Health Impact Review of SB 5313
Concerning health insurance discrimination (2021 Legislative Session)

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WASHINGTON STATE BOARD OF HEALTH

HEALTH EQUITY
Governor's Interagency Council on Health Disparities

Full review
The full Health Impact Review report is available at:
https://sboh.wa.gov/Portals/7/Doc/HealthImpactReviews/HIR-2021-06-SB5313.pdf

Acknowledgements
We would like to thank the key informants who provided consultation and technical support during this Health Impact Review.

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(2021 Legislative Session)

Evidence indicates that SB 5313 has the potential to decrease adverse benefit determinations and blanket exclusions for medically necessary gender affirming treatment, which could decrease denial of care, delay of care, and/or foregoing care; improve health outcomes; and decrease health inequities for transgender and gender diverse individuals. It is unclear how the bill would impact health inequities for transgender and gender diverse people enrolled in Apple Health plans.

BILL INFORMATION

Sponsors: Liias, Randall, Darneille, Das, Dhingra, Frockt, Hunt, Keiser, Kuderer, Lovelett, Nguyen, Nobles, Pedersen, Robinson, Stanford, Van De Wege, Wilson, C.

Summary of Bill:
For health carriers providing coverage under an Apple Health (i.e., Medicaid) plan (Chapter 74.09 RCW); Public Employees Benefit Board (PEBB) plan or School Employees Benefit Board (SEBB) plan (RCW 41.05.075); or a plan offered on the Exchange (Chapter 48.43 RCW) issued or renewed on or after January 1, 2022:

- Establishes that it is an unfair practice for a health carrier to issue an adverse benefit determination for gender affirming treatments that are medically necessary, and states that these treatments may not be excluded as cosmetic.
    - Defines gender affirming treatment as a service prescribed to an individual to address the specific needs of that patient, to alleviate suffering, and/or address a condition related to an individual's protected gender identity characteristics and/or secondary sex characteristics more aligned with an individual's gender identity.
- Requires that healthcare providers with experience providing and delivering gender affirming care review insurance claims for gender affirming treatment.
- Requires a health carrier that does not have an adequate network for gender affirming treatment to ensure access to treatment at no greater expense than if care had been provided by an in-network provider.

HEALTH IMPACT REVIEW

Summary of Findings:
This Health Impact Review found the following evidence for provisions in SB 5313:

- **Informed assumption** that prohibiting health carriers from denying medically necessary, gender affirming treatment prescribed to Two Spirit, transgender, nonbinary, and other gender diverse individuals will decrease adverse benefit determinations and blanket exclusions for treatments. This informed assumption is based on provisions in the bill and information from key informants.

- **Unclear evidence** how current provisions of SB 5313 would impact Apple Health plans since provisions could impact federal funding available for the Medicaid program in Washington State.
- **Informed assumption** that decreasing adverse benefit determinations and blanket exclusions for medically necessary gender affirming treatment will decrease denial of care, delay of care, and/or foregoing care for treatments. This informed assumption is based on peer-reviewed published evidence and information shared by key informants.
- **Strong evidence** that decreasing denial of care, delay of care, and/or foregoing care for medically necessary gender affirming treatment will improve health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals.
- **Strong evidence** that improving health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals will decrease health inequities experienced by these individuals.
- **Unclear evidence** for how current provisions of SB 5313 would impact health inequities for transgender and gender diverse people enrolled in Apple Health plans since provisions could impact federal funding available for the Medicaid program in Washington State.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State (RCW 43.20.285). For the purpose of this review 'health disparities' have been defined as differences in disease, death, and other adverse health conditions that exist between populations (RCW 43.20.270). Differences in health conditions are not intrinsic to a population; rather, inequities are related to social determinants (e.g., access to healthcare, economic stability, racism). This document provides summaries of the evidence analyzed by State Board of Health staff during the Health Impact Review of Senate Bill 5309 (SB 5313).

Staff analyzed the content of SB 5313 and created a logic model depicting possible pathways leading from the provisions of the bill to health outcomes. We consulted with experts and contacted key informants about the provisions and potential impacts of the bill. We conducted an objective review of published literature for each pathway using databases including PubMed, Google Scholar, and University of Washington Libraries.

Staff also completed key informant interviews to gather additional supporting evidence. In total, we spoke with 21 key informant interviewees, including: 7 staff representing three state agencies working with health carriers and plans; 8 individuals representing community and/or advocacy organizations working within the transgender community to navigate insurance issues; 4 individuals who work for clinics serving trans patients; 1 individual representing health carriers in Washington State; and 1 additional subject matter expert. More information about key informants and detailed methods are available upon request.

The following pages provide a detailed analysis of the bill, including the logic model, summaries of evidence, and annotated references. The logic model is presented both in text and through a flowchart (Figure 1). The logic model includes information on the strength-of-evidence for each pathway. The strength-of-evidence has been defined using the following criteria:

- **Very strong evidence:** There is a very large body of robust, published evidence and some qualitative primary research with all or almost all evidence supporting the association. There is consensus between all data sources and types, indicating that the premise is well accepted by the scientific community.
- **Strong evidence:** There is a large body of published evidence and some qualitative primary research with the majority of evidence supporting the association, though some sources may have less robust study design or execution. There is consensus between data sources and types.
- **A fair amount of evidence:** There is some published evidence and some qualitative primary research with the majority of evidence supporting the association. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Expert opinion:** There is limited or no published evidence; however, rigorous qualitative primary research is available supporting the association, with an attempt to include

viewpoints from multiple types of informants. There is consensus among the majority of informants.

- **Informed assumption:** There is limited or no published evidence; however, some qualitative primary research is available. Rigorous qualitative primary research was not possible due to time or other constraints. There is consensus among the majority of informants.
- **No association:** There is some published evidence and some qualitative primary research with the majority of evidence supporting no association or no relationship. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Not well researched:** There is limited or no published evidence and limited or no qualitative primary research and the body of evidence has inconsistent or mixed findings, with some supporting the association, some disagreeing, and some finding no connection. There is a lack of consensus between data sources and types.
- **Unclear:** There is a lack of consensus between data sources and types, and the directionality of the association is ambiguous due to potential unintended consequences or other variables.

This review was subject to time constraints, which influenced the scope of work for this review. The annotated references are only a representation of the evidence and provide examples of current research. In some cases only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore, the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question, so are referenced multiple times.

Analysis of SB 5313 and the Scientific Evidence

Summary of relevant background information

- Relevant terminology:[A]
    - *Gender* is a social construct used to classify a person as a man, woman or some other identity. It is fundamentally different from the sex one is assigned at birth.
    - *Gender identity* means a sense of one's self as trans, genderqueer, woman, man, or some other identity, which may or may not correspond with the sex and gender one is assigned at birth. Gender identity is independent of sexual orientation.
    - *Cisgender* is a gender identity that society deems to match the person's assigned sex at birth. The prefix cis- means "on this side of" or "not across." A term used to highlight the privilege of people who are not transgender.
    - *Transgender* is an adjective used most often as an umbrella term and is frequently abbreviated as *trans*. This adjective describes a wide range of identities and experiences of people whose gender identity and/or expression differs from conventional expectations based on their assigned sex at birth – including non-binary and genderqueer people. Not all trans people undergo medical transition (surgery or hormones).
        - Another commonly held definition: Someone whose determination of their sex and/or gender is not universally considered valid; someone whose behavior or expression does not "match" their assigned sex according to society's expectations.
    - *Trans man,* a person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.
    - *Trans woman,* a person may choose to identify this way to capture their gender identity as well as their lived experience as a transgender person.
    - *Two Spirit* is an umbrella term encompassing sexuality and gender in Indigenous Native American communities. Two Spirit people often serve integral roles in their communities, such as leaders and healers. It may refer to an embodiment of masculinity and femininity but this is not the only significance of the term. There are a variety of definitions and feelings about the term two spirit – and this term does not resonate for everyone. Two Spirit is a cultural term reserved for those who identify as Indigenous Native American. Although the term itself became more commonly used around 1990, two spirit people have existed for centuries.
    - *Non-binary* or *genderqueer* is a gender identity in which individuals "identify with a gender that is temporarily or permanently neither exclusively masculine nor feminine but rather is composed of masculine and feminine parts (e.g., [two] spirit), oscillates between genders (e.g., genderfluid), is situated beyond the binary (e.g., genderqueer), or rejects the binary (e.g., agender)."[1] For some people who identify as non-binary there may be overlap with other concepts and identities like gender expansive and gender non-conforming.
    - *Gender non-conforming* is a term more commonly used to describe a demographic or experience rather than a term someone may identify themselves

[A] Unless otherwise cited, definitions are adapted from University of California, Davis LGBTQIA Glossary with review by relevant key informants in 2018 and 2021.

as. It indicates someone does not subscribe to gender expressions or roles expected by society.
    - *Cissexism/genderism* refers to the pervasive system of discrimination and exclusion that oppresses people whose gender and/or gender expression falls outside of cis-normative constructs. This system is founded on the belief that there are, and should be, only two genders and that one's gender, or most aspects of it, are inevitably tied to sex.
    - *Misgendering* is the act of attributing a gender to someone that is incorrect/does not align with their gender identity.
    - *Gender dysphoria* is a mental health diagnosis broadly defined as "distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)."[2] Not all transgender people experience gender dysphoria, but the diagnosis and associated psychotherapy and/or gatekeeping requirements are historically and presently tied to access of gender affirming treatment (personal communications, 2018 and February 2021).
- The World Professional Association for Transgender Health (WPATH), is a non-profit, interdisciplinary professional and educational organization devoted to transgender health. WPATH publishes the internationally accepted Standards of Care and Ethical Guidelines for the treatment of individuals with gender dysphoria. The guidelines "are designed to promote the health and welfare of transgender, transsexual, and gender variant persons in all cultural settings."[3] They "articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria and help professional understand the parameters within which they may offer assistances to those with these conditions."[3]
    - For example, WPATH suggests in its Standards of Care (Version 7) that patients obtain one referral from a mental health professional for hormone therapy and top surgery and an additional referral letter for bottom surgery from a clinician with at least a master's degree or its equivalent in a clinical behavioral science field from an accredited institution.[4,5]
- The 2010 Patient Protection and Affordable Care Act (ACA) details ten essential health benefits that must be included in every individual and small employer health plan.[6,7] However, the ACA does not include gender affirming treatment as an essential health benefit, and individual health plans on the private health market are not required to provide coverage for gender affirming treatments (personal communication, Health Benefit Exchange [HBE], February 2021).
- The ACA is currently being challenged in the U.S. Court System. The U.S. Supreme Court heard oral arguments in November 2020 in a suit to invalidate the ACA.[8] The Kaiser Family Foundation stated that "the ACA remains in effect while the litigation is pending. However, if all or most of the law is ultimately struck down, it will have complex and far-reaching consequences for the nation's health care system, affecting nearly everyone in some way."[8] The court's ruling on the ACA would impact healthcare coverage and affordability in Washington State.[9]
- In June 2020, the United States Department of Health and Human Services issued rules that narrowed the scope of Section 1557 in the ACA to "remove gender identity and sex stereotyping from the definition of prohibited sex-based discrimination and eliminated

the provision that prohibits a health plan from categorically or automatically excluding or limiting coverage or health services related to gender transition."[10] This rule change was blocked by federal courts citing an August 2020 Supreme Court ruling "that found discrimination based on sex, encompasses sexual orientation and gender identity in the context of employment."[10]

- In 2020, the Washington HBE began offering new public option plans as part of Cascade Care.[11] On average, these plans decrease deductibles by $1,000 and "provide more access to first dollar services and co-pays (including primary care visits, mental health services, and generic drugs)."[11] As of December 2020, approximately 40% of new enrollees on the Exchange were selecting a public option plan.[11] Similar to other health plans offered on the Exchange, coverage of gender affirming treatments are not required as part of Cascade Care (personal communication, HBE, February 2021).
- Washington State law prohibits health plans and Apple Health from discriminating "on the basis of gender identity or expression, or perceived gender identity or expression, in the provision of non-reproductive health care services."[10]
- WAC 182-531-1675 (Washington apple health – Gender dysphoria treatment program) outlines covered and noncovered services related to gender affirming treatments for Apple Health plans. The WAC is currently open for rulemaking and proposed changes would remove the "noncovered services" list from statute, allowing requests for any service deemed medically necessary to be approved for coverage (personal communication, HCA, February 2021).
- According to the Office of the Insurance Commissioner (OIC), "[i]f a health insurer covers medically necessary services for its enrollees, it cannot exclude or deny those services for a transgender person because of the person's gender identity. Health insurers are required to cover procedures that are part of a gender transition process if they're covered for other policy holders for different reasons."[12] Service examples include: hormone therapy, counseling services, mastectomy, and breast augmentation and reconstruction.
- In 2018, OIC initiated an investigation into Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. in response to complaints that the companies specifically excluded breast augmentation as a treatment for gender dysphoria.[13] According to the press release, the companies issued blanket denials rather than considering individual cases.[13] On August 1, 2018, OIC announced that as a result of the investigation, "the companies will now cover chest reconstruction for transgender women" with a physician prescription for the treatment.[13] Additionally, both were required to complete a review of all denials of this treatment since January 2016.
- In 2018, Washington's 65th Legislature required (Chapter 119, Laws of 2018) the Governor's Interagency Council on Health Disparities (Council) to conduct a literature review on disparities in access to reproductive healthcare based on socioeconomic status, race/ethnicity, sexual orientation, gender identity, geography, and other factors. In the development of the Report to the Legislature, Council staff conducted a series of key informant interviews in 2018 to gain additional context and background information, to refine their understand of the literature, and to develop recommendations. Some of the

information previously shared by key informants is also relevant to this Health Impact Review of SB 5313 and is referenced as personal communication from 2018.

- The Coronavirus Disease 2019 (COVID-19) pandemic has impacted uninsured rates. While the uninsured rate in Washington State remained constant between 2018 and 2019 (at approximately 6.1%), the Office of Financial Management (OFM) predicted that the number of uninsured in Washington State increased in 2020 as a result of the COVID-19 pandemic.[14] OFM estimates suggested that the uninsured rate doubled in May 2020.[14] However, as of December 2020, the rate had returned to pre-pandemic levels due to the increase in Apple Health enrollment and, to a lesser degree, in enrollment in Qualified Health Plans on the Exchange.[14] The Urban Institute noted that "the COVID-19 pandemic and ensuing economic crisis...will put even more [individuals] at risk of uninsurance and in need of affordable coverage options."[15]

Summary of SB 5313

For health carriers providing coverage under an Apple Health (i.e., Medicaid) plan (Chapter 74.09 RCW); Public Employees Benefit Board (PEBB) plan or School Employees Benefit Board (SEBB) plan (RCW 41.05.075); or a plan offered on the Exchange (Chapter 48.43 RCW) issued or renewed on or after January 1, 2022:

- Establishes that it is an unfair practice for a health carrier to issue an adverse benefit determination for gender affirming treatments that are medically necessary, and states that these treatments may not be excluded as cosmetic.
    - Defines gender affirming treatment as a service prescribed to an individual to address the specific needs of that patient, to alleviate suffering, and/or address a condition related to an individual's protected gender identity characteristics and/or secondary sex characteristics more aligned with an individual's gender identity.
- Requires that healthcare providers with experience providing and delivering gender affirming care review insurance claims for gender affirming treatment.
- Requires a health carrier that does not have an adequate network for gender affirming treatment to ensure access to treatment at no greater expense than if care had been provided by an in-network provider.

