 696–704 (2014).

maturity, and timing should be considered.⁷⁸ (Ex. H). For practitioners, the question is not so much should the SOC be departed from, but what are the best criteria to apply when making such departures.⁷⁹ Documentation of departures from the SOC in offering vaginoplasty to people under 18 has existed for over a decade.⁸⁰ (Ex. I). Most surgeons have historically been quiet about this practice, however, since it is a departure from the SOC,⁸¹ (Ex. J) but this silence is changing rapidly.

A case-by-case approach is what is currently recommended when deciding to perform surgery on a patient who is under 18.⁸² Clinicians note that “[d]ecisions in such cases must necessarily be individualized.”⁸³ Clinicians recognize that special circumstances may warrant surgery in a minor, while still using the SOC as guidelines.⁸⁴ (Ex. K). One recommended practice is characterized as follows:

⁷⁸ Ellie Zara Ley, Toby R. Meltzer, and Linda L. Takata, *Surgical Options in Transgender Youth*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* 111, 112-113 (2018).

⁷⁹ See Milrod, *How Young Is Too Young*, *supra* note 46, at 339 (“The practitioner, whether solo or in a team, must rely mainly on clinical impressions, the therapeutic relationship, and the personal conviction that the decision to proceed with surgery is the right one.”).

⁸⁰ J. C. Capozuca and C. C. Wheeler, “Departures from the Standards of Care II: Two Cases of Gender Transition in Adolescence” in *Select Symposium Abstracts from WPATH 20th Biennial Symposium Chicago Illinois USA September 2007*, 10 *INT’L J. OF TRANSGENDERISM* 173, 178 (2008) (discussing two cases of surgery in minors); Sam Winter, *Thai transgenders in focus: Demographics, transitions and identities*, 9 *INT’L J. OF TRANSGENDERISM* 47, 49 (2006) (“Several had undergone SRS in their teens, one as early as 15.5 years.”).

⁸¹ Simona Giordano, César Palacios-González & John Harris, *Sex Change Surgery for Minors: Should Doctors Speak Out?*, in *PIONEERING HEALTHCARE LAW: ESSAYS IN HONOUR OF MARGARET BRAZIER* 181, 186 (Catherine Stanton ed., 2016).

⁸² Colebunders, *supra* note 47, at 229.

⁸³ Scott F. Leibowitz & John D. Lantos, *Affirming, Balanced, and Comprehensive Care for Transgender Teenagers*, 143 *PEDIATRICS* e20190995 (June 2019).

⁸⁴ Cécile A. Unger, *Gynecologic care for transgender youth*, 26 *CURRENT OPINIONS IN OBSTETRICS AND GYNECOLOGY* 347, 351 (2014).

Genital surgery should be possible before the age of 18 if all members of the treatment team—psychotherapists, endocrinologists or family physician, and the surgeon—are in complete agreement that the adolescent has understood the surgical procedure in terms of risks, benefits, and alternative options with the same degree of competence as someone who is age 18 years or older.⁸⁵

Over half of the surgeons practicing in this area have performed vaginoplasty on an individual under age 18.⁸⁶ Nearly all surgeons relied on the term “maturity” rather than chronological age to determine patients’ readiness for the procedure. Only one third of the surgeons thought that age 18 was an appropriate criterion.⁸⁷ Indeed, due to the logistic concerns of many teenagers turning eighteen and leaving the parental home, “the penultimate senior high school year was considered the most ideal to undergo surgery.”⁸⁸

A 2018 *Adolescent Medicine: State of the Art Review (AM:STARS)* on *LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities* indicates that vaginoplasty is appropriate for people under 18.⁸⁹ The preface indicates that the volume “provides new information and resources and promotes best practices.”⁹⁰ (Ex. L). Given that this was published in 2018, it is a reflection of the current standard of care in the field.

The Center for Gender Surgery at Boston Children’s Hospital note that “a number of American surgeons perform vaginoplasty procedures in patients under the age of 18 to allow young women to begin their adult lives feeling safe and affirmed in their gender” and concluded “that it is

⁸⁵ Colebunders, *supra* note 47, at 231.

⁸⁶ Milrod, *Age Is Just a Number*, *supra* note 52, at 626.

⁸⁷ *Id.* at 630.

⁸⁸ *Id.* at 631. In the penultimate year of high school, minors are typically 16 to 17 years old.

⁸⁹ Ley, *supra* note 78.

