

**STATE OF CONNECTICUT
COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES**

**IN RE: PETITION FOR DECLARATORY RULING REGARDING
HEALTH INSURERS' CATEGORIZATION OF CERTAIN GENDER CONFIRMING
SURGERIES AS COSMETIC**

AFFIDAVIT OF RANDI ETTNER, PH.D.

1. I am a licensed clinical and forensic psychologist with a specialization in the diagnosis, treatment, and management of individuals with gender dysphoria. I received my doctorate in psychology (with honors) from Northwestern University in 1979. I am a Fellow and Diplomate in Clinical Evaluation of the American Board of Psychological Specialties, and a Fellow and Diplomate in Trauma/Post-Traumatic Stress Disorder.

2. I have evaluated, diagnosed, and treated 3,000 individuals with gender dysphoria and mental health issues related to gender variance from 1980 to the present. I have published four books related to the treatment of individuals with gender dysphoria, including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey & Eyler; Rutledge 2007); and the 2d edition (co-editors Monstrey & Coleman; Routledge, June 2016). In addition, I have authored numerous articles in peer-reviewed journals regarding the provision of health care to the transgender population. I have served as a member of the University of Chicago Gender Board and am on the editorial boards of The International Journal of Transgenderism and Transgender Health. I am the Secretary and a member of the Board of Directors of the World Professional Association of Transgender Health (WPATH), and an author of the WPATH *Standards of Care for the Health of Transsexual, Transgender and Gender-nonconforming People* (7th version) (hereinafter "Standards of Care"), published in 2011. I have lectured throughout North America, Europe,

South America and Asia on topics related to gender dysphoria and have given grand rounds on gender dysphoria at university hospitals. I am the honoree of the externally-funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. I have been an invited guest at the National Institute of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and in November 2017 was invited to address the Director of the Office of Civil Rights of the United States Department of Health and Human Services regarding the medical treatment of gender dysphoria. I received a commendation from the United States Congress House of Representatives on February 5, 2019 recognizing my work for WPATH. A copy of my *Curriculum Vitae* is attached as Exhibit A.

3. Facial feminization surgery, breast augmentation and related treatments that bring the body into congruence with an individual's affirmed gender are essential, and often life-saving, treatments for gender dysphoria. I submit this affidavit to describe: (1) the goals of treatment for gender dysphoria; (2) the necessity of treatments that bring the body into congruence with an individual's affirmed gender; and (3) specifically, the scientific literature establishing the safety, efficacy and medical necessity of facial feminizing surgeries when used as treatment of gender dysphoria.

4. The term "gender identity" is a well-established concept in medicine, referring to one's internal sense of their own gender. All human beings develop the conviction of belonging to a particular gender, such as male or female, early in life.

5. At birth, infants are classified as male or female. This classification becomes the person's birth-assigned sex. For most people, their gender identity matches the sex they were assigned at birth. Generally, persons born with the typical physical characteristics of males have

a male gender identity, and those with the typical physical characteristics of females have a female gender identity. However, for transgender individuals, this is not the case.

6. An individual whose gender identity is different than their assigned birth sex is transgender.

7. If unaddressed, the incongruence between a transgender person's birth-assigned sex and one's gender identity may result in gender dysphoria, a serious medical condition characterized by clinically significant and persistent distress and discomfort with one's assigned birth sex.

8. Because gender dysphoria results from an incongruence between gender identity and assigned sex at birth, a person with a diagnosis of gender dysphoria is transgender.

9. The diagnostic criteria for gender dysphoria in Adolescents and Adults is set forth in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (302.85) and are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

10. Without treatment, individuals with gender dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues. They are often socially isolated as they carry a burden of shame and low self-esteem, attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time damages the development of a healthy personality and interpersonal relationships. Without treatment, many people with gender dysphoria are unable to adequately function in occupational, social or other areas of life.