Health impact of SB 5313

Evidence indicates that SB 5313 has the potential to decrease adverse benefit determinations and blanket exclusions for medically necessary gender affirming treatment, which could decrease denial of care, delay of care, and/or foregoing care; improve health outcomes; and decrease health inequities for transgender and gender diverse individuals. It is unclear how the bill would impact health inequities for transgender and gender diverse people enrolled in Apple Health plans.

Pathway to health impacts

- The potential pathway leading from the provisions of SB 5313 to decreased health inequities are depicted in Figure 1. This review makes the informed assumption that prohibiting health carriers from denying medically necessary, gender affirming treatment prescribed to Two Spirit, transgender, nonbinary, and other gender diverse individuals will decrease adverse

benefit determinations and blanket exclusions for treatments. This informed assumption is based on provisions in the bill and information from key informants. Based on available evidence, it is unclear how current provisions of SB 5313 would impact Apple Health plans since provisions could impact federal funding available for the Medicaid program in Washington State. This review makes the informed assumption that decreasing adverse benefit determinations and blanket exclusions for medically necessary gender affirming treatment will decrease denial of care, delay of care, and/or foregoing care for treatments. This informed assumption is based on peer-reviewed published evidence and information shared by key informants. Strong evidence that decreasing denial of care, delay of care, and/or foregoing care for medically necessary gender affirming treatments will improve health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals.[16-27] Strong evidence that improving health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals will decrease health inequities experienced by these individuals.[25,27-31]l It is unclear how current provisions of SB 5313 would impact health inequities for transgender and gender diverse people enrolled in Apple Health plans since provisions could impact federal funding available for the Medicaid program in Washington State.

Scope

Due to time limitations, we only researched the most direct connections between the provisions of the bill and decreased health inequities and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- How improved insurance coverage may impact the availability of trans-competent providers. Key informants expect the supply of trans-competent providers over time to increase and that insurance coverage will likely help the progression (personal communications, February 2021). Literature and key informants identify the lack of competent providers willing to care for transgender and gender diverse patients as a barrier.[4] Key informants noted that lack of healthcare providers in Washington State providing gender affirming treatment limits access and use of care (personal communications, February 2021). Availability of trans-competent providers varies by surgical procedure. Whether providers are in-network, geographically accessible, or accepting clients may also limit access and use of services. For example, there are only three providers enrolled in Apple Health that perform bottom surgery, and only one of these providers is located in Washington State (personal communication, HCA, February 2021). Limited provider availability can reduce timely access for procedures (e.g., 3-month to 2-year long waitlists).

Magnitude of impact

In the U.S., approximately 1.4 million adults and 150,000 youth ages 13 to 17 years identify as transgender.[17] Researchers have noted this is "likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining 'transgender' in a way that is inclusive of all gender-diverse identities."[16] Research also estimate roughly 80% of the trans population has a binary understanding of their gender identity, whereas 20-40% are non-binary or genderqueer.[1] Staff at Seattle Children's Hospital's Gender Clinic estimate 1/3 of the clinic's patients identify as non-binary (personal communication, February 2021).

Evidence shows "the transgender population is less likely to be insured than both the lesbian, gay, and bisexual (LGB) and general populations and often faces challenges in accessing needed healthcare services."[17] Those who have insurance also report issues receiving coverage for gender affirming care.[4,16,21,25,27,32] The 2015 U.S. Transgender Survey included 1,667 respondents from Washington State. Survey results from Washington residents found that in the 12-months preceding the survey 29% of respondents experienced a problem with their insurance related to being transgender (e.g., being denied coverage for care related to gender transition).[33] Among the broader national sample, 25% of those who sought coverage for hormones in the preceding 12-months were denied coverage as were 55% of those who sought coverage for transition-related surgery.[25] Additionally, while 78% of respondents wanted hormone therapy related to gender transition, only 49% had ever received it.[25]

The provisions of SB 5313 apply to health carriers providing coverage under an Apple Health plan; PEBB/SEBB plan; or a plan offered on the Exchange. HCA purchases healthcare for more than 2.5 million Washington residents through Apple Health, PEBB, and SEBB.[34] As of January 2020, Washington Healthplanfinder had about 200,000 people enrolled in individual coverage across the state.[34]

Data related to adverse benefit determinations or health insurance denials are available through health carriers. HCA and OIC, as health insurance regulatory agencies, can receive health insurance-related complaints from individuals and providers (personal communication, OIC, February 2021). The majority of health insurance-related complaints received by OIC are related to adverse benefit determinations or coverage denials (though complaints can be made for other reasons) (personal communication, OIC, February 2021). OIC has regulatory authority to receive complaints against any health carrier licensed to offer full-benefit health plans in Washington State, including carriers for most PEBB/SEBB health plans. OIC will assist with and refer complaint cases against PEBB/SEBB plans to HCA, and HCA as a regulatory agency can also receive insurance complaints directly (personal communication, OIC, February 2021). Since 2014, OIC has received a total of 158 cases of health insurance complaints related to gender identity (approximately 23 cases per year, on average), including 18 cases in 2020 (personal communication, OIC, February 2021).

One key informant noted that without systems-level data from the state and insurers operating in Washington, it is unclear whether the repeated denials and exclusions documented in community reflect the majority of trans patients' interactions with insurers or if these instances are a smaller subset of challenging cases that require a more tailored review by regulators to identify a solution (personal communication, February 2021). OIC confirmed that it is not possible to determine what percentage of individuals receiving adverse benefit determinations or coverage denials file complaints (personal communication, OIC, February 2021). However, they noted that the OIC phone number for complaints is printed at the bottom of every adverse benefit determination, that OIC has issued guidance for carriers and consumers around gender identity, and that proponents for transgender healthcare are aware of the OIC complaint process, which could make it more likely individuals file a health insurance-related complaint relating to gender affirming treatments (personal communication, OIC, February 2021).

In response to a 2020 public records request, OIC provided data on 58 cases opened between 2017 and 2020 specific to denials related to gender affirming treatment (unpublished data, OIC, 2020). Key informants who shared the data noted that Washington State law changed in 2019 with the implementation of RCW 48.43.0128 (Nongrandfathered health plans—Prohibited discrimination—Rules). However, review of the denials data found that surgeries which should have been covered under state law before the implementation of RCW 48.43.0128 were denied both before and after the rules went into effect (personal communication, February 2021). A memo from OIC accompanying the 2020 responsive records states, "Reviewed procedure claim denials come from public and private insurance policies alike. These coverage denials can be seen across age groups, from minors to a spectrum of adults, including elder medicare [sic.] recipients seeking treatment" (unpublished data, OIC, 2020). In summarizing the complaints received by OIC, the memo states, "it is common to see cases in which insurers rejected gender-affirming claims under the grounds that they internally classified the procedure as cosmetic. Often, these are labeled explicitly as Transgender Service exclusions. This exclusion has been affirmed even when the applicant obtained the required documentation stating that the procedure is medically necessary. Often in responses to complaints, a reviewer internally selected by the insurer would affirm that the procedure was cosmetic" (unpublished data, OIC, 2020). OIC also noted that "those seeking services and procedures are often navigating insurance policies that don't have coding structures built for services and procedures for people who are not cisgender. As a result, transgender people can be denied because some policies do not have coding options for procedures filed under certain documented sex and gender identities" (personal communication, February 2021).

Logic Model

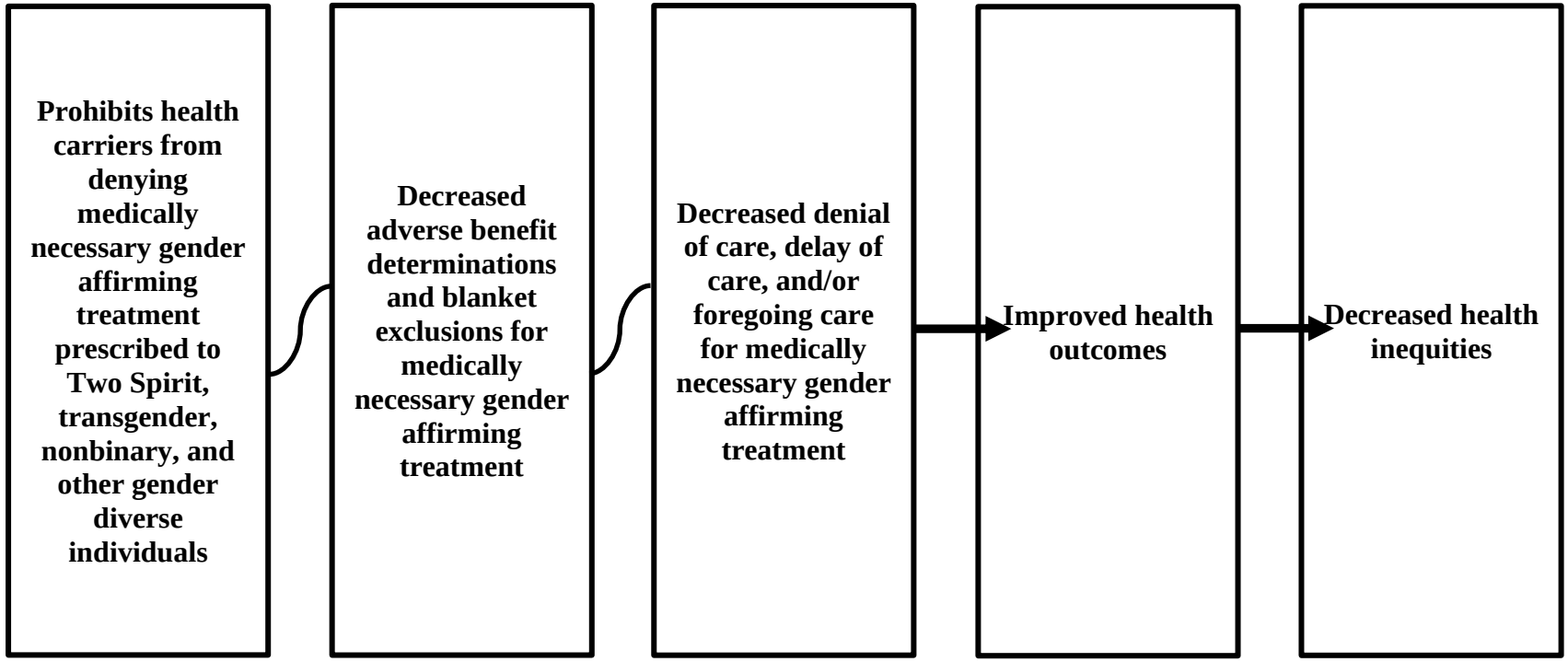

Figure 1:

Concerning health insurance discrimination

SB 5313

Summaries of Findings

Will prohibiting health carriers from denying medically necessary, gender affirming treatment prescribed to Two Spirit, transgender, nonbinary, and other gender diverse individuals decrease adverse benefit determinations and blanket exclusions for treatments?
This review makes the informed assumption that prohibiting health carriers from denying medically necessary, gender affirming treatment prescribed to Two Spirit, transgender, nonbinary, and other gender diverse individuals will decrease adverse benefit determinations and blanket exclusions for treatments. This informed assumption is based on provisions in the bill and information from key informants.

Many healthcare rights and services for Two Spirit, transgender, nonbinary, and other gender diverse individuals are protected in Washington State statute. However, these services may not be provided (personal communications, February 2021). Key informants from the transgender community and those who work with trans patients agreed that under current state law many gender affirming treatments and procedures (e.g., hormone therapy, puberty blockers, top surgery, bottom surgery) should already be covered by insurers in Washington State (personal communications, February 2021). However, the lived experience of community members and the time and resources required of patient navigators, clinical providers, and clinic staff to ensure that trans patients receive the gender affirming care they require and that services are paid for by insurance indicate that current protections in statute are not working as intended for all trans Washingtonians. Key informants shared that insurance denials continue to disparately affect transgender individuals in Washington State (personal communication, 2018 and January 2021). One key informant noted that without systems-level data from the state and insurers operating in Washington, it is unclear whether the repeated denials and exclusions documented in community reflect the majority of trans patients' interactions with insurers or if these instances are a smaller subset of challenging cases that require a more tailored review by regulators to identify a solution (personal communication, February 2021).

Health plans offered on the Exchange
The 2010 Patient Protection and Affordable Care Act (ACA) details ten essential health benefits that must be included in every individual and small employer health plan.[6,7] The ACA does not include gender affirming treatment as an essential health benefit, and individual health plans on the private health market are not required to provide coverage for gender affirming treatments (personal communication, Health Benefit Exchange [HBE], February 2021). However, health carriers in Washington State reported providing coverage for gender affirming treatments when care is determined medically necessary for the treatment of a mental health diagnosis (personal communication, Association of Washington Healthcare Plans, February 2021). Some health carriers reported using WPATH standards to determine when treatments were considered medically necessary (personal communication, Association of Washington Healthcare Plans, February 2021). Health carriers stated that blanket exclusions are not used, and that individuals may receive an adverse benefit determination for noncovered services or if services are not determined to be medically necessary (personal communication, Association of Washington Healthcare Plans, February 2021).

In addition, health carriers offering plans on the Exchange are prohibited from, "cancelling or failing or refusing to issue/renew insurance on the basis of sexual orientation, which includes gender identity; discriminating against individuals because of their gender identity or sexual orientation (RCW 48.43.0128); and issuing auto initial denials of coverage from reproductive health care services that are ordinarily or exclusively available to individuals of one gender, based on the individual's gender assigned at birth, gender identity, or gender otherwise recorded (RCW 48.43.072)" (personal communication, HBE, February 2021).