⁹⁰ Michelle Forcier et al., *Preface LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* xi (2018).

appropriate to offer vaginoplasties to certain individuals before the age of majority so that they can safely embark on their adult lives.”⁹¹ (Ex. M).

Enclosed are letters from six expert providers in the field documenting that clinicians routinely perform surgery for people under 18 and that it is in accordance with current clinical practice. (Ex. N). The letters are from surgeons Thomas Satterwhite, MD, Marci Bowers, MD, Toby Meltzer, MD, and Jens Berli, MD, along with transgender adolescent experts Uri Belkind, MD of Callen-Lorde Community Health Center and Johanna Olson-Kennedy, MD, Medical Director of the Center for Transyouth Health and Development at Children’s Hospital Los Angeles.⁹² In addition, Drs. Gary Alter⁹³ and Christine McGinn⁹⁴ are on record as performing vaginoplasties on people under 18.

C. Delaying care is not clinically appropriate or a neutral act.

There are significant challenges experienced by the population of transgender women that has been on puberty suppression treatment followed by cross-sex hormones at an early age. Many of these adolescents experience their entire puberty in their affirmed sex and have no need to tell peers about their transgender status.⁹⁵ This leaves transgender

⁹¹ Elizabeth R. Boskey et al., *Ethical Issues Considered When Establishing a Pediatrics Gender Surgery Center* 143 PEDIATRICS e20183053 (June 2019).

⁹² Dr. Olson’s letter is a redacted letter she wrote in support for one of her minor patients. Her appeal was successful, and insurance covered her patient’s vaginoplasty.

⁹³ Erika Brown, *Beverly Hills plastic surgeon, Gary Alter, MD, performs gender reassignment surgery on youngest transsexual patient in the United States*, PRWEB, Sept. 3, 2014, <http://www.prweb.com/releases/2014/09/prweb12141694.htm>.

⁹⁴ Anemona Hartocollis, *The New Girl in School: Transgender Surgery at 18*, N.Y. TIMES, Jun. 16, 2015 (“Dr. Christine McGinn, estimated that she had done more than 30 operations on children under 18, about half of them vaginoplasties for biological boys becoming girls.”), <https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html>.

⁹⁵ Milrod, *How Young Is Too Young*, *supra* note 46, at 340; Colebunders, *supra* note 47, at 229.

adolescents vulnerable to having their private medical information becoming public and exposing them to harassment and peer victimization.⁹⁶ Transgender people are more often targeted by bullying and have higher rates of suicide.⁹⁷ Repeated disclosures “can reproduce the stigma and further propel the individual toward feelings of shame and inadequacy.”⁹⁸ The “potential loss of a social network or being excluded from peer groups” can make a transgender teenager “secretive in friendships and guarded when meeting new people in order to maintain privacy regarding the genital incongruence.”⁹⁹ “Goffman’s theory of stigma postulates that the transitioning adolescents must prove their affirmed gender to others. If others question the individual’s gender identity, including the presence of gender-congruent genitals, he or she fails to manage the stigma and becomes ‘discredited.’”¹⁰⁰

In addition, postponing romantic relationships and dating until the age of 18 can also lead to psychological struggles and challenges.¹⁰¹ Being a teenager with atypical genitals makes “the exploration of sexual self-pleasuring, romantic relationships, and engaging in physical contact with a romantic partner extremely difficult, if not impossible.”¹⁰² Avoiding such dating or physical affection until age 18 “may cause a delay in healthy, age-appropriate emotional development because of dysphoria or discomfort with incongruent genitals.”¹⁰³ The longer the wait, the more frustrated the transgender teen becomes because her non-

⁹⁶ Milrod, *How Young Is Too Young*, *supra* note 46, at 340; Colebunders, *supra* note 47, at 229; Bizic, *supra* note 47, at 5.

⁹⁷ Milrod, *How Young Is Too Young*, *supra* note 46, at 340.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.*; Bizic, *supra* note 47, at 5.

¹⁰¹ Bizic, *supra* note 47, at 5.

¹⁰² Milrod, *How Young Is Too Young*, *supra* note 46, at 340; Colebunders, *supra* note 47, at 229.