11. Gender dysphoria is highly treatable and can be ameliorated or cured through medical treatment. The standards of care for treatment of gender dysphoria are set forth in WPATH's Standards of Care. The WPATH Standards of Care are the internationally recognized guidelines for the treatment of gender dysphoria, and inform medical treatment throughout the world. The *American Medical Association*, the *Endocrine Society*, the *American Psychological Association*, the *American Psychiatric Association*, the *World Health Organization*, the *American Academy of Family Physicians*, the *American Public Health Association*, the *National Association of Social Workers*, the *American College of Obstetrics and Gynecology* and the *American Society of Plastic*

Surgeons all endorse protocols in accordance with the WPATH Standards of Care. *See, e.g.,* American Medical Association, Resolution 122 (A-08) (2008); Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. of Clinical Endocrinology & Metabolism 3132, (2009); American Psychological Association Council of Representatives, Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2008).

12. In accordance with the Standards of Care, many transgender individuals undergo a medically-indicated and supervised gender transition. This process ameliorates the debilitation of gender dysphoria and allows transgender individuals to live life consistent with their gender identity. The Standards of Care recommend an individualized approach to gender transition, consisting of one or more of the following protocol components of evidence-based care for gender dysphoria:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g. breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support improving body image; or promoting resilience.

13. A key component of medical treatment for people with gender dysphoria is to live, function in society, and be regarded by others consistent with their gender identity. Because the essence of gender dysphoria is the incongruence of the body and one's identity, the goal of gender

transition is to establish an authentic appearance in a person's affirmed gender in order to eliminate the debilitating symptoms of gender dysphoria. If this goal is impeded, it will undermine an individual's core identity and psychological health.

14. There are fundamental anatomic differences between male and female faces that develop during childhood and puberty. As one group of surgeons described, "certain areas of the face are easily recognizable as masculine or feminine. . . . The principal differences between masculine and feminine facial features are related to bone structure, although other important differing characteristics also exist, such as skin type, distribution of facial hair and fat, type of hair and hairline shape, the prominence of the thyroid cartilage or Adam's apple, and differentiating characteristics in soft tissues." Luis Capitán et al., *Facial Feminization Surgery: The Forehead. Surgical Techniques and Analysis of Results*, 134 *Plastic and Reconstructive Surgery* 609, 610-613 (2014).

15. As Berli et al. noted, "[facial feminization surgery] is not a single procedure, but a collection of operative interventions, many of which overlap with traditional cosmetic surgical procedures." Jens U. Berli et al., *Facial Gender Confirmation Surgery – Review of the Literature and Recommendations for Version 8 of the WPATH Standards of Care*, *Int'l. J. of Transgenderism* 264, 268 (2017). Berli et al. described the various procedures as including structural and nonstructural procedures. Structural procedures include, "Forehead reconstruction (including eyebrow repositioning), techniques to increase or decrease the malar-zygomatic complex, lower jaw and chin contouring, rhinoplasty, and laryngeal chondroplasty." *Id.* at 266. Nonstructural procedures include, "Blepharoplasty, midfacelift/at grafting, upper lip shortening techniques, techniques to readapt the cervical and lower third soft tissues in patients who have undergone mentomandibular recontouring, and hairline treatment or redefinition (medical,

surgical, or transplantation).” *Id.*

16. No treatment for gender dysphoria can be deemed cosmetic. Gender confirming surgeries are not cosmetic procedures because they do not have the goal of enhancing beauty or appearance. Rather, gender confirming surgeries including, but not limited to facial feminizing surgeries, breast and chest surgeries, and genital surgeries, when undertaken to treat gender dysphoria are clinically indicated by medical consensus for purposes of treatment. The goal of facial feminization surgery, for example, is to modify facial characteristics from male to female in order to allow a person to live and function in their affirmed gender, thereby reducing or eliminating their gender dysphoria. The underlying medical diagnosis and the goal of treatment in accordance with accepted medical standards establish the medical necessity of gender confirming surgeries.