Health plans offered on the Exchange must also meet state law and be approved by the Washington State Office of the Insurance Commissioner (OIC). SB 5313 would change state law to prohibit health carriers in Washington from denying medically necessary gender affirming treatment prescribed to Two Spirit, transgender, nonbinary, and gender diverse individuals. Therefore, health carriers offering health plans on the Exchange would be prohibited from issuing adverse benefit determinations or blanket exclusions for gender affirming treatment as required by SB 5313 in order for plans be offered on the Exchange, including individual and small group/small employer health plans (personal communication, HBE, February 2021).

PEBB/SEBB plans
All health plans offered under PEBB/SEBB cover gender affirming treatments, though specific coverage varies by plan (personal communication, Health Care Authority (HCA), February 2021). Most plans cover treatments like hormone therapy, mastectomy, genital surgeries, etc. However, currently some treatments are classified as "cosmetic" or do not meet medical necessary criteria (as established by health carriers) and are not covered by PEBB/SEBB plans (e.g. facial feminization, facial electrolysis) (personal communication, HCA, February 2021). While some carriers have already extended coverage to include facial feminization (personal communication, HCA, February 2021), SB 5313 would require all carriers to provide coverage for this treatment. Therefore, SB 5313 would likely increase coverage of gender affirming treatments, including treatments currently classified as "cosmetic" by some carriers (e.g., facial feminization).

Health carriers offering PEBB/SEBB plans (with the exception of the Uniform Medical Plan) must also meet state law and be approved by OIC (personal communication, HCA, February 2021). SB 5313 would change state law to prohibit health carriers in Washington from denying medically necessary gender affirming treatment prescribed to Two Spirit, transgender, nonbinary, and gender diverse individuals. Therefore, health carriers offering PEBB/SEBB plans would be prohibited from issuing adverse benefit determinations or blanket exclusions for gender affirming treatment as required by SB 5313 (personal communication, HCA, February 2021).

Apple Health plans
It is unclear how SB 5313 would impact coverage of prescribed gender affirming treatments under Apple Health plans due to technical barriers and alignment with federal Medicaid and Medicaid Managed Care regulations.

Coverage of gender affirming treatments under Apple Health varies depending on the type of service and the type of coverage provided. Most individuals on an Apple Health plan receive coverage through a Medicaid Managed Care Organization, and all non-surgical gender affirming

treatments are covered (e.g., hormone therapy, mental health services) (personal communication, HCA, February 2021). However, key informants noted that different standards of care applied by different Managed Care Organizations can be a barrier to non-surgical care (personal communications, February 2021). Surgical and electrolysis treatments are not covered under Medicaid Managed Care, and coverage must be requested through Apple Health fee-for-service (personal communication, HCA, February 2021). Therefore, a Managed Care Organization will issue an adverse benefit determination for any request for a surgical or electrolysis treatment (personal communication, HCA, February 2021). Preauthorization requests for surgical or electrolysis treatments must be submitted to the Apple Health fee-for-service program by the surgeon that will be performing the procedure (personal communication, HCA, February 2021). Requests are reviewed based on WPATH standards of care to determine if they are medically necessary (personal communication, HCA, February 2021). Key informants who work with trans patients stated that the processes between Managed Care Organizations and fee-for-service is not easy to navigate and may result in delay of care (personal communications, February 2021) Since provisions of SB 5313 would require Managed Care Organizations to cover gender affirming treatments, removing the need for individuals to request coverage through fee-for-service, the bill would likely increase coverage for gender affirming treatments provided under Apple Health plans.

However, the current provisions of SB 5313 do not align with federal Medicaid and Medicaid Managed Care regulations (personal communication, HCA, February 2021). Compliance with proposed bill provisions could violate federal Medicaid and Medicaid Managed Care regulations and could jeopardize the ability for the state to obtain federal Medicaid match dollars (personal communication, HCA, February 2021). For example, among other technical barriers, HCA noted that SB 5313 creates a new definition of an adverse benefit determination that is not aligned with the definition used by Medicaid Managed Care Organizations (personal community, HCA, February 2021). Additionally, the provisions would prohibit adverse benefit determinations regardless of whether a client has another form of insurance or meets Medicaid eligibility requirements, which could also impact the receipt of federal funding (personal communication, HCA, February 2021). These technical barriers are due to the alignment of state and federal Medicaid regulations, and are not specific to the coverage of gender affirming treatment or services (personal communication, HCA, February 2021).

Additionally, HCA's Transgender Health Program ensures care meets requirements in WAC 182-531-1675 (Washington apple health – Gender dysphoria treatment program). The program outlines specific surgical services that are covered through Medicaid fee-for-service (e.g., breast reconstruction, genital surgery, hysterectomy).[35] The program notes that, "there are different requirements [for preauthorization] depending on what service you want to have performed. For top surgery, [HCA] require[s] a letter from a licensed mental health care provider, a letter from the provider managing your hormone therapy, and a letter from the surgeon who will perform the surgery."[35] Key informants have noted that preauthorization requirements can be a barrier to care (personal communication, August 2018). In addition, some gender affirming treatments (e.g., facial feminization) are not currently covered through Apple Health free-for-service (personal communication, HCA, February 2021). However, WAC 182-531-1675 is currently open for rulemaking and proposed changes would remove the "noncovered services" list from statute,

allowing requests for any service deemed medically necessary to be approved for coverage (personal communication, HCA, February 2021).

Overall, key informants representing state agencies responsible for implementing SB 5313 stated that the bill adds specificity to insurance policies and procedures and would likely decrease adverse benefit determinations and cosmetic blanket exclusions for medically necessary gender affirming treatment (personal communications, HCA and OIC, February 2021). Key informants from the transgender community and those who work with trans patients overwhelmingly agreed that SB 5313 would hold insurers more accountable for providing medically necessary gender affirming treatment and would result in fewer denials for trans patients. In addition, since PEBB/SEBB health plans and individual/small group health plans would adhere to these provisions in order to meet state law and be offered on the Exchange, we have made the informed assumption that the bill would decrease adverse benefit determinations and blanket exclusions for medically necessary, gender affirming treatment. However, since provisions in SB 5313 may impact federal funding available for the Medicaid program in Washington State, it is unclear how the bill in its current iteration would impact Apple Health plans and individuals enrolled in them.

Will decreasing adverse benefit determinations and blanket exclusions for medically necessary gender affirming treatment decrease denial of care, delay of care, and/or foregoing treatment?

This review makes the informed assumption that decreasing adverse benefit determinations and blanket exclusions for medically necessary gender affirming treatment will decrease denial of care, delay of care, and/or foregoing treatment. This informed assumption is based on peer-reviewed published evidence and information shared by key informants in Washington that insurance related issues (e.g., adverse benefits determinations and cosmetic blanket exclusions) are significant barriers to trans and gender diverse Washingtonians receiving gender affirming, medically necessary, and lifesaving healthcare.

Multiple key informants who work with trans youth and/or adults shared that, while in many cases gender affirming care is ultimately covered by insurers, it's often not without significant effort on behalf of the trans patient (personal communications, February 2021). It can take months to years of appealing adverse benefit determinations and/or claim denials, submitting duplicative referral letters (i.e., not in accordance with WPATH Standards of Care), and undergoing unnecessary and unwanted testing and/or treatments[4,36] to access the care that aligns with a trans patient's individual goals and their medical provider's recommended care plan (personal communications, February 2021). Published evidence indicates that "even when expenses are covered, families describe high levels of stress navigating and submitting claims appropriately."[16] Key informants also noted that it should not be a pre-requisite for trans patients to know of non-profits that support trans community members in navigating trans healthcare in order to receive medically necessary, gender affirming care (personal communications, February 2021).

Key informants who work in clinics that provide gender affirming care noted that insurance billing codes are a systemic challenge for trans patients and providers to navigate. The billing codes are based in a binary system (i.e., male, female) with no specific recognition of trans

people. The billing codes specific to gender dysphoria are technically mental health codes, and, as a result, insurance companies may (i.e., it varies) deny claims received from medical providers using one of these codes (personal communication, February 2021). A 2012 study similarly found claims for recommended gender care were denied by insurers on the basis that gender dysphoria was a mental health disorder, not a physical one, and the treatment was therefore not medically or surgically necessary.[16] Alternatively, medical billing codes commonly used for gender affirming care are specific to "endocrine disorders," a catch-all for endocrine-related treatment (personal communication, February 2021). Key informants who work in billing shared that it often feels like a guessing game to determine which is the appropriate code to use for services as it varies insurer to insurer, treatment to treatment, and at times base on the insurance company staff member who processes the claim (personal communications, February 2021). Staff shared one instance in which the insurer reported the claim would have been paid had it been submitted under a different code. When asked if they could resubmit under the appropriate code, the insurer informed them that constituted insurance fraud (personal communication, February 2021).

Peer-reviewed evidence shows at least some trans patients feel that "their mental health was inappropriately used as rationale to deny care."[4] For example, "Despite [WPATH Standards of Care] being set up as flexible guidelines, many providers or insurers use them as absolute requirements and will deny coverage if not established to the letter" (personal communication, Tobi Hill-Meyer, August 2018). Moreover, insurance pre-authorization and utilization reviews are often conducted by staff members without expertise or experience providing gender affirming care (personal communication, January 2021). In many cases where care is delayed or claims are denied, it is the result of insurers not being aware of Washington State law and/or guidelines outlined in WPATH's Standards of Care or because the reviewer personally does not agree with the care being requested or provided (personal communication, February 2021). Key informants recounted personal and patient experiences in which pre-authorized gender affirming surgeries were at risk of, or were, delayed because an insurer requested additional mental health provider referral letters as little as a day before a scheduled surgery adding to patients' stress and anxiety (personal communications, February 2021).

Non-binary, genderqueer, and gender diverse patients (i.e., whose gender identities do not align with a cis-normative, binary understanding of gender) face additional insurance barriers and discrimination when accessing gender affirming care (personal communication, February 2021). Key informants recounted personal and patient experiences in which insurers denied provider recommended procedures stating they were "not gender affirming procedures." For example, a state-funded insurer denied a non-binary patient's pre-authorization for a breast reduction, whereas the insurer would have covered a mastectomy (personal communication, February 2021). By limiting the types of treatments and procedures available to segments of the trans community, insurers fail to recognize the diversity of non-binary patients' personal transition goals (personal communication, January 2021). Such denials function as another form of blanket exclusion in which the insurers determine which non-binary and gender diverse patients are "trans enough" (personal communications, February 2021)

Trans youth and adolescents younger than 18 years face many of the same insurance barriers described above as well as some unique barriers as a result of their status as minors. Seattle

Children's Hospital's Gender Clinic noted that they do not currently track insurance denials (personal communication, February 2021). However, staff reported four denials for the first week in February 2021 which is roughly standard (personal communication, February 2021). A recent uptick in denials from Apple Health for top surgery has prompted clinic staff to reconsider how providers write their referral letters, which takes away from staff time dedicated to working directly with patients and families (personal communication, 2021). Key informants working with youth, adolescents, and their families shared that a unique insurance barrier for minors seeking gender affirming treatment is the requirement that both parents or legal guardians approve of the treatment (personal communication, February 2021). If one parent or legal guardian is not supportive care can be significantly delayed as both sides pursue legal avenues. Moreover, evidence indicates that trans youth and adolescents may be estranged from their family (e.g., trans youth are more likely to experience homelessness, be in the foster care system). Results of the 2015 U.S. Transgender Survey show 15% of those who were out to their immediate family ran away from home and/or were kicked out of the house because they were transgender.[25]

Peer-reviewed literature has documented denials and/or delay of services by insurers and providers[18] present significant barriers for transgender individuals receiving appropriate healthcare.[4,27,32,36] In a survey of 256 transgender and gender nonconforming individuals, insurance was the second most commonly reported barrier to care.[4] Among U.S. Transgender Survey respondents 25% experienced a problem within the last year with their insurance related to being transgender, and 55% of those who sought coverage for transition-related surgery in the past year were denied.[25] For example, despite the growing body of literature that shows puberty blockers help ameliorate mental health challenges faced by transgender adolescents, a retrospective review of medical records found 59.3% of transgender adolescent patients prescribed puberty blockers were specifically denied insurance coverage for care.[21] Of those initially denied coverage, four subsequently received care.[21] However, the median time between insurance denial and start date for hormone therapy was 9 months (range 8-20 months).[21]

Staff representing clinics that serve trans patients in Washington explained that insurers may also delay care by denying pre-authorizations or changing the administration method (e.g., injection, cream) of a treatment (e.g., hormones) without the provider's knowledge (personal communication, February 2021). Often such changes are related to treatment cost, and result in a back-and-forth between the insurer and the provider and/or a requirement for the patient to try other treatments deemed inappropriate by the provider for the specific patient until they can access the original prescribed treatment (personal communication, February 2021). Staff stated that insurers do not interfere with provider recommended care for other types of healthcare needs (e.g., diabetes treatment) (personal communications, February 2021).

Key informants discussed other barriers to care not addressed in the bill which could still result in denial of care, delayed care, and/or foregoing care, including lack of insurance,[28,37] gaps in insurance coverage,[27] cost of care (e.g., clinical visits, procedures, and co-pays),[25,27,37] other required services (e.g., therapist visits, lab work),[4] limited trans-competent provider availability (i.e., trained in gender affirming treatment),[4,27,38-42] travel (e.g., to a competent provider),[4] missed work, discrimination by providers and/or clinic staff,[4,27,40] and fear of discrimination based on past clinical experiences.[25,28,33] Key informants also noted that the current and historical

challenges of accessing gender affirming care may result in some in the trans community not trying to access care they would otherwise want (personal communication, February 2021).

However, since SB 5313 would likely decrease adverse benefit determinations and blanket exclusions, we have made the informed assumption that provisions of the bill would likely decrease denial of care, delayed care, and/or foregoing care for medically necessary gender affirming treatments for some Two Spirit, transgender, nonbinary, and other gender diverse individuals.

Will decreasing denial of care, delay of care, and/or foregoing care for medically necessary gender affirming treatment improve health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals?

There is strong evidence that decreasing denial of care, delay of care, and/or foregoing care for medically necessary gender affirming treatment will improve mental and physical health outcomes and personal safety for Two Spirit, transgender, nonbinary, and other gender diverse individuals.

The California Department of Insurance issued an Economic Impact Assessment that determined that antidiscrimination rules for health insurers would yield "significant benefits to transgender individuals including suicide reduction, improvements in mental health, reduction in substance use rates, higher rates of adherence to HIV care, and reduction in self-medication."[17] Key informants underscored the importance of gender affirming care for trans and gender diverse people's mental health, physical health, and personal safety.