¹⁰³ *Id.*

transgender “female peers are engaging in romantic or sexual relationships without these obvious constraints.”¹⁰⁴

Worse outcomes in adults are associated with late—rather than early—treatment.¹⁰⁵ In fact, post-surgical regret is associated with an age above 30 years at first surgery, not youth.¹⁰⁶ Although potential regret is a concern, “it is also considered important to avoid life-long suffering due to postponement of treatment.”¹⁰⁷ Specifically, early treatment can prevent “delay or arrest in areas that are particularly important during adolescence (e.g. peer relationships, romantic involvements or academic achievement) which may, in itself, lead to additional, yet avoidable problems. Thus, early treatment may be particularly suitable to prevent unnecessary psychological and emotional problems.”¹⁰⁸ Indeed, Dutch researchers note “the psychological functioning of adult transsexuals is worse than in adolescent transsexuals from the same clinic who had been treated in early adolescence. The poorer psychological functioning of adult transsexuals compared with adolescent transsexuals could partly result from the enduring distress the adults had experienced in their lives.”¹⁰⁹

Delaying surgery is not neutral. Incongruent genitals are a barrier in friendships and with potential romantic relationships. As researchers have noted: “Poor peer relationships were found to be the strongest predictor for emotional and behavioural problem scores in gender diverse youth. Social ostracism has been suggested to be an important risk

¹⁰⁴ Milrod, *How Young Is Too Young*, *supra* note 46, at 340; Colebunders, *supra* note 47, at 229.

¹⁰⁵ Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. SEXUAL MEDICINE 1892, 1895 (2008).

¹⁰⁶ Bizic, *supra* note 47, at 5.

¹⁰⁷ Smith et al., *Adolescents with Gender Identity Disorder*, *supra* note 76.

¹⁰⁸ *Id.*

¹⁰⁹ Baudewijntje P. C. Kreukels & Peggy T. Cohen-Kettenis, *Puberty Suppression in Gender Identity Disorder: The Amsterdam Experience*, 7 NAT. REV. ENDOCRINOL. 466-72 (2011).

factor that contributes to increased psychological distress in gender diverse adolescents.”¹¹⁰

In the context of puberty suppression, researchers note that “[n]onintervention is not a neutral option, but has a negative life-long impact on the quality of life of nontreated adolescents. Realizing the potential harmfulness of nonintervention, one may even wonder whether not treating may not only be doubtful on ethical grounds, but also have legal implications.”¹¹¹ Like its adult counterpart, untreated gender dysphoria in adolescents is strongly correlated with depressed health outcomes such as depression and anxiety.¹¹² Transgender youth have higher rates of anxiety, depression, substance abuse, and suicide than their cisgender (non-transgender) peers.¹¹³ Delays in access to medical treatment are specifically correlated with suicidal ideation and attempt.¹¹⁴

¹¹⁰ Nastasja M. de Graaf et al., *Psychological Functioning in Adolescents Referred to Specialist Gender Identity Clinics Across Europe: A Clinical Comparison Study Between Four Clinics*, 27 EUROPEAN CHILD & ADOLESCENT PSYCHIATRY 909 (2017).

¹¹¹ Luk Gijs & Anne Brewaeys, *Surgical treatment of gender dysphoria in adults and adolescents: recent developments, effectiveness, and challenges*, 18 ANNUAL REV. SEX RESEARCH 178, 214 (2007).

¹¹² See, e.g., Annelous L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study*, 8 J. SEXUAL MEDICINE 2276, 2276 (2011) (finding that behavioral and emotional problems and depressive symptoms decreased, while general functioning improved significantly during hormone suppression treatment).

¹¹³ Samantha J. Gridley et al., *Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth*, J. OF ADOLESCENT HEALTH 1, 2 (2016).; Michelle M. Johns et al. *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*. 68 MORBIDITY AND MORTALITY WEEKLY REPORT 67, 70 (2019) (Youth Risk Behavior Survey of 131,901 students finding “transgender students are at disproportionately higher risk than are cisgender students for violence victimization, substance use, and suicide risk”).

¹¹⁴ Louis Bailey et al., *Suicide Risk in the UK Trans Population and the Role of Gender Transition in Decreasing Suicidal Ideation and Suicide Attempt*, 19 MENTAL HEALTH REVIEW JOURNAL 209, 214-15 (2014).

Harm reduction “has been widely acknowledged among clinicians, with the vast majority endorsing medical intervention during early puberty to prevent psychological suffering and potentially costly and more invasive treatments in later adulthood.”¹¹⁵ This rationale provides an independent basis for clinicians to proceed with surgery.