17. For some patients, facial feminization surgeries may be the sole and most effective method of treating their gender dysphoria. In addition to the significant dysphoria many transgender women experience when they look in the mirror and see a male face, these procedures also address features that are visible to others on a daily basis. They affect the social perception of gender that determines how a transgender person functions in the world. If an individual with gender dysphoria is being “misgendered” in social, family, work and other settings, this will amplify their dysphoria and exacerbate psychological harm and dysfunction and other sequelae of gender dysphoria. Furthermore, an individual with gender dysphoria who is not able to establish an authentic appearance will be at significant risk of interpersonal violence and discrimination, which threaten not only one’s psychological well-being, but also one’s bodily integrity.

18. The therapeutic goals of facial feminization surgery for transgender women have been

well-described in peer-reviewed medical literature. See, e.g., Kevin Chen et al., *Facial Recognition Neural Networks Confirm Success of Facial Feminization Surgery*, 145 *Plastic and Reconstructive Surgery* 203, 203 (2020) (“For many patients, feminizing the face is an even more important step to their journey of reaching the desired gender than ‘top’ (breast augmentation) or ‘bottom’ (vaginoplasty) surgeries. Being identified as female in everyday exchanges with the public is of utmost importance. In these interactions the face is the main visible feature of determining gender and frequently, despite years of hormonal therapy and expert application of makeup, hair or wigs, patients are often still misidentified as male.”); Jens U. Berli et al., *Facial Gender Confirmation Surgery – Review of the Literature and Recommendations for Version 8 of the WPATH Standards of Care*, *Int’l. J. of Transgenderism* 264, 265 (2017) (“The profound impact masculine facial features have for transfemale patients can affect all aspects of their lives. As a result, individuals may not only continue to suffer from internal dysphoria, but also be facing discrimination and possible social hostility.”); Luis Capitán et al., *Facial Feminization Surgery*, 134 *Plastic and Reconstructive Surgery* 609, 613 (2014) (“[F]acial feminization is a key element in the treatment of gender dysphoria and ... it can be more important from the patient’s psychological point of view, in terms of their psychological adaptation, than the sexual reassignment itself, which is related to the patient’s personal life.”); Tiffany A. Ainsworth et al., *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 *Quality of Life Research* 1019, 1020-1022 (2010) (“The social impact of transition can include ostracization from both work and personal environments. This can include loss of job, home, and social support groups. It is not uncommon for these women to suffer from depression, anxiety and suicidal tendencies The overall goal of FFS is to better align the facial features of gender with the inward identification of gender.”).

19. I am familiar with the scientific literature on the outcomes of facial feminization surgery as treatment for gender dysphoria. This research establishes that facial feminization surgery for transgender females is a safe, effective, evidence-based treatment that improves gender congruence and alleviates the symptoms of gender dysphoria.

20. Principles of evidence-based medicine establish evidence-based grades according to study design and quality. These grades are:

- Level A: Consistent randomized controlled clinical trial, cohort study, all or none, clinical decision rule validated in different populations.
- Level B: Consistent retrospective cohort, exploratory cohort, outcomes research, case-control study, or extrapolations from Level A studies.
- Level C: Case-series study, or extrapolation from Level B studies.
- Level D: Expert opinion, without explicit critical appraisal, or based on physiology, bench research, or first principles.

21. Randomized controlled clinical trials (Level A) are generally not feasible in surgery, including facial feminization surgery, as it is not possible to design an experiment in such a way as to ensure double-blind conditions in which neither group knows whether it received the treatment.

22. Berli et al. conducted a review of the most recent literature on facial feminization surgery, alternatively referred to in this article as Facial Gender Confirmation Surgery (FGCS), focusing on the results of three retrospective cohort studies.