Mental health

Transgender adolescents and adults have higher rates of depression, anxiety, eating disorders, self-harm, and suicide.[16] The American Academy of Pediatrics states, "There is no evidence that risk for mental illness is inherently attributed to one's identity as [transgender or gender-diverse]. Rather, it is believed to be multifactorial, stemming from an internal conflict between one's appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as [transgender and gender diverse], discrimination, stigma, and social rejection."[16] This understanding has been affirmed by the American Psychological Association (2008) and the American Psychiatric Association, which stated in 2012: "Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.…[Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals."[16] Evidence indicates that the practice of insurance companies denying claims for gender affirming treatments "contributes to stigma, prolonged gender dysphoria, and poor mental health outcomes."[16]

A developing body of literature indicates that accessing gender affirming care improves trans and non-binary patient's mental health. A systematic review of literature found a statistically significant reduction in depression, somatization, interpersonal sensitivity, anxiety, hostility, and phobic anxiety/agoraphobia after initiating hormone therapy.[18] Authors noted that there were limited prospective, longitudinal studies evaluating impact over time.[18] More recently, a study

found chest dysphoria (i.e., distress or discomfort one feels because of chest tissue that has developed after undergoing an endogenous female puberty) was "high among presurgical transmasculine youth, and [chest reconstruction surgery] positively affected both minors and young adults."[19] All postsurgical participants affirmed the statement, "It was a good decision to undergo chest reconstruction."[19] Self-reported regret was near 0; one out of 68 reported experiencing regret "sometimes".[19]

Evidence shows that gender-based discrimination affecting access to services is a strong predictor of suicide risk among transgender persons.[17] Moreover, lack of access to gender affirming care may directly contribute to poor mental health. A survey of 697 transgender individuals found those with gender dysphoria who had not undergone gender affirming treatment were twice as likely to experience moderate to severe depression and four times more likely to experience anxiety than their surgically-affirmed peers.[20] Another study found treatment with pubertal suppression (commonly referred to as puberty blockers) among those who wanted it was associated with lower odds of lifetime suicidal ideation compared to those who wanted but did not receive it.[22] Key informants noted that puberty blockers are a completely reversible treatment that can give young patients time to determine their gender and treatment goals, by pausing breast, testicle, and penis development.[21,43] Treatment with puberty blockers can also reduce the need for other gender affirming care by preventing unwanted secondary-sex characteristic development (e.g., deepening voice which may require surgery and/or voice coaching) (personal communications, February 2021).

Physical health

Insurance denials "may lead patients to seek nonmedically supervised treatments that are potentially dangerous."[16] For example, qualitative interview data from transgender and gender nonconforming individuals in New Orleans found the community is "committed to accessing gender affirming care regardless of the associated risks of care outside of provider supervision" (e.g., traveling abroad for care, accessing hormones online or shared by friends, getting silicone on the black market).[23] One respondent stated, "There've been a few trans people who have pretty major health concerns because of street silicone injections" (Transgender Male, 23, white).[23] Key informants in Washington confirmed that denial of gender affirming care can prompt desperation that contributes to some pursuing nonmedically supervised treatments or treatments abroad (personal communications, February 2021).

There is also evidence that binding (i.e., compression of chest tissue for masculine gender expression among people assigned female at birth) is associated with negative health outcomes. In a study of 1,800 adults (18 years and older) who identify on the masculine spectrum, 97.2% of participants reported at least one negative outcome they attributed to binding.[44] "The most commonly reported outcomes were back pain (53.8%), overheating (53.5%), chest pain (48.8%), shortness of breath (46.6%), itching (44.9%), bad posture (40.3%) and shoulder pain (38.9%)."[44] However, participants also reported that "binding made them feel less anxious, reduced dysphoria-related depression and suicidality, improved overall emotional wellbeing and enabled them to safely go out in public with confidence."[44] Results of this and a study of trans-masculine and gender-diverse adolescents and young adults demonstrate that, despite negative physical impacts, binding is an important practice, particularly for perceived safety.[24,44] The majority of

participants in both studies (66.6% and 90%) who practiced binding indicated that they wanted to undergo chest reconstruction surgery in the future.[24,44]

Personal safety

Key informants in Washington confirmed that denial of gender affirming care presents a safety risk for trans patients. Trans people who are "visually or otherwise perceived by others as transgender or gender non-conforming may be more vulnerable to negative interactions in public or other settings."[25] The 2015 U.S. Transgender Survey showed nearly half (48%) of all respondents were denied equal treatment (14%), verbally harassed (46%), and/or physically attacked (9%) in the past year because of being trans.[25] In addition, "Those who said that others could usually or always tell that they were transgender (66%) were more likely to report having one or more of these experiences because of being transgender, in contrast to those who said others could rarely or never tell that they were transgender (39%)."[25] Results showed "Transgender women of color were more likely to be harassed by strangers because of their gender identity or expression, particularly multiracial (51%) and American Indian (47%) women."[25] Moreover, "those who said that others could always or usually tell that they were transgender, even without being told (55%), were substantially more likely to have been verbally harassed by strangers, in contrast to those who said that people could rarely or never tell that they were transgender (22%)."[25]

Additionally, transgender people face high rates of violence, including physical attacks, sexual assault, and intimate partner violence.[25] Among the 2015 survey respondents, 54% experienced some form of intimate partner violence, 47% were sexually assaulted at some point in their lifetime, and 10% had been sexually assaulted in the past year.[25] Respondents who were currently working in the underground economy (i.e., sex work, drug sales, and other activities that are currently criminalized) were more than 3 times as likely to have been sexually assaulted in the last year.[25] Those who had lost their job because of their gender identity or expression (37%) were more likely to have participated in the underground economy.[25] Transgender women of color were also more likely to participate in the underground economy for income, including Black, American Indian, multiracial, and Latina respondents.[25]

Key informants affirmed these experiences of victimization are representative of trans people's experiences in Washington and underscore the medical necessity of gender affirming care inclusive of facial feminization surgeries and hair removal or electrolysis (personal communications, February 2021). WPATH states "medically necessary gender affirming/confirming surgical procedures…include…facial hair removal, certain facial plastic reconstruction, voice therapy and/or surgery" in its 2016 "Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A."[26] WPATH cited evidence that non-genital surgical procedures (i.e., subcutaneous mastectomy for those on the transmasculine spectrum; facial feminization surgery, and/or breast augmentation among those on the transfeminine spectrum) "are often of greater practical significance in the patient's daily life than reconstruction of the genitals."[26] WPATH affirmed, "The medical procedures attendant to gender affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment".[26]

Therefore, decreasing denial of care, delay of care, and/or foregoing care of medically necessary gender affirming treatment is likely to improve physical and mental health outcomes and personal safety for Two Spirit, transgender, nonbinary, and other gender diverse individuals.

Will improving health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals decrease health inequities experienced by these individuals?
There is strong evidence that improving health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals will decrease health inequities experienced by these individuals. However, it is unclear how SB 5313 will impact health inequities for those enrolled in Apple Health plans.

Inequities are not inherent to an individual's identity. Rather, inequities are influenced by social determinants that systematically marginalize groups due to their identity. For example, mental health outcomes are not inherent to an individual's gender identity. Rather, they are influenced by social determinants of health like cissexism/genderism, which contributes to inequities like socioeconomic status, access to healthcare, and interactions with medical professionals. Inequities can be exacerbated or alleviated by intersecting identities (e.g., race/ethnicity, educational attainment).

Evidence shows that transgender and gender diverse people experience adverse benefit determinations and blanket exclusions that result in denials, delays, and/or foregone care. A 2012-2013 study of LGBTQ emerging adults in an urban Midwestern area found transgender patients were statistically significantly more likely than cisgender participants to experience denial of services or unequal treatment and queer/questioning individuals reported them at higher rates compared to gay/lesbian and bisexual individuals.[28]

In addition, it is well documented that the transgender population experiences worse health outcomes (i.e., mental health,[17,29,31] physical health,[27] and personal safety[30]) than the general population and cisgender peers. For example, "transgender individuals in the U.S. are up to three time more likely than the general population to report or be diagnosed with mental health disorders, with as many as 41.5 percent reporting at least one diagnosis of a mental health or substance use disorder."[17] The American Medical Association states, "The increased prevalence of these mental health conditions is widely thought to be a consequence of minority stress,[31] the chronic stress from coping with societal stigma and discrimination because of one's gender identity and expression."[17] The prevalence of suicide attempts among transgender people is substantially higher than among the U.S. general population. Nearly half (48%) of all respondents to the 2015 U.S. Transgender Survey reported that they had seriously considered suicide in the past 12 months, compared to 4% of the U.S. general population.[25] Nearly, one-quarter (24%) of respondents reported making plans to die by suicide in the preceding 12 months, compared to 1.1% in the U.S. population.[25] The rate of attempted suicide in the past year (7%) was nearly 12 times the rate of attempted suicide in the U.S. population in the past year (0.6%).[25] The prevalence of suicide ideation and attempts is also higher for transgender youth than their cisgender lesbian, gay, and bisexual peers. Results of a 2018 survey of LGBTQ youth (aged 13-24 years) showed that transgender and non-binary respondents were more likely than their cisgender peers to report having considered suicide (54% vs. 31%, respectively) and attempted suicide (29% vs. 14%, respectively).[29]

An estimated 50% of transgender people are sexually abused or assaulted at some point in their lives. The U.S. Department of Justice reports "this indicates that the majority of transgender individuals are living with the aftermath of trauma and fear of possible repeat victimization."[30] Due to intersectionality, sexual violence is even higher in some subpopulations within the transgender community, including people of color, individuals living with disabilities, those experiencing homelessness, and those who are involved in the sex trade.[25,30] This aligns with evidence from the U.S. Transgender Survey. Additionally, 54% of respondents experienced some form of intimate partner violence, and nearly one-quarter (24%) reported severe physical violence by an intimate partner, compared to 18% in the general U.S. population.[25] Seventy-seven percent of those who did income-based sex work experienced IPV.[25]

Therefore, improving health outcomes for Two Spirit, transgender, nonbinary, and other gender diverse individuals is likely to decrease health inequities by these individuals.

Individuals enrolled in Apple Health plans

Based on their experience supporting trans patients navigate health insurance, key informants shared that pre-authorization denials, adverse benefit determinations, and cosmetic exclusions seem to affect patients across carriers and health plans, with variability by treatment and procedure type and gender identity (personal communications, February 2021). However, they noted that trans patients of lower socioeconomic status face multiple disadvantages that make it more difficult to navigate and overcome insurance barriers (personal communications, February 2021). Evidence also indicates that "insurance denials can reinforce a socioeconomic divide between those who can finance the high costs of uncovered care and those who cannot."[16]

Results of the 2015 U.S. Transgender Survey found that 13% of respondents nationwide were insured through Medicaid.[17] Washington specific insurance data were not reported, however 28% of respondents in the state were living in poverty (compared to 12% of the total U.S. population), and the unemployment rate among respondents was nearly three times higher (14%) than the unemployment rate in the total U.S. population at the time of the survey (5%).[25,33] Employment discrimination (e.g., not being hired, not being promoted, or being fired because of their gender identity or expression), verbal and sexual harassment in the workplace, and other forms of mistreatment (e.g., forced to use a restroom that did not match their gender identity, being told to present in the wrong gender in order to keep their job) all contribute to economic hardship and instability.[25,33]

In 2018, the Ingersoll Gender Center in Seattle conducted a survey of trans community members to inform a vision for greater access to gender affirming healthcare.[45] Community found that the trans respondents insured through Apple Health who responded to the survey were more likely than those on other types of insurance plans to be: experiencing homelessness or unstable housing; a person of color; making less than $25,000 per year; and disabled.[45]

National data indicate that transgender people of color experience greater economic inequities than white transgender respondents and the U.S. population generally.[25] Overall, survey respondents were more than twice as likely as the U.S. population to be living in poverty, and

transgender people of color were more than three times as likely as the U.S. population to be living in poverty.[25]

Since the current provisions of SB 5313 do not align with federal Medicaid and Medicaid Managed Care regulations and compliance with proposed bill provisions could violate federal Medicaid and Medicaid Managed Care regulations and jeopardize the ability for the state to obtain federal Medicaid match dollars (personal communication, HCA, February 2021), it is unclear how SB 5313 will impact health inequities for transgender and gender diverse people enrolled in Apple Health plans.

Annotated References

1. **Koehler A., Eyssel J., Nieder T.O. Genders and Individual Treatment Progress in (Non-)Binary Trans Individuals. *The Journal of Sexual Medicine.* 2017;2018(15):102-113.** Koehler et al. describe the umbrella term *trans* as it refers to "the wide spectrum of individuals experiencing their gender as not in line with their sex assigned at birth." Trans is inclusive of "genders within the binary (e.g., transsexual woman) and non-binary or genderqueer (NBGQ) genders." Specifically, "NBGQ individuals identify with a gender that is temporarily or permanently neither exclusively masculine nor feminine but rather is composed of masculine and feminine parts (e.g., 2-spirit), oscillates between genders (e.g., genderfluid), is situated beyond the binary (e.g., genderqueer), or rejects the binary (e.g., agender)." They cite research that approximately 80% of the trans-population has a binary understanding of their gender (i.e., exclusively masculine or feminine), whereas at least 20% identify as NBGQ." Despite this diversity the diagnostic criteria for gender issues have usually followed a binary understanding. Previous qualitative research has identified themes including the need for NBGQ individuals to position themselves and their identity within the gender binary to receive (access to) the care they desire and issues with health insurance, among others. Authors sought to provide further evidence on NBGQ individuals' genders, experiences, and needs regarding transition-related healthcare. A survey was developed according to a participatory approach and completed online by a non-clinical sample of trans (umbrella term) and be at least 16 years of age living in Germany. Data collection occurred over 2-months in the sumemr of 2015. The study sample included 415 participants, of which 339 (81.7%) reported a binary gender, and 76 (18.3%) reported a NBGQ gender, and 20 (62.5% of the NBGQ group) reported an additional NBGQ gender not listed. "Of those who accessed transition-related health care, binary participants reported a significantly larger percentage compared with NBGQ participants for all 4 treatment categories (mental health counseling, hormonal treatment, treatments regarding primary sex characteristics, and additional treatments not concerning primary sex characteristics." Specific to planned treatments, there was no sigificant differences for mental health counseling, hormonal treatments, and those that did not concern primary sex characteristics. A significantly larger percentage of binary participants reported intentions to undergo treatments regarding primary sex characteristics than did NBGQ participants. "Binary participants required an average number of 6.0 treatments; whereas, NBGQ individuals required an average number of 4.0 treatments." Authors recommend future research of NBGQ issues as "existing research (especially within health care) has focused primarily on a binary understanding of gender and therefore has failed to map health-related needs of NBGQ individuals."

2. **Health The World Professional Association for Transgender. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. 7th ed2011.** The WPATH Standards of Care (SOC) (Version 7) are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. "The SOC articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the SOC recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments."