There are no published studies specifically on vaginoplasty in people under 18, but studies on chest surgery in trans men under 18 show 93% of patients being satisfied with the surgery “all of the time.”¹¹⁶ No youth reported regret about the procedure.¹¹⁷ The medical evidence establishes that it is medically necessary regardless of chronological age,¹¹⁸ and there is no evidence of statistically significant regret or adverse outcomes in minors who undergo chest surgery.¹¹⁹ And trans males who had *not* undergone surgery—as compared to those who had undergone surgery—had significant effects of chest dysphoria in the areas of emotional well-being, physical well-being, recreational, occupational, social and life relationships.¹²⁰

One of the principal objections to genital surgery prior to the age of 18 is that transgender individuals might “change their mind.” Data has shown that if youth continue to experience gender dysphoria and endorse transgender identities in early adolescence (age of 12 or 13), they are extremely unlikely to “go back” to their assigned gender at birth.¹²¹ Research has additionally shown that transgender youth who had more

¹¹⁵ Milrod, *How Young Is Too Young*, *supra* note 46, at 340-41.

¹¹⁶ Johanna Olson-Kennedy & Jonathon Warus, *The Impact of Male Chest Reconstruction on Chest Dysphoria In Transmasculine Adolescents and Young Men; A Preliminary Study*, 60 JOURNAL OF ADOLESCENT HEALTH S88 (2017).

¹¹⁷ *Id.*

¹¹⁸ See Olson-Kennedy, *supra* note 29 (finding “professional guidelines and clinical practice should consider patients for chest surgery based on individual need rather than chronological age.”).

¹¹⁹ Olson-Kennedy, *supra* note 29 at 435.

¹²⁰ *Id.*

¹²¹ A.L. de Vries AL et al., *Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study*, 8 J. OF SEXUAL MED. 2276-2283 (2011).

intense gender dysphoria in childhood are more likely to continue into adolescence and adulthood with gender dysphoria, desiring physical gender transition. The youth who undergo medical intervention in adolescence are intensely gender dysphoric and need genital surgery to participate safely and comfortably in single-sex spaces such as locker rooms, schools, and restrooms. The regret rates of adults undergoing genital surgery are less than 1%.¹²² The recommendation that transgender young women postpone genital surgery until the age of 18 in the United States is problematic for the following reasons:

1. Affirmed female adolescents are not able to explore dating and intimacy with a partner due to discomfort and fear about their genitals, as well as fear for their personal safety.
2. Many transgender young women who were able to access early intervention such as puberty blockade and hormones have supportive and loving parents who will provide the safest and healthiest environments for aftercare; if young women undergo extensive surgery right after high school, many will either have to delay enrollment into college, or go to college and lose the care that they would otherwise receive from their parents in their own home.
3. Typically, surgeries that involve removal of the gonads are restricted to those individuals who have reached the age of consent because they will render an individual infertile.

Transgender youth who have undergone puberty suppression in the earliest stages of puberty and continued on with cross sex hormones do not have mature sperm or eggs that could be cryopreserved for future use. In essence, they have already consented to medical sterilization. The concern of infertility is irrelevant in transgender youth who have undergone this trajectory of care.

D. Other insurers and state Medicaid plans acknowledge this care to be medically necessary.

That a categorical ban on surgery for people under 18 is not in alignment with prevailing medical opinion is also reflected by the fact that

¹²² WPATH STANDARDS OF CARE *supra* note 37, at 8.

other insurance companies recognize the medical necessity of vaginoplasty for trans women under age 18. Blue Cross and Blue Shield of Florida has no minimum age requirement for surgery.¹²³ Blue Cross Blue Shield of Massachusetts, for example, provides that surgery for people under 18 “will be considered on a case-by-case basis.”¹²⁴ The Boston Medical Center HealthNet Plan and Well Sense Health Plan provide that for members under 18, the plan medical director will review the request and that “[a]dolescent members may be eligible for interventions when adolescents and their parents (or guardian) make informed decisions about treatment.”¹²⁵ EmblemHealth provides that requests for surgery for people under 18 “will be reviewed on a case-by-case basis.”¹²⁶ YourCare allows surgery “coverage for individuals under 18 in specific cases if medical necessity is demonstrated and prior approval is received.”¹²⁷ Government health plans such as Medicaid will also cover surgery for minors.¹²⁸

¹²³ BCBS of Florida, *Gender Reassignment Surgery* (Dec. 28, 2018) (listing no age requirement for surgery), <http://mcgs.bcbsfl.com/MCG?activity=openSearchedDocMcg&imgId=75J4M66GQ3V05H6KLPD>.

¹²⁴ BCBS of Massachusetts, *Transgender Services* (Mar. 1, 2019), [https://www.bluecrossma.com/common/en_US/medical_policies/189%20Gender%20Affirming%20Services%20\(Transgender%20Services\)%20prn.pdf](https://www.bluecrossma.com/common/en_US/medical_policies/189%20Gender%20Affirming%20Services%20(Transgender%20Services)%20prn.pdf).