23. The first study reviewed was Ainsworth et al. *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 Quality of Life Research 1019 (2010). This was a study of 247 transgender women who had undergone FGCS either alone or in combination with genital or breast reconstruction. Jens U. Berli et al., *Facial*

Gender Confirmation Surgery – Review of the Literature and Recommendations for Version 8 of the WPATH Standards of Care, Int’l. J. of Transgenderism 264, 266 (2017); Tiffany A. Ainsworth et al., *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 Quality of Life Research 1019, 1019 (2010). Study participants completed standardized and reliable psychometric evaluations. Transgender female patients who had undergone FGCS alone or in conjunction with other gender-confirming surgeries scored substantially higher than participants who underwent only gender-confirming surgery without FGCS or no surgical intervention at all. *Id.* at 1023. The authors concluded that FGCS had substantial benefits to transgender female patients and noted that its results “suggest[] a more satisfactory quality of life outcome in regard to physical, mental and social functioning following FFS than without such surgery.” *Id.* at 1021. Notably, “the [mental component summary] of transwomen with surgical intervention of any sort is not significantly different to that of the general population.” *Id.* at 1023.

24. The second study was Luis Capitán et al., *Facial Feminization Surgery*, 134 Plastic and Reconstructive Surgery 609, (2014). In this study, 91.3% of 172 transgender female patients who underwent forehead contouring alone or in combination with other FGCS procedures were completely satisfied, which Berli et al. conclude “offer[s] more evidence that FGCS has substantial impact on trans female patient quality of life.” *Id.* at 615; Jens U. Berli et al., *Facial Gender Confirmation Surgery – Review of the Literature and Recommendations for Version 8 of the WPATH Standards of Care*, Int’l. J. of Transgenderism 264, 267 (2017).

25. The third study Berli et al. reviewed was Mirco Raffiani et al., *Full Facial Feminization Surgery: Patient Satisfaction Assessment Based on 180 Procedures Involving 33 Consecutive Patients*, 137 Plastic and Reconstructive Surgery 438, 444 (2016). This study concluded that

patients who underwent facial feminization surgery demonstrated significant improvements in quality-of-life evaluation outcome scores.

26. Berli and his co-authors determined that these three studies, in combination, establish “overall Level B evidence for beneficial quality-of-life outcomes for trans female patients after FGCS” and concluded:

FGCS should be treated as a vital gender-confirming tool due to its ability to drastically alter the quality of life of patients undergoing these procedures. *The current level of evidence is close to the maximal level of evidence that can be expected for a surgical procedure.* FGCS can no longer be deemed an aesthetic component of gender-confirming care ... Facial gender confirmation surgery needs to be part of comprehensive surgical gender-confirming care.

Jens U. Berli et al., *Facial Gender Confirmation Surgery – Review of the Literature and Recommendations for Version 8 of the WPATH Standards of Care*, Int’l. J. of Transgenderism 264, 265-268 (2017) (emphasis added).

27. In addition to retrospective data that demonstrate the efficacy of facial feminization surgery to improve quality of life, a prospective multi-center study of 66 adult patients with gender dysphoria found similar results. Ian T. Nolan, et al. *Prospective Quality of Life Outcomes after Facial Feminization Surgery: An International Multi-Center Study*, Abstract., Northeastern Society of Plastic Surgeons (October 2019), <https://meeting.nesps.org/abstracts/2019/64.cgi>. This study demonstrates “improved quality of life outcomes, ‘feminized cephalometrics’ [radiographs of the head to obtain craniofacial images], and high patient satisfaction” in a prospective cohort of transgender women undergoing facial feminization surgery. *Id.* The authors conclude that “this data suggests a valuable role of FFS in gender affirmation for many transgender women and argues for its necessity in treating gender dysphoria in certain patients.” *Id.* An earlier 2017 report of preliminary results from another prospective cohort study with 15 patients utilized a validated

quality of life outcome assessment and concluded that facial feminization surgery “has a significant positive impact on transgender patient quality of life with minimal complications.” Thomas Satterwhite, et al., *Abstract: Prospective Quality of Life Outcomes after Facial Feminization Surgery*, 5 *Plastic and Reconstructive Surgery – Global Open Abstract Supplement* 9S 204, 204 (2017). The authors concluded that “these preliminary results and previous research points to the medical necessity of FFS for transgender patients.” *Id.*