3. **WPATH. 2021; Available at: https://www.wpath.org/. Accessed 5 February 2021, 2021.**
Website for the World Professinoal Association for Transgender Health (WPATH). Members engage in clinical and academic research "to develop evidence-based medicine and strive to promote a high quality of care for transsexual, transgender, and gender-nonconforming individuals internationally." The most current version is Volume 7 of the WPATH Standards of Care is available in 18 different languages.

4. **Puckett Jae A., Cleary Peter, Rossman Kinton, et al. Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals. *Sexuality Research and Social Policy: Journal of NSRC.* 2017(August).**
Puckett et al. examined rates of trans/gender nonconforming (TGNC) individuals pursuing or desiring to pursue different forms of gender-affirming care as well as qualitative responses regarding barriers encountered. Researchers conducted an analysis of data from an ongoing research study evaluating the impact of stigma on psychosocial issues effecting TGNC individuals. Data were collected during the baseline survey of the daily diary study and a one-time survey. Participants included 256 TGNC individuals (78.9% White, ages 16-73, Mean age = 28.4). Among participants, 61.3% were receiving hormone therapy, 22.7% had undergone top surgery (chest reconstruction), and 5.5% had undergone bottom surgery (vaginoplasty, phalloplasty, metoidioplasty, or other specific procedures). Authors cite evidence that TGNC individuals experience discrimination within health care setting in many forms, including "misgendering or being referred to as an inappropriate gender (e.g., being referred to as a man/male when a person is female identified) in providers' offices, unnecessarily invasive scrutiny into patients' personal lives, and outright denial of care to TGNC patients." GNC individuals face many of the barriers to care that transgender men and transgender women do, but lack of knowledge and education related to genderqueer or non-binary identities can limit patient access to quality care. Overall, 166 participants reported barriers to pursuing hormone therapy, 134 participants reported barriers to top surgery, 85 reported barriers to bottom surgery, and 22 reported barriers to puberty blockers (note, few participants considered puberty blockers, possibly due to age). Responses were grouped thematically into barriers. The financial cost of care was the most commonly cited barrier to receiving gender-affirming care (i.e., cost of lab work, doctor's visits, therapist visits to receive a letter of support for obtaining hormone therapy or surgeries). Insurance was the next most commonly endorsed barrier often coupled with challenges to employment. Even those with insurance experienced barriers including, having limited providers, having transgender specific exclusions, limiting the total expenditures on transgender-related healthcare to amounts below the cost of procedures. Limited availability of care (i.e., lack of competent providers willing to care for TGNC patients) often caused travel-related challenges to access services. Other barriers discussed include: bias and stigma from medical professionals (i.e., physicians, nurses, office staff, pharmacy staff); lack of provider education (e.g., feel the need to educate their providers about care needs); unnecessary exams (e.g., breast exams); mental health professionals as "gatekeepers"; requirements related to diagnoses (e.g., Gender Identity Dysphoria) and letters of recommendation from a psychologist and psychiatrist; lack of social support and fear of repercussions (i.e., family); fear of ridicule and discrimination; concern about quality of outcomes; lack of information about gender-affirming care; having other medical issues also presents barriers; age and timing of care (e.g., parental consent requirements, physician bias, lack of knowledge of puberty blockers). Authors

state that "[g]iven the benefits of gender-affirming care, it is important to assess and overcome the barriers that prohibit TGNC individuals from pursuing services, if they choose to do so." Authors recommend providers and frontline staff improve cultural competency to work with all patients (e.g., preferred language, resources, and protocol changes), professional organizations (e.g., institute guidelines for working with TGNC patients), state and federal polices (prohibit discrimination based on gender identity and expression), and health insurance (i.e., remove exclusions to gender-affirming care).

5. **Collazo Aiden, Austin Ashley, Craig Shelley L. Facilitating Transition Among Transgender Clients: Components of Effective Clinical Practice. *Clinical Social Work Journal.* 2013(41):228-237.**

Collazo et al. provided an overview of key components of trans-specific clinical practice and the role of social workers in supporting and facilitating client transition. Authors highlighted World Professional Association for Transgender Health (WPATH) recommendations and updates to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which encourage physicians to focus on the distress caused by gender incongruence and not the gender identity itself. Authors cited evidence that the changes in DSM-5 (2013) aimed to improve the diagnostic coding that is used to help people access transition-related medical care. Similarly, the WPATH Standards of Care (SOC), which offer guidance to clinicians working with transsexual, transgender, and gender nonconforming people to achieve positive health and well-being, have evolved to depathologize transgender care. In providing recommendations, authors discussed patients' negative experiences in healthcare settings; feelings of distrust; and clinicians as perceived "gatekeepers" rather than "advocates". Additionally, fear of and experienced lack of confidentiality; bias, discrimination, harassment, and stigmatization; medical denials due to transgender or gender non-conforming identity act as barriers to care. Specifically, "the NTDS found that 28% were harassed and experienced violence in medical settings, 19% were denied care, and 2% were victims of violence in doctor's offices. Additionally, physicians' lack of understanding of trans-specific medical needs also limits patient access to appropriate access to care. Authors also highlighted how patients perceive WPATH SOC recommendations and/or requirements as barriers to care, especially when competent providers are limited. The SOC recommends clinicians evaluate readiness using real life experience (RLE), "a continuous period of living full-time as the gender which one identifies, such as: (a) using a name and gender pronoun consistent with gender identity, (b) having an appearance (clothing, hairstyle, accessories) consistent with gender identity, and (c) being know in one's desired gender role to significant people in one's life (e.g., friends, family, partners, co-workers, teachers)." SOC requires a minimum of 1 year of RLE before consideration for genital surgery and recommends 3 months of RLE before referring for other aspects of medical transition (e.g., hormone therapy and top surgery). However, there is a lack of research demonstrating an association between postsurgical outcomes and mastery of RLE, and many transgender individuals view it as a barrier to medical treatment. Similarly, SOC recommends patients receive a letter of support for hormone replacement therapy and/or top surgery and an additional referral letter from a clinician with at least a master's degree or its equivalent in a clinical behavioral science field from an accredited institution. WPATH maintains these standards ensure the clinician’s ability to distinguish co-existing mental health issues from gender dysphoria.

6. **What health insurance plans must cover. 2019; Available at: https://www.insurance.wa.gov/what-health-insurance-plans-must-cover. Accessed 12/30/2019, 2019.**
The Office of the Insurance Commissioner provides information about what health plans in Washington State must cover based on the Affordable Care Act and state requirements.

7. **What Marketplace health insurance plans cover: 10 essential health benefits. 2019; Available at: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/. Accessed 12/30/2019, 2019.**
The U.S. Centers for Medicare & Medicaid Services outlines the 10 essential health benefits required by the Affordable Care Act.

8. **Affordable Care Act. 2020; Available at: https://www.kff.org/tag/affordable-care-act/?paged=2. Accessed 1/5/2021, 2021.**
The Kaiser Family Foundation provides updates and resources about the current challenge of the Affordable Care Act in the U.S. Court System. The U.S. Supreme Court heard oral arguements in November 2020 in a suit to invalidate the Affordable Care Act. They noted, "the ACA remains in effect while the litigation is pending. However, if all or most of the law is ultimately struck down, it will have complex and far-reaching consequences for the nation's health care system, affecting nearly everyone in some way."

9. **AG Ferguson Statement on Seeking Supreme Court Review of ACA [press release]. January 3, 2020 2020.**
In this press release, the Washington State Office of the Attorney General provided comment on the current status of the Affordable Care Act (ACA) in the U.S. Court System. Attorney General Bob Ferguson asked the U.S. Supreme Court to review the lower court's decision in a challenge to the Affordable Care Act. Washington State, as part of a 20 state coalition is, "seeking review of a decision in the U.S. Court of Appeals for the Fifth Circuit, which held that the individual mandate is unconstitutional, but declined to further rule on the validity of the ACA's remaining provisions." The court's ruling on the ACA would impact health care coverage and affordability in Washington State.

10. **Attanasio G. Senate Bill Report: SB 5313 (An acat relating to health insurance discrimination). Senate Committee on Health & Long Term Care;2021.**
The Senate Bill Report for SB 5313 provides background information summarizing relevant 2020 court rulings related to insurance discrimination under the 2010 Patient Protection and Affordable Care Act (ACA).

11. **MacEwan P. Update from the Health Benefit Exchange: Current Activities, Presentation to the House Health and Wellness Committee, December 1, 2020. Washington Health Benefit Exchange;2020.**
On December 1, 2020, Pam MacEwan provided an update from the Health Benefit Exchange (HBE) to the House Health and Wellness Committee of the Washington State Legislature. Among other updates, HBE provided an overview of 2021 Exchange Health Plans. The shared that average rates were likely to decrease in 2021. Thirteen health carriers were offering plans on the Exchanges, with a total of 115 Qualified Health Plans. Each county in Washington had at

least two carriers offering plans, which was an increase from 2020 with 8 counties only having one carrier offer plans. In addition, King , Pierce, and Thurston Counties had carriers offering 69 to 73 plans. As part of Cascade Care, 5 carriers were offering new public option plans in 19 different counties. On average, Cascade Care plans offer a $1,000 decrease in deductibles and "provide more access to first dollar services and co-pays (including primary care visits, mental health services, and generic drugs)." Approximately 40% of new 2021 enrollees were selecting Cascade Care plans.

12. **Transgender medical coverage rights. Available at. Accessed August, 2018.**
Washington State law and the federal Affordable Care Act prohibit health insurance companies from discriminating against individuals based on their gender identity and related medical conditions. This webpage outlines trangender rights to coverage as well as means to file complaints for unfairly denied coverage for medical services.

13. **Kreidler prompts Kaiser to write new policy to treat transgender women fairly [press release]. 1 August 2018 2018.**
This press release from the Washington State Office of the Insurance Commissioner (OIC) announced that Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. will no longer deny breast augmentation, or chest reconstruction, for transgender women. The decision is the result of an OIC investigation into the companies in early 2018 prompted by three consumers seeking help from the office. The companies specifically excluded breast augmentation as treatment for gender dysphoria, the clinical diagnosis for transgender men and women, and issued blanket denials rather than considering individual cases. The companies' new policy covers chest augmentation for transgender women with a physician prescription for the treatment. By October 28, 2018, both companies will complete a review of all denials of this treatment since January 2016. The release notes that the Affordable Care Act requires insurers to cover services for transgender individuals if they cover the services for cisgender individuals. Additionally, "Washington state's mental health parity laws don't allow insurers to categorically deny a treatment that is medically necessary to treat a mental health condition."

14. **Yen W. Washington State Health Services Research Project: Statewide Uninsured Rate Remailed Unchanged from 2018 to 2019.Research Brief. Washington State Office of Financial Management, Health Care Research Center; December 2020 2020.**
In this Research Brief, Washington State Office of Financial Management (OFM) describes trends in health coverage through 2019. Overall, Washington State's uninsured rate remained constant from 2018 to 2019 at approximately 6.1% uninsured. In addition, "no population group experienced a statistically signficant change in its uninsured rate between 2018 to 2019." OFM provides uninsured rates by age, sex, race/ethncity, and family income. The uninsured rates for the three lowest income groups remained approximately four times higher than the highest income group. However, based on weekly estimates of uninsured rates during the COVID-19 pandemic, OFM estimated that the uninsured rate for 2020 is likely to be higher. OFM estimates suggest that the uninsured rate doubled in May 2020 compared to before the pandemic. As of December 2020, the rate has returned to pre-pandemic levels largely due to the increase in enrollment in Medicaid and, to a lesser degree, in Qualified Health Plans on the Exchange.

15. **McMorrow S., Dubay L., Kenney G.M., et al. Uninsured New Mothers' Health and Health Care Challenges Highlight the Benefits of Increasing Postpartum Medicaid Coverage. Urban Institute;2020.**
Researchers from the Urban Institute analyzed data from the 2015-2018 National Health Interview Survey and 2015-2017 data from the Pregnancy Risk Assessment and Monitoring System (PRAMS) to evaluate the impact of losing Medicaid coverage on postpartum health outcomes. Relevant to this review, authors noted that "the COVID-19 pandemic and ensuing economic crisis...will put even more [people] at risk of uninsurance and in need of affordable coverage options."

16. **Rafferty J., American Academy of Pediatrics (AAP) Committee on Psychosocial Aspects of Child and Family Health; AAP Committee on Adolescence; AAP Section on Lesbian Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics.* 2018;142(2).**
This American Academy of Pediatrics policy statement from the Committe on Psycholsocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, reviews relevant concepts and challenges and provides suggestions for pediatric providers working with transgender and gender-diverse children and adolescents. AAP cites evidence estimating the U.S. transgender population as well as information indicating that children report being aware of gender incongruence at young ages (average 8.5 years) but often don't disclose such feelings until an average of 10 years later. The policy statement reports transgender adolescents and adults have higher rates of depression, anxiety, eating disorders, self-harm, and suicide. For example, a retrospective cohort study found 56% of transgender youth reported previous suicide ideation, and "31% reported a previous suicide attempt ccompared with 20% and 11% among matched youth who identified as cisgender, respectively. In regards to pubertal suppression, AAP reports "the available data reveal that pubertal suppression in children who identify as [transgender or gender-diverse] generally leads to improved psychological functioning in adolescence and young adulthood." They note treatment can reduce the need for later surgery by preventing otherwise irreversible secondary sex characteristics (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc.). Research on long-term risks of pubertal suppression (e.g., bone metabolism and fertility, is currently limited and provides varied results. Additionally, some experts beleive that genital underdevelopment may limit some potential reconstruction options. Authors note that insurance denials for gender-affirming care are a significant barrier.

17. **Association American Medical. Issue brief: Health insurance coverage for gender-affirming care of transgender patients. American Medical Association; 2019 2019.**
This 2019 American Medical Association Issue Brief provides an overview of health insurance coverage for gender-affirming care of transgender patients. Authors provide background defining gender identity (i.e., an individual's concept of self as male, female, a blend of both, or neither), defines transgender persons (i.e. those individuals' gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth), and cites evidence estimating the U.S. population of transgender people (i.e., approximately 1.4 million adults and 150,000 youth ages 13 to 17 years). Additionally, "Individuals may also identify as gender expansive, meaning they identify with neither traditional binary gender role nor a single gender

narrative or experience." This issue brief uses the term transgender as inclusive of patients with transgender or gender expansive identities. Authors note "many but not all transgender people experience gender dysphoria, a medical condition defined by the American Psychiatric Association as a 'conflict between a person's physical or assigned gender and the gender with which he/she/they identify.'" Authors go on to discuss barriers to care; federal and state polices that affect insurance coverage of gender-affirming care for transgender and gender expansive patients; potential cost savings of providing transgender inclusive health coverage; health implications for trans individuals; and medical society opinions by AMA and GLMA.