¹²⁵ Boston Medical Center HealthNetPlan, *Gender Reassignment Surgery* (Nov. 1, 2016), <https://www.bmchp.org/~media/e4a2002b868d40c789a3d1f525f74a07.pdf>.

¹²⁶ EmblemHealth, *Gender Reassignment Surgery Medical Guideline MG.MM.SU.28l* (Dec. 14, 2018), https://www.emblemhealth.com/~media/Files/PDF/_med_guidelines/MG_Gender_Reassignment_Surgery.pdf.

¹²⁷ YourCare, *Gender Reassignment Surgery* (Dec. 7, 2017), <https://www.yourcare-healthplan.com/Portals/0/PDFs/CMPs/Gender%20Reassign%20Surg%207.01.84.pdf>.

¹²⁸ *E.g.*, Husky Health Connecticut, *Gender Affirmation Surgery* (Jan. 28, 2019), https://www.huskyhealthct.org/providers/provider_postings/policies_procedures/Gender_Affirmation_Surgery.pdf (Genital surgery is typically not carried out in adolescents until the adolescent has the capacity to make fully informed decisions and consent to treatment.); Washington Apple Health—Gender dysphoria treatment program, WAC 182-531-1675, <http://app.leg.wa.gov/wac/default.aspx?cite=182-531-1675> (covering GnRH analogs and allowing for surgery under age 18 for those eligible under Early and Periodic Screening, Diagnosis, and Treatment medical necessity criteria); Oregon Health Authority, *Prioritized List of Health Services*, Guideline Note 127

III. Vaginoplasty is the most clinically appropriate level of service considering the potential benefits and harms to the patient.

Severe dysphoria can lead to depressive episodes and suicidal ideation. Withholding coverage for the procedure could potentially result in a variety of more severe, avoidable co-morbid symptoms.¹²⁹ Transgender youth are demonstrated to be at disproportionate risk for suicidal ideation and life-threatening behaviors attributable to their transgender status.¹³⁰ Delayed eligibility for medical interventions is associated with increased psychiatric comorbidity in transgender adolescents.¹³¹ In light of these risk factors, a “more individualized approach, as in the ‘case by case’ system, will ensure that a right decision is made in accordance with the patient’s maturity, age, and judgment.”¹³²

In addition to the negative psychological harm of delaying the surgery, there are negative physical effects of minimizing dysphoria through binding. The practice of tucking and taping the penis is a common self-help measure undertaken by trans woman to relieve gender dysphoria. This risks tissue damage that could impede surgery. The need to tuck and tape, as well as dysphoric symptoms, would be alleviated permanently through vaginoplasty.

(Mar. 20, 2019), <https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2019%20Prioritized%20List%20of%20Health%20Services.pdf> (listing no age requirement for surgery); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l)(3)(ii) (“[P]ayment for gender reassignment surgery, services, and procedures for patients under eighteen years of age may be made in specific cases if medical necessity is demonstrated and prior approval is received.”).

¹²⁹ Leena Nahata et al., *Mental Health Concerns and Insurance Denials Among Transgender Adolescents*, 4 LGBT HEALTH 188, 191-2 (2017).

¹³⁰ Arnold H. Grossman & Anthony R. D’Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE AND LIFE-THREATENING BEHAVIOR 527, 535 (2007); Sari L. Reisner et al., *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, 56 J. OF ADOLESCENT HEALTH 274 (2015).

¹³¹ Annelou L.C. de Vries et al., *Psychiatric comorbidity in gender dysphoric adolescents*, 52 J. CHILD PSYCHOLOGY AND PSYCHIATRY 1195, 1201 (2011).

¹³² Bizic, *supra* note 47, at 3.

The possible harms of the surgery are those associated with major surgeries in general. However, moving forward with surgery will improve quality of life, end the need to tuck and tape, and treat one of the main causes of dysphoria. As the benefits of the surgery outweigh the risks and the surgery itself is widely accepted as appropriate treatment for a patient with gender dysphoria, the procedure is, by the plan's definition, medically necessary.

IV. Conclusion

Specialists with experience treating gender dysphoria in people under 18 concur that where the individual has well-documented, persistent gender dysphoria and otherwise meets WPATH's readiness and eligibility criteria, mature individuals are appropriate surgical candidates. Surgery for minors is considered appropriate clinical treatment and is thus medically necessary under the plan.