28. A groundbreaking study published in 2020 demonstrated that facial feminization surgical procedures ensure that transgender women are identified as female, which is critical to eliminating the debilitation of gender dysphoria. Kevin Chen et al., *Facial Recognition Neural Networks Confirm Success of Facial Feminization Surgery*, 145 *Plastic and Reconstructive Surgery* 203, 209 (2020). This study used facial recognition neural networks, a type of artificial intelligence, to determine if transgender women who underwent facial feminization surgery are more likely to be perceived as female. *Id.* at 204. Non-transgender female control images were correctly identified as female 98% of the time. *Id.* at 205. Images of transgender women prior to facial feminization surgery were misidentified as male 47% of the time. *Id.* Conversely, images of those same transgender women taken after they received facial feminization surgery were correctly identified 98% of the time. The authors concluded that “[f]acial feminization surgery results in clear, significant and objective improvements in gender recognition.” *Id.* at 209.

29. I have reviewed the assessment of research by Anthem BlueCross BlueShield in Exhibit A to the Petition for Declaratory Ruling in this matter (heading “Facial Feminization and Masculinization Procedures”). Anthem concludes that the research regarding facial feminization surgery is limited to “case series studies” which “do not describe the impact of facial feminization procedures on gender dysphoria symptoms or quality of life using a validated or quantifiable

method.” As demonstrated by the research studies discussed above, Anthem’s assessment is inaccurate and not reflective of current research. In fact, four of the five cited studies by Anthem are prior to 2010.

30. To overcome the ethical challenges of research in plastic and reconstructive surgery, studies must be well-designed and sufficiently powered. This is currently accomplished by larger population multi-center studies, meta-analysis and systematic review. Prospective studies that utilize validated instruments and statistical analysis eliminate bias and generate more robust evidence than poorly designed and underpowered level A graded studies. The growing assemblage of well-designed research documents the efficacy of facial feminization surgery as treatment for gender dysphoria and is consistently statistically significant and irrefutable.

31. Further, it is not true, as Anthem contends, that reports on complication rates are lacking. For example, a 2016 literature review of facial feminization procedures found that out of 1,121 patients, there were only seven complications, which is exceedingly low for any surgery. Shane D. Morrison et al., *Facial Feminization: Systematic Review of the Literature*, 137 *Plastic and Reconstructive Surgery* 1759, 1761 (2016). *See also* Michael B. Cohen et al., Patient Satisfaction After Aesthetic Chondrolaryngoplasty, *Plastic and Reconstructive Surgery - Global Open* (October 2018), https://journals.lww.com/prsgo/Fulltext/2018/10000/Patient_Satisfaction_after_Aesthetic.4.aspx. (concluding that “[a]esthetic chondrolaryngoplasty [commonly referred to as a tracheal shave] is “safe and effective surgery” and that “no patients had permanent voice change”); Jeffrey H. Spiegel, *Facial determinants of female gender and feminizing forehead cranioplasty*, 121 *The Laryngoscope* 250, 259 (2010) (complication rate of less than 2%).

32. The procedures used as part of facial feminization surgery and other treatments, such as

breast augmentation, include many of the same procedures used to treat other medical conditions. For example, blepharoplasty is a treatment for ptosis (drooping eyelids that interfere with vision), facial reconstruction procedures are utilized following oncological surgery or post traumatic injury, breast augmentation is undertaken as part of breast reconstruction following a medically indicated mastectomy, and voice therapy may be indicated after medically indicated surgery on vocal chords. The fact that these analogous procedures are routinely performed and considered safe in medicine provides additional evidence of their safety when performed as treatment for gender dysphoria. There is no basis to conclude that the same procedures are less safe for one diagnosis than another.