18. **White Hughto J.M., Reisner S.L. A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals. *Transgender Health.* 2016;1.1.**
Authors conducted a review of evidence from prospective cohort studies of the relationship between hormone therapy and changes in psychological functioning and quality of life in transgender persons accessing hormone therapy over time. No randomized controlled trials were identified. All included studies were non-randomized (observational) and uncontrolled, prospective cohort studies. Authors excluded One-time cross-sectional studies, single case reports, case series, review articles, commentaries, letters, and studies that did not contain original data, as well as studies following participants for less than 3 months. Databases were searched from inception through November 2014 with a search strategy and inclusion / exclusion criteria informed by researchers with expertise in conducting systematic reviews. Three studies (2 in Italy; 1 in Belgium) met inclusion criteria, and they enrolled a total of 247 participants (180 MTF, 67 FTM). Two studies reported on psychological functioning and found a statistically significant reduction in depression, somatization, interpersonal sensitivity, anxiety, hostility, and phobic anxiety/agoraphobia after initiating hormone therapy, with one studying observing significant results 3-6 moths posthormone initiation and the other 12 months posthormone initiation. The analysis determined there is low quality evidence suggesting that quality of life may be improved for MTF individuals accessing hormone therapy. Authors recommend additional longitudinal designs with control groups be conduted in the U.S. to examine outcomes over-time.

19. **Olson-Kennedy J., Warus J. , Okonta V., et al. Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohorts. *Journal of the American Medical Association Pediatrics.* 2018;172(5):431-436.**
Olson-Kennedy et al. conducted original research (cohort study) to examine the amount of chest dysphoria in transmasculine youth who had had chest reconstruction surgery compared with those who had not undergone this surgery. Researchers collected survey data at a large, urban (Los Angeles, CA), hostpital- affiliated ambulatory clinic specializing in transgender youth care. They assessed chest dysphoria composite score (range 0-51, with higher scores indicating greater distress) in all participants; desire for chest surgery in patients who had not had surgery; and regret about surgery and complications of surgery in patients who were postsurgical. Youth were eligible to complete the survey if they were between 13 and 25 years old, assigned female at birth, identified their gender as something other than female, were able to read and understand English, and were able to provide consent. The sample included 136 completed surveys (68 from postsurgical participants [mean age 19, range 14-25 years] and 68 from nonsurgical participants

[mean age 17, range 13-24 years]). Survey results found "Chest dysphoria composite score mean (SD) was 29.6 (10.0) for participants who had not undergone chest reconstruction, which was significantly higher than mean (SD) scores in those who had undergone this procedure (3.3 [3.8]; P < .001)." Additionally, "Among the nonsurgical cohort, 64 (94%) perceived chest surgery as very important, and chest dysphoria increased by 0.33 points each month that passed between a youth initiating testosterone therapy and undergoing surgery." All postsurgical participants affirmed the statement, "It was a good decision to undergo chest reconstruction." Among the postsurgical cohort, the most common complication of surgery was loss of nipple sensation, whether temporary (59%) or permanent (41%). Serious complications were rare and included postoperative hematoma (10%) and complications of anesthesia (7%). Self-reported regret was near 0." One participant, who was older than age 18 years at the time of surgery, reported experiencing regret "sometimes." Authors noted that the nonsurgical participants were comprised of a convenience sample and that there could be unknown imbalances between the nonsurgical and postsurgical cohorts that may have counfounded findings. Authors concluded, "chest dysphoria was high among presurgical transmasculine youth, and surgical intervention positively affected both minors and young adults."

20. **Owen-Smith A., Gerth J. , Sineath R.C., et al. Association between gender confirmation treatments and perceived gender congruence, body image satisfaction and mental health in a cohort of transgender individuals. *Journal of Sex Med.* 2018;15(4):591-600.**

Owen-Smith et al. examine the degree to which individuals' body-gender congruence, body image satisfaction, depression and anxiety differed by gender confirmation surgeries groups in cohorts of transmasculine (TM) and transfeminine (TF) individuals. Researchers invited 2,136 individuals to participate, and 697 (33% response rate) completed the survey, including 347 TM and 350 TF individuals. Authors noted more than half of survey respondents (55% of TM and 57% of TF respondents) were non-Hispanic Whites. The proportion of Hispanics (19%) was similar to that of the overall cohort (from which the sample was driven), but the proportion of Blacks and Asians were lower (3% and 7%, respectively) that the larger study. Authors accounted for this non-response by applying weighted models. Just 4% of survey respondents had no history of gender-confirming treatment and approximately one-third received hormone therapy without any surgery. Top surgery was more common among TM participants (41% compared to 8% among TF participants), while bottom surger was more common among TF (33%) compared to TM (11%) of participants. Seven individuals reported receiving surgery (most TM who had top surgery) but not hormone treatment. "Receipt of procedures aimed at changing secondary sex characteristics was reported in 11.5% of participants (1.2% of TM and 21.7% of TF individuals). Authors found, "The proportion of participants with low body-gender congruence scores was significantly higher in the 'no treatment' group (prevalence ratio [PR]=3.96, 95% confidence interval [CI] 2.72–5.75) compared to the 'definitive bottom' surgery group." Weighted models adjusting for non-response were generally similar to the main findings. Overall, among both TM and TF participants, "body-gender congruence and body image satisfaction were higher among individuals who had more extensive GCT compared to those who have received less treatment or no treatment at all." Additionally, results also indicated that "depression, and especially anxiety, were lower among individuals who received a more extensive GCTs compared to those who received less treatment or no treatment at all." Authors recommend additional research to ascertain the benefits and harms of interventions, particularly

for thos with more severe pre-existing psychiatric illness and those with varying levels of social support. Authors noted in study limitations that those enrolled in the larger study sampled may not be representative of the transgender population in the U.S. (e.g., socioeconomic status, insurance status, etc.)

21. **Nahata L. , Quinn G.P. , Caltabellotta N.M. , et al. Mental Health Concerns and Insurance Denials Among Transgender Adolescents. *LGBT Health.* 2017;4(3):188-193.**
Nahata et al. conducted a retrospective medical record review (2014-2016) to examine: "(1) the prevalence of mental health diagnoses, self-injurious behaviors, and school victimization and (2) rates of insurance coverage for hormone therapy, among a cohort of transgender adolescents at a large pediatric gender program, to understand access to recommended therapy." Researchers identified 79 records (51 transgender males, 28 transgender females) that met inclusion criteria (mean age: 15 years, range 9-18). According to authors, gonadotropin-releasing hormone (GnRH) analogues, or "puberty blockers," are often recommended in the early stages of puberty to "prevent or alleviate dysphoria, by averting permanent changes to the body that misalign with identified gender." While long-term outcome data have not yet been collected in the U.S., "a Dutch group found that adolescents managed in a multidisciplinary healthcare setting with puberty suppression followed by gender affirming hormone therapy had similar mental health out comes to those observed in the general population." Data indicate decreases in depressive symptoms, reduced behavioral and emotional problems, and an improvement in general functioning among adolescents following administration of puberty blockers. Authors cite evidence that "socially transitioned prepubertal transgender children had similar mental health outcomes as age-matched controls." Review of medical records found 92.4% of patients had been diagnosed with one or more of the following mental health conditions: depression, anxiety, PTSD, eating disorders, ASD, and bipolar disorder. Additionally, 74.7% of subjects reported suicidal ideation, 55.7% exhibited self-harm, and 30.4% had a history of at least one suicide attempt. Of the 27 patients prescribed GnRH analogues, 8 (29.6%) received insurance coverage (median age: 15.3 years, range: 12.8-17.3 years) and began therapy. One patient who did not receive insurance coverage paid out of pocket. "Of the remaining 18 patients, 2 had no documented information about coverage and 16 were denied coverage (mean age: 15.3 years, range: 10.8-18.8 years) and could not start treatment." Of the 16 patients who were denied insurance coverage for GnRH analogues, "4 subsequently had documentation of beginning gender-affirming hormone therapy; the median time between...insurance denial and start date for hormone therapy was 9 months (range: 8-20 months)." Despite the cohort's high risk for suicide attempts, suicidal ideation, and self-harm and clear recommendations from professional organizations as to the importance of hormonal therapy, insurance companies denied access to puberty blockers for the majority of transgender adolescents in this study. Authors conclude, low insurance coverage rates and prohibitively high out-of-pocket costs for puberty suppression leaves many youth unable to access treatment.

22. **Turban J.L., King D. , Carswell J.M., et al. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics.* 2020;145(2).**
Turban et al. used data from the 2015 US Transgender Survey (USTS), a cross-sectional survey of 20,619 transgender adults aged 18 to 36 years, to examine self-reported history of pubertal suppression during adolescence. Authors restricted the analysis to those 17 of younger in 1998 (i.e., the year pubertal suppression for transgender youth became available in the US). Authors

further restricted data to those who selected “puberty blocking hormones (usually used by youth ages 9–16)” in response to the question “Have you ever wanted any of the health care listed below for your gender identity or gender transition? (Mark all that apply).” This resulted in a sample of 3,494 individuals between the ages of 18 and 36 years (mean age 23.4 years) who ever wanted pubertal suppression as part of their gender-affirming medical care. The final sample was 45.2% assigned male at birth. Authors used multivariable logistic regression to examine associations between pubertal suppression and adult mental health outcomes, including measures of suicidality. Authors controlled for demographic variables (i.e., age, age of social transition, age of initiation of gender-affirming hormone therapy, current gender identity, sex assigned at birth, sexual orientation, race, education level, employment status, relationship status, total household income at time of collectoin in 2015, family support for gender identity, and current hormone treatment. This was the first study examining access to pubertal suppression and suicidality. "Of the sample, 3,494 [16.9%] reported that they ever wanted pubertal suppression as part of their gender-related care [...] Of them, 89 [2.5%] received pubertal suppression." Authors noted that wanting this pubertal suppression as part of their care may have been influenced by an individual's knowledge of the treatment at the developmentally suitable time. Additionally, it may reflect "the diversity of experience among transgender and gender-diverse people, highlighting that noat all will want every type of gender-affirming intervention." Variables associated with those who wanted and received pubertal suppression compared to those who wanted but did not receive it were: younger age, age of social transition, age of initiation of hormonal therapy, feminine gender identity, male sex assigned at birth, heterosexual sexual orientation, higher total household income, and greater family support of gender identity." Nonbinary and genderqueer respondents were less likey to have accessed pubertal suppression, which authors hypothesized may reflect clinician discomfort delivering this treatment to patients whose gender identity is outside binary categorization. Univariate analyses showed "when comparing those who received pubertal suppression with those who did not, receiving pubertal suppression was associated with decreased odds of past-year suicidal ideation, lifetime suicidal ideation, and past-month severe psychological distress." After controlling for demographic variables, "pubertal suppression was associated with decreased odds of lifetime suicidal ideation." Among those who had received pubertal suppression, 60% traveled less than 25 miles for gender-affirming care, 29% traveled 25-100 miles, and 11% traveled more than 100 miles. Treatment with pubertal suppression among those who wanted it was association with lower odds of lifetime suicidal ideation than those who wanted but did not receive it. Approximately 9 of 10 transgender adults who wanted but did not receive pubertal suppression endorsed lifetime suicidal ideation. Authors conclude results add to existing literature on the relationship between pubertal suppression to improved mental health outcomes. By preventing irreversible, gender-noncongruent changes that result from endogenous puberty (e.g., bone structure, voice changes, breast developmetn, and body hair growth) which may cause significant distress to transgender youth, they are allowed more time to choose whether they want "to induce exogenous gender-congruent puberty or allow endogenous puberty to progress." Additionally, others have theorized that gender-affirming medical care may have benefits related to "implied affirmation of gender identity by clinicians, which may in turn buffer against minority stress."

23. **Glick J.L., Andrinopoulos K.M., Theall K.P., et al. ‘‘Tiptoeing Around the System’’: Alternative Healthcare Navigation Among Gender Minorities in New Orleans. *Transgender Health.* 2018;3.1.**

Glick et al. conducted in-depth interviews with Gender Minority (i.e., transgender and gender nonconforming) individuals to assess alternative navigation strategies used to cope with barriers to healthcare access. Authors conducted in-depth interviews with trans and gender nonconforming individuals (n=18) and healthcare providers (n=5) identified thorugh purposive sampling in New Orleans, LA, in 2015. Members of organizations serving the African American community as well as one white potential participant cited lack of financial incentive and research fatigue as reasons for nonparticipation. Transcribed interview data were coded, sorted, and analyzed for key themes. Commonly identified healthcare barriers included costs and insurance obstacles, identifying a competent providers, and anticipated discrimination. Alternative navigation strategies to covercome biomedical system access barriers included traveling abroad for surgical procedures, ordering hormones online, and sharing with friends. Respondents also discussed covert body modification with illicit silicone as an issue when sourcing outside the biomedical sphere. One respondent noted, "There's tons of underground body modificaiton stuff besides hormones, like silicone injections. [...] A lot of times it's not actually silicone, it's concerning. There have been a few trans people who have pretty major health concerns because of street silicone injections" (Transgender Male, 23, white). Another interviewee shared, "You gotta find someone who likes you, knows what they're doing, and has the proper product. You have to test the product. If you don't know what the product is then you shouldn't even be bothering. If you don't know what the real deal is, leave it alone." (Transgender Woman, age undisclosed, African American). Authors concluded, "the healthcare-seeking behavior of [trans and gender nonconforming] individuals demonstrates great resilience....[commitment] to accessing gender-affirming care regarless of associated risks of care outside of provider supervision."

24. **Julian J.M., Salvetti B, Held J.I. , et al. The Impact of Chest Binding in Transgender and Gender Diverse Youth and Young Adults. *Journal of Adolescent Health.* 2020(2020):1-6.**

Julian et al. conducted a national, cross-sectional study to understand binding trends among adolescents and young adults and to recognize how chest binding impacts chest dysphoria and life satisfaction. Researchers collected 684 surveys from adolescents and young adults aged 13-24 years. Authors were able to compare responses from participants who bind and those who do not bind. Participants in the binding cohort reported less "misgendering" than did the non-binding cohort. Authors noted, "Previous literature has addressed the negative impact of being misgendered on individuals' mental health; however, this is the first study to connect the impact of chest binding, specifically on misgendering."

25. **James S.E., Herman J.L. , Rankin S. , et al. The Report of the 2015 U.S. Transgender Survey Washington, DC: National Center for Transgender Equality;2016.**

This report summarizes the results of the 2015 U.S. Transgender Survey (USTS) and provides insights into the impact of stigma and discrimination on the health of many transgender people. The 2015 USTS is the largest survey examining the experiences of transgender people in the U.S. It includes 27,715 respondents from all fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases oversees. Respondents encountered high levels of mistreatment when seeking health care. For example, in the year prior to completing the survey, one-third (33%) of those who saw a health care provider had at least one negative experience related to being transgender (e.g., being verbally harassed or refused treatment due to

their gender identity). "Nearly one-quarter (23%) of respondents reported that they did not seek the health care they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person, and 33% did not go to a health care provider when needed because they could not afford it." Fifty-four percent of respondents to the U.S. Transgender Survey experienced some form of IPV and 24% reported severe physical violence by an intimate partner, compared to 18% of the U.S. population. The report also provides insight into the compounding impact of other forms of discrimination.

26. **Health World Professional Assocation for Transgender. Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. 2016.**

In this WPATH Position Statement, the international, interdisciplinary, professional organization outlines medical necessity and the importance of clinically appropriate treatments being determined on an individualized and contextual basis, in consultation with the patients medical proviers. "The current Board of Directors of the WPATH herewith expresses its considered opinion based on clinical and peer reviewed evidence that gender affirming/confirming treatments and surgical procedures, properly indicated and performed as provided by the Standards of Care, have proven to be beneficial and effective in the treatment of individuals with transsexualism or gender dysphoria. Gender affirming/confirming surgery, also known as sex reassignment surgery, plays an undisputed role in contributing toward favorable outcomes."

27. **Kates Jen, Ranji Usha, Beamesderfer Adara, et al. Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.: The Henry J. Kaiser Family Foundation; 2015:1-27.**

This Kaiser Family Foundation issue brief provides an overview of the challenges sexual and gender minorities experience in accessing health care. The analysis categorizes barriers as structural, economic, or social and examples include gaps in insurance coverage, cost-related hurdles, and poor treatment from health care providers, respectively. Authors also discuss the intersection of sexual orientation and gender identity with other factors (e.g., sex, race/ethnicity, and class) that shape an individual's health, access to care, and experience with the health care system. Authors also discuss barriers to care experienced by the transgender population, which is much more likely to live in poverty and less likely to have health insurance than the general population. One survey found that 48% of transgender respondents had postponed or went without care when they were sick because they could not afford it. Additionally, authors found evidence that "many health plans include transgender-specific exclusions that deny transgender individuals coverage of services provided to non-transgender individuals, such a surgical treatment related to gender transition, mental health services, and hormone therapy." Moreover, studies show that up to 39% of transgender people have faced some type of harrassment or discrimination in health care settings. This is further complicated by the general lack of competent training provided in medical schools and public health school curricula regarding LGBT health issues. The report presents additional information indicating groups within the LGBTQIA population are at greater risk of sexual assault and other negative reproductive health related outcomes.

28. **Macapagal K., Bhatia R., Greene G. J. Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults. *LGBT Health.* 2016;3(6):434-442.**
Macapagal et al. evaluated healthcare access, use, and experiences in a diverse, predominantly racial and ethnic minority (86%) sample of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) emerging adults (N=206) aged 18-27 years, a group with unique barriers to healthcare. Conducted in a large, Midwestern city, a longitudinal study used a community sample of participants (ages 13 to 24 years old at baseline) who identified as LGBT, queer, or questioning (i.e., reporting some degree of same-sex attraction or behavior, but unsure of or questioning their sexual orientation identity). This article analyzed data from 206 participants who answered questions about their experiences at the 48-month follow-up assessment from June 2012-March 2013. Most participants identified as assigned female at birth (55%) and gay or lesbian (61%). Ten percent of the sample identified as transgender (14 transgender women, 6 transgender men, and 1 person who identified as transgender and nonbinary). Two transgender women identified as heterosexual with respect to their gender identity, while the other transgender individuals identified as LGBQ. Results indicate that 43% of respondants were uninsured and 26% had no usual place of care. The majority of participants (84%) had not been denied service or equal tratment and were not verbally harassed/disrespected in healthcare settings because of their LGBTQ identity. However, transgender patients were statistically significantly more likely than cisgender participants to experience these barriers (P<0.001), and queer/questioning individuals reported them at higher rates compared to gay/lesbian and bisexual individuals (P=0.001). While most participants (88.3%) did not report postponing or not seeking medical treatment due to LGBTQ-based discrimination, transgender participants were more likly than cisgender participants to delay care (P<0.001). Similarly, queer/questioning participants reported delaying care more frequently than gay/lesbian and bisexual participants (P=0.038). Additionally, of those participants who reported disclosing their LGBTQ identity to their provider, those who identified as transgender were more likely to report a negative outcome than cisgender participants (P<0.001). Queer/questioning respondants also reported negative effects at higher rates than did gay/lesbian and bisexual participants (P=0.001). These results support evidence that subgroups within the LGBTQ community experience greater barriers to care related to their sexual orientation or gender identities. Authors conclude that "[a]lthough LGBTQ emerging adults experienced fewer barriers to care than observed in previous studies on LGBTQ adults, the results suggest that queer, questioning, and transgender individuals may face additional healthcare challenges compared with their LGB and cisgender counterparts." The generalizability of findings is limited by the sample size; the fact that participants were recruited from one urban area, which may not be representative of the access to LGBT-inclusive healthcare; the focus on participants' perceptions of healthcare experiences rather than objective experiences; and that comparisons to cisgender heterosexual emerging adults were made to existing national data.

29. **National Survey on LGBTQ Youth Mental Health.New York, New York: The Trevor Project;2019.**
The Trevor Project conducted a quantitative cross-sectional design to collect data using an online survey platform between February 2, 2018 and September 30, 2018. A sample of youth ages 13-24 years was recruited via targeted ads on social media. A total of 34,808 youth completed the online survey. A final sample of 25,896 eligible participants (i.e., lived in the U.S., LGBTQ

identity) were included after excluding those who did not complete more than half of survey items, completed the survey within 3 minutes, or input mischievous answers (e.g., selected all religious affiliations, race/ethnicity options, provided obvious hate speech against LGBTQ in free response items). The sample included participants who identified as white (72%), Hispanic (14%), mixed race (7%), Asian (3%), Black (3%), and American Indian/Alaska Native (1%). Participants were diverse in sexual orientation (45% gay or lesbian, 33% bisexual, and 22% something else) and gender identity (35% cisgender male, 33% transgender and non-binary, and 32% cisgender female). Overall, 39% of LGBTQ youth seriously considered attempting suicide in the previous 12 months, "with more than half of transgender and non-binary youth having seriously considered." Over 18% of LGBTQ respondents attempted suicide in the previous 12 months. Moreover, 29% of transgender and non-binary respondents reported having attempted suicide compared to 14% of cisgender respondents. Younger youth (ages 13-17) reported considering suicide (47%) and attempting suicide (26%) more than older youth (ages 18-24; 31% and 11%, respectively). Additionally, 71% of respondents reported feeling sad or hopeless for at least two weeks in the past year. "[Seventy-eight percent] of transgender and non-binary youth reported being the subject of discrimination due to their gender identity and 70% of LGBTQ youth reported discrimination due to their sexual orientation." Results indicate that "[g]ender identity (for those identifying as transgender and non-binary) is disclosed at a lower rate than sexual orientation (for those not identifying as straight)." Among both groups, disclosure is greatest to their LGBTQ friends (1) and straight friends (2) and lowest to their doctor or healthcare professional. Respondents reported disclosure of their sexual orientation (43%) and disclosure of their gender identity (40%) to a teacher or guidance counselor.

30. **U.S. Department of Justice. Responding to Transgender Victims of Sexual Assault Justice for Victims - Justice for All [Program Website]. Available at: https://ovc.ojp.gov/sites/g/files/xyckuh226/files/pubs/forge/sexual_numbers.html. Accessed 8 February 2021, 2021.**

This U.S. Department of Justice's Office of Justice Programs' Office for Victims of Crime (OVC) webpage provides statistics documenting transgender people's experience of sexual violence. OVC cites evidence that 1 in 2 transgender individuals are sexually abused or assaulted at some point in thier lives. Moreover, certain subpopulations are at greater risk of victimization. For example, "the 2011 *Injustice at Every Turn: A Report* of the National Transgender Discrimination Survey found that 12 percent of transgender youth report being sexually assaulted in K–12 settings by peers or educational staff; 13 percent of African-American transgender people surveyed were sexually assaulted in the workplace; and 22 percent of homeless transgender individuals were assaulted while staying in shelters." Evidence indicates that 15 % of transgender individuals report being sexually assaulted while in police custody or jail, "which more than doubles (32%) for African-American transgender people."

31. **Lefevor T.G., Boyd-Rogers C.C., Sprague B.M., et al. Health Disparities Between Genderqueer, Transgender, and Cisgender Individuals: An Extension of Minority Stress Theory. *Journal of Counseling Psychology.* 2019;66(4):385-395.**

Lefevor et al. conducted analyses to examine differences between demographic and outcome measures of cisgender, transgender, and genderqueer individuals. The study sample was pulled from the Center for Collegiate Mental Health's 2012-2016 database. Of the 278,100 eligible students, 892 identified as transgender (0.3%). Researchers then randomly selected a comparison

sample of 892 cisgender women, 892 cisgender men, 892 transgender individuals, and 892 individuals self-identifying their gender (hereafter *genderqueer*), yielding a final sample of 3,568 students. The sample was largely white (71.6%), young (mean age = 22.08 years), undergraduate (87.55%), and diverse regarding religious orientation. Authors used the Standardized Data Set of questions routinely completed by students during initial visits to college counseling centers, including demographic variables, experiences (*Never, 1, 2-3, 4-5, 5+)* of victimization (i.e., experiencing harassing, controlling, and/or abusive behavior from another person; expericencing a traumatic event; and having sexual contact without giving consent), and activities (*Never, 1, 2-3, 4-5, 5+)* related to self-harm--suicidality (i.e., made a suicide attempt, seriously considering attempting suicide, and purposely injured themselves without suicidal intent). Authors used SDS and Countiling Center Assessment of Psychological Symptoms--34 (CCAPS-34), a multidimensional measure of psychological distress standardized for use among collge students. Researchers conducted two comparisons: one comparing differences in outcomes between cisgender and transgender and genderqueer individuals and a second compared transgender men and women with genderqueer individuals on outcomes to isolate the effects of having a nonbinary gender identity. Analyses "found significant differences based on gender identity in all three proxies of distral stressors (harassment, trauma, sexual assault)." Transgender and genderqueer individuals were significantly more likely to have experienced harassment, trauma, and sexual assault than cisgender men and women. They also found that genderqueer individuals experienced harassment, trauma, and sexual assault more frequently than do transgender peers. Approximately 50% of genderqueer individuals reported each of these experiences. Authors also found significant differences between gender identity groups on all mental health outcome variables. Transgender and genderqueer individuals were more likely to have experienced generalized anxiety, social anxiety, depression, psychological distress, and eating disorders than do cisgender individuals. Furthermore, genderqueer respondents experienced more generalized anxiety, depression, psychological distress, and eating concerns than do transgender individuals. Finally, transgender and genderqueer individuals were more likely to have engaged in self-injury, have contemplated suicide, have current suicidal ideation, and have made a suicide attempt, than have cisgender women and men. "Approximately two thirds of [transgender and genderqueer] participants had contemplated suicide with nearly half having made an attempt. Meanwhile, differences between transgender and genderqueer individuals were not significant. Overall, authors conclude, "This study suggests that individuals who identify outside the gender binary (e.g., genderqueer, gender nonconforming) experience more discrimination, victimization, poor mental health outcomes, and suicidality or self-harm than do both trans- and cisgender men and women."

32. **Medicine Ethics Committee of the American Society for Reproductive. Access to fertility services by transgender persons: an Ethics Committee opinion. *Fertil Steril.* 2015;104(5):1111-1115.**

This statement by the Ethics Committee of the American Society for Reproductive Medicine explores the ethical considerations surrounding the provision of fertility services to transgender individuals and concludes that denial of access to fertility services is not justified. Although difficult to determine, the World Professional Association of Transgender Health (WPATH) estimates the prevalence from 1:12,000 to 1:45,000 for male-to-female (MTF) individuals and 1:30,400 to 1:200,000 for female-to-male (FTM) individuals. Evidence indicates that "many transgender persons are of reproductive age at the time of transition, and confirms that many may

wish to have children after transition." Historically, individuals who deviate from the heteronormative family have been denied access to assisted reproductive technology (ART). While use of ART by gay and lesbian patients is becoming more accepted, programs vary in their acceptance of transgender patient requests for fertility treatment or fertility preservation. The American Academy of Child and Adolescent Psychiatry affirms that "there is no evidence to support that parents who are....transgender are per se deficient in parenting skills, child-centered concerns, and parent-child attachments compared with heterosexual parents." The Code of Professional Ethics of the American Congress of Obstetricians and Gynecologists (ACOG) states, "the principle of justice requires strict avoidance of discrimination based on sexual orientation or perceived gender." Additionally, the ACOG Committee on Health Care for Transgender Individuals reiterates, "ACOG opposes discrimination based on gender identity." Evidence suggests that many transgender patients continue to face stigma and confusion by providers, "often in the form of insensitivity to preferred gender pronouns, displays of discomfort, and substandard care." Authors recommend improving relations between transgender patients and health-care providers by consulting with organizations devoted to supporting transgender people and increasing cultural competency education.

33. **2015 U.S. Transgender Survey: Washington State Report.Washington, DC: National Center for Transgender Equality;2017.**
This report summarizes the experiences of U.S. Transgender Survey (USTS) respondents living in Washington State (N=1,667). Data collected included information regarding health; socioeconomic status; employment; education; housing, homelessness, and shelter access; public accomodations; restrooms; police interactions; and identity documents. In 2015, "29% of respondents experienced a problem in the past year with their insurance related to being transgender." For example, individuals reported being denied coverage for care related to gender transition or for routine care because they were transgender. Of those who saw a health care privider in the past year, 38% reported at least one negative experience related to being transgender (e.g., refused treatment, verbally harassed, physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care). "In the past year, 22% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 32% did not see a doctor when needed because they could not afford it." Moreover, 14% of respondents in Washington were unemployed, 28% were living in poverty, and 37% reported experiencing homelessness at some point in their lives.

34. **Authority Washington State Health Care. Cascade Care FAQs.2020.**
This one-pager about Cascade Care presents Frequently-Asked-Questions about the new Public Option plans in Washington State. It also provides estimates of the number of enrollees on Apple Health, PEBB, SEBB, and Heatlhplanfinder plans.