33. Importantly, I have been unable to find even a single study of facial feminization surgery that has any findings other than positive results, including the studies cited by Anthem. No study has refuted the positive impact of facial feminizing surgery on transgender women experiencing gender dysphoria. It is unethical from a medical perspective to withhold care that the medical community knows to be safe and effective in treating a serious medical condition.

34. In addition to facial feminization surgery, many other procedures may be medically necessary to treat individualized cases of gender dysphoria. Breast augmentation, for example, is medically necessary for some transgender women who have insufficient breast development from hormone therapy, in order to establish an authentic female appearance. Transgender women who are taller, are big boned, and who may have a lower rib cage will typically need breast augmentation to treat their gender dysphoria. Given the mass and torso size of these individuals, they will appear masculine in a profile and frontal view and will need breast augmentation to balance their size. This is in contrast to a non-transgender woman who chooses breast augmentation to increase her self-esteem with no underlying medical diagnosis. A recent literature

review found that the majority of transgender women (60-70%) do not gain adequate breast development after a sufficient duration on hormone therapy. Katrien Wierckx, *Clinical Review: Breast Development in Trans Women Receiving Cross-Sex Hormones*, 11 J. of Sexual Medicine 1240, 1244 (2014). A prospective cohort study of transgender women undergoing augmentation mammoplasty found that it improved psychosocial well-being postoperatively with no serious complications. Roman Weigart, *Patient Satisfaction with Breasts and Psychosocial, Sexual, and Physical Well-Being after Breast Augmentation in Male-to-Female Transsexuals*, 132 Plastic and Reconstructive Surgery 1421, 1428 (2013).

35. Similarly, there are aspects of voice that highlight feminization or masculinization. Voice or speech therapy may be necessary in appropriate cases for individuals with gender dysphoria to establish an authentic gender presentation. None of these or other similar treatments can be considered cosmetic when prescribed as part of a treatment plan for gender dysphoria. Rather, the medical necessity of a therapy must be assessed on a case-by-case basis depending on the severity and presentation of a person's gender dysphoria.

36. In 2016, WPATH, which is the leading medical association establishing standards of care for treatment of gender dysphoria, issued a Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. WPATH identified certain "medically necessary gender affirming/confirming surgical procedures," including facial feminization surgery, breast augmentation, and voice therapy and/or surgery and concluded that:

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 treatment of the diagnosed condition.

World Prof'l Ass'n for Transgender Health, *Position Statement on Medical Necessity of*

Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. 3 (2016). This position statement updates and clarifies the 7th version of WPATH's Standards of Care, which were drafted in 2010 and issued in 2011.

37. My experience with patients over almost 40 years as a practicing psychologist has underscored the essential and life-saving nature of treatments that allow a person with gender dysphoria to establish an authentic gender appearance. For example, one of my patients was violently assaulted on public transportation because her face revealed a gender appearance inconsistent with how she was otherwise living. In another case, a patient went to renew her passport and was told, "you don't look like a Roxanne." She went home and put a gun to her head. Facial feminizing surgery and other treatments are not cosmetic or optional when undertaken as treatment for gender dysphoria. Rather, they are critical to ensuring that people with that condition can live safely and comfortably free of the distress created by the incongruence between their gender and body.

38. Insurance or benefit policies that categorically exclude certain treatments for gender dysphoria or deem them cosmetic without an assessment of medical necessity for a particular individual, are not reasonably supported by scientific or clinical evidence or standards of professional practice. These exclusions fail to take into account the robust body of research that these procedures alleviate or eliminate gender dysphoria.

SIGNED UNDER THE PENALTIES OF PERJURY THIS/1 DAY OF JANUARY, 28
2020.

Randi Ettner Ph.D.
RANDI ETTNER, PHD.