35. **Transgender Health Program. 2021; Available at: https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transgender-health-program. Accessed 2/4/2021.**
Washington State Health Care Authority's Transgender Health Program outlines specific gender affirming surgical services that are covered through Medicaid fee-for-service.

36. **Kosenko K. , Rintamaki L. , Raney S. , et al. Transgender Patient Perceptions of Stigma in Health Care Contexts. *Medical Care.* 2013;51(9):819-822.**
Kosenko et al. developed and conducted a study to explore transgender patients' experiences with health care. A total of 152 transgender adults were recruited to complete an online questionnaire about their health care. Questions asked if and how patients had been mistreated. Participants' description of mistreatment were analyzed and grouped thematically. Six themes emerged: gender insensitivity, displays of discomfort, denied services, substandard care, verbal abuse, and forced care. The most frequently reported problematic health care interactions related to gender insensitivity (31.46%), displays of discomfort (28.67%), and denial of services (20.97%). Authors suggest findings be used to increase providers' cultural competency and inform their interactions with transgender patients. Study strengths include: 1) highlighting voices within a group that has historically been marginalized and silenced and 2) providing specific examples of provider behaviors perceived as insensitive by transgender patients. Limitations include "the use of nonprobability sampling techniques, which limits generalizability" and the study's failure to assess when the instances of mistreatment occurred.

37. **Discrimination in America: Experiences and Views of LGBTQ Americans. National Public Radio, Robert Wood Johnson Foundation, Harvard T.H. Chan School of Public Health;2017.**
This report is part of a series titled “Discrimination in America", which is based on a survey conducted for National Public Radio, the Robert Wood Johnson Foundation, and Harvard T.H. Chan School of Public Health. "The survey was conducted January 26 – April 9, 2017, among a nationally representative, probability-based telephone (cell and landline) sample of 3,453 adults age 18 or older." This report presents the results specifically for a nationally representative probability sample of 489 LGBTQ adults. "While many surveys have explored Americans’ beliefs about discrimination, this survey asks people about their own personal experiences with discrimination." A subset of survey questions address discrimination experienced in health care settings. Overall, 18% of LGBTQ Americans report they have avoided doctors or health care out of concern they would be discriminated against. That experience was reported at a higher rate among transgender respondants (22%). Additionally, 31% of transgender individuals surveyed said they have no regular doctor or form of health care and 22% said they were currently uninsured. More broadly, 16% of LGBTQ Americans surveyed said they have been personally discriminated against when going to the doctor or health clinic because they are LGBTQ. Approximately a third of LGBTQ people surveyed said that transgender people in their area often experience discrimination when going to a doctor or health clinic (31%). Moreover, "LGBTQ women are significantly more likely to say that both LGB and transgender people often face discrimination when going to a dotor or health clinic: 23% of LGBTQ women say that where they live, gay, lesbian, or bisexual people are often discriminated against when going to a doctor or health clinic, compared to only 7% of LGBTQ men." Additionally, 43% of LGBTQ women reported that transgender people are often discriminated against at the doctor or health clinic, while only 17% of LGBTQ men shared this perspective. Among transgender individuals, 20% said that transgender people often face discrimination when going to a doctor or health clinic and 10% report being personally discriminated against because they are transgender when accessing health care. In regards to the quality of available doctors or health care services in thier area, 11% of LGBTQ Americans surveyed said their community environment was worse than in other places to live and 35% reported it to be better than other places. Researchers report non-

response bias and question wording and ordering as potential sources of non-sampling error. Researchers compensated by weighting sample data by cell phone/landline use and demographics (sex, age, education, and Census region) to reflect the true population.

38. **Mansh Matthew, Garcia Gabriel, Lunn Mitchell R. From Patients to Providers: Changing the Culture in Medicine Toward Sexual and Gender Minorities.** ***Academic Medicine.*** **2015;90(5):574-580.**

This perspective considers the needs of sexual and gender minorities (SGMs), inclusive of all nonheterosexual and/or noncisgender individuals, and discuss potential strategies to improve access to quality care for SGM patients by focusing on the negative culture in medicine towards SGM providers. Authors cite evidence from a 2014 survey, in which the majority of LGBT patients believed that "providers were not prepared to care for them." Additionally, more than half reported experiencing discrimination when accessing health care. Others reported denial of care due to the provider's religious belief or that providers lack the necessary knowledge to provide appropriate care. Authors discuss "1) modernizing research on the physician workforce, 2) implementing new policies and programs to promote supportive training and practice environments, and 3) developing recruitment practices that ensure a diverse, competent, physician workforce inclusive of SGM individuals."

39. **Carrotte E. R., Vella A. M., Bowring A. L., et al. "I am yet to encounter any survey that actually reflects my life": a qualitative study of inclusivity in sexual health research.** ***BMC Med Res Methodol.*** **2016;16:86.**

Carrotte et al. conducted a qualitative study with young gender and sexually diverse (GSD) people to inform inclusive changes to the annual *Sex, Drugs, and Rock'n'Roll* (SDRR) survey of general and sexual health. Researchers convened two semi-structured focus groups in Melbourne with a total of 16 participants (age range: 21-28 years) who were were mostly cisgender women, and there were two transgender participants and one non-binary participant. Participants had a range of sexual identities including lesbian, queer, bisexual, pansexual, and asexual. Focus group discussions were transcribed verbatim and analysed thematically. Participants identified heteronormativity, which "describes a set of social assumptions and norms which are based on heterosexual, cisgender [gender identity matches sex assigned at birth] experiences, influenced by social biases, privileges and stereotyping" as a barrier to sexual healthcare. Specifically, heteronormativity specifically serves as a barrier to sexual health-seeking behavior. Participants identified physician discomfort and stigmatizing lanugage or assumptions about a patients' sexual experiences as common barriers to developing rapport and receiving appropriate care. Transgender participants "acknowledged the difficulties of understanding and communicating their sexual health needs to doctors who appeared uncomfortable or were unfamiliar with transgender experiences and bodies. Additionally, most participants expressed that heteronormativity facilitates text-based miscommunication. "Participants reported specific challenges with completing forms with regards to gender and sex – including having no options that describe them, not knowing how to ‘best’ respond to questions, and trying to balance providing accurate information with information that actually describes their experiences." Specifically, the common choice between 'male' and 'female' can be upsetting for transgender and non-binary people.

40. **Klein D. A., Berry-Bibee E. N., Keglovitz Baker K., et al. Providing quality family planning services to LGBTQIA individuals: a systematic review. *Contraception.* 2018.**
Klein et al. conducted a systematic review to synthesize findings from peer-reviewed literature examining the provision of family planning services, specifically services to prevent or achieve pregnancy, to lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA) clients to inform clinical and research strategies. Of the 7193 abstracts published from January 1985 through April 2016 that met search parameters; 19 descriptive studies met inclusion criteria. Two included studies focused on the perspectives of health care providers towards LGBTQIA clients. While 17 studies that documented client perspectives; of those 12 elucidated factors facilitating a client's ability to enter into care, and 13 examined client experience during care. Two studies specifically discussed confidentiality as a barrier to LGBTQ youth accessing services. In 1998, Allen et al. conducted a client-level study in Colorado and Wyoming with gay, lesbian, and bisexual youth (n=102) ages 18-23 years. Barriers included concerns about confidentiality. Results showed, "participants who reported being informed about their right to medical confidentiality were three times more likely to have discussed sexual orientation with their provider." A 2002 study by Ginsburg et al. included self-described LGBTQ youth ages 14 to 23 years (n=94). Participants expressed privacy concerns including fear about information related to their sexuality getting back to their parents.

41. **Obedin-Maliver J., Makadon H. J. Transgender men and pregnancy. *Obstet Med.* 2016;9(1):4-8.**
This commentary reviews basic issues for clinicians to consider when caring for a transgender man or other gender-nonconforming individual "whose gender identity is different than their female sex assigned at birth, and who are considering, are carrying, or who have completed a pregnancy." The article provides guidance for learning and teaching reasonable standards of care to provide gender-affirming quality care. Authors cite evidence that there remains a gap between information taught in health professional schools and postgraduate training programs and the needs of transgender individuals. The article discusses fertility, psychological considerations, physical considerations, pregnancy completion and outcomes, and pregnancy and postpartum management.

42. **Obedin-Maliver Juno, Goldsmith Elizabeth S., Stewart Leslie, et al. Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education. *JAMA.* 2011;306(9):971-977.**
Obedin-Maliver et al. developed and piloted a 13-question, Web-based questionnaire between May 2009 and March 2010 to "characterize LGBT-related medical curricula and associated curricular development practices and to determine deans' assessment of thier institutions' LGBT-related curricular content." Of the 176 allopathic or osteopathic medical schools in Canada and the United States surveyed, 150 (85.2%) responded, and 132 (75.0%) fully completed the questionnaire. The median reported time dedicated to teaching LGBT-related content in the entire curriculum was 5 hours (interquartile range [IQR], 3-8 hours). Of the 132 schools that completed the questionnaire, 9 (6.8%; 95% CI, 2.5%-11.1%) reported 0 hours during preclinical years and 44 (33.3%; 95% CI, 25.3%-41.4%) reported 0 hours during clinical years. Deans were also asked to report the presence or absense of 16 LGBT-related topics either required or provided within the elective curriculum. Of those 132 institutions that completed the questionnaire, 83 (62.9%) reported teaching at least half the 16 topics and 11 (8.3%) reported

teaching all 16: sexual orientation, HIV, gender identity, STI, safer sex, DSD/Intersex, barriers to care, mental health issues, LGBT adolescents, coming out, unhealth relationsihps/IPV, substance use, chronic disease risk, SRS, body image, and transitioning. Authors concluded that "the median reported time dedicated to LGBT-related topics in 2009-2010 was small across US and Canadian medical schools, but the quantity, content covered, and perceived quality of instruction varied substantially." Many deans endorsed dissatisfaction with their institutions' coverage of LGBT-related topics and suggested strategies for increasing curricular content.

43. **Children's Seattle. Puberty Blockers. In: Seattle Children's AM, ed2016.**
This patient and family education resource includes information on puberty, the use of puberty blockers and how they work as well as a discussion of risks and cost.

44. **Peitzmeier S., Gardner I , Weinand J. , et al. Health impact of chest binding among transgender adults: a community-engaged, crosssectional study. *Culture, Health & Sexuality.* 2017;19(1):64-75.**
Peitzmeier et al. conducted a cross-sectional survey of transgender and gender non-conforming adutlls to assess the health impacts of chest binding. The survey was conducted online with a non-random sample of adults who were assinged a female sex at birth and had had experience of binding (n=1800). Of participants, 51.5% reported daily binding an 97% reported at least one of 28 negative outcomes attributed to binding. " Analyses found frequency (i.e., days/week) was consistently associated with negative outcomes (22/28 outcomes). "The most commonly reported outcomes were back pain (53.8%), overheating (53.5%), chest pain (48.8%), shortness of breath (46.6%), itching (44.9%), bad posture (40.3%) and shoulder pain (38.9%)." Symptoms related to skin/soft tissue (46.3%) and pain symptoms (74.0%) were most common. Although binding is associated with many negative physical health outcomes, participants consistently affirmed the advantages of binding outweighed the negative physical effects. Specifically, "Many participants said that binding made them feel less anxious, reduced dysphoria-related depression and suicidality, improved overall emotional wellbeing and enabled them to safely go out in public with confidence." Therefore, options to minimize risk and empower patients with research to make informed decisions balancing their physical and mental health is recommended. Results are the "first empirical evidence on the prevalence and correlates of self-reported health outcomes related to chest binding among transmasculine individuals."

45. **Access Ingersoll Gender Center Healthcare. A Vision for Greater Access to Gender Affirming Healthcare.2019.**
This report from Ingersoll Gender Center is grouned in a vision of "a healthcare system that centers the collective self determination of our communities to be able to determine with our providers the type of gender affirming care that is right for thier health and their bodies, and to have healthcare systems and insuracne companies support and honor those decisions instead of impeding them." Officially formed in 1977, Ingersoll is one of the oldest organziations by and for transgender and gender nonconforming communities in the U.S. This report was informed by two focus groups that had a total of 25 attendees (held in October 2018) and 87 survey responses (conducted in Fall 2018). Focus group questions provided a deeper dive into questions about the barriers community members faced when accessing gender affirming healthcare that could not be addressed in the survey. Data were reviewed and compared to trends seen in the organization's direct services and data from other sources when possible. In the combined sample, 31% of

participants identified as people of color; 56% identified as disabled, sick, and/or chronically ill; and 52% of respondents made less than $24,000 per year. Specific to survey participants, 54% were non-binary/gender non-conforming, 24% were trans women/trans femme; and 22% were trans men/trans masc. Focus groups had a similar breakdown, however there was a higher percentage of trans women/trans femmes who participated in focus groups. Authors noted that there is a lack of trans led research on the healthcare experiences due to institutional barriers communities face. Moreover, existing research is often not led by trans people and focuses on negative outcomes. The report highlights both negative outcomes as well as community strengths on which to build. Among survey respondents, 71.1% know what kind of insurance coverage plan they have and a pretty good idea of what that plan covers. However, 47% of survey respondents couldn't find a gender affirming surgeon that would work with their insurance. "Community members cited confusing standards of care and insurance practices as the largest barriers outside of cost that prevented them from accessing the gender affirming care they needed." Results highlighted confusion in navigating changing policies (i.e. federal and state laws and rulings related to their rights and access to care). More than half of survey respondents and focus group participants reported they were "not aware or inconsistently aware of the gender affirming care that they are entitled to" and "either did not know or weren't sure if they understood Washington State & Federal laws and rulings that guaranteed thier righs and access to medical care." This confusion often resulted in delayed life saving gender affirming healthcare. Ingersoll also found that the trans folks on Apple Health insurance who responded to the survey were more likely than thos on other types of insurance plans to be: experiencing homelessness or unstable housing (25% compared to 7.4%); a person of color (46.8% compared to 31.4%); making less than $25,000 (84.3% compared to 33%); and disabled (62.5% compared to 53%). Among those on Apple Health, 33% reported that their therapist did not bill insurance. Additionally, unlike other groups, "transgender and gender diverse people on Apple Health reported that a major barrier to getting the care they needed - specifically surgeries - was the burdensome qualifications around needing letter written by providers." Authors also included information from a provider survey sent to the consult group for over 500 providers committed to learning best practices and expanding access to gender affirming care. "Providers noted the urgen need to address systemic barriers in the Apple Health system - like the need to access doctoral level mental health credentials for surgical referral letters." Just 9.9% of responding providers had doctoral level mental health credentials. Funding for this report came from Communities of Opportunity and Seattle Foundation