LEGISLATIVE COMMITTEE MINUTES

SB331

Bill as Introduced

SB 331 - AS INTRODUCED

2018 SESSION

18-2938
01/05

SENATE BILL 331

AN ACT prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

SPONSORS: Sen. Daniels, Dist 11; Rep. Weyler, Rock. 13

COMMITTEE: Finance

ANALYSIS

This bill provides that sex reassignment drug or hormone therapy or surgery shall not be covered under the state Medicaid plan.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

18-2938
01/05

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eighteen

AN ACT prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Findings. The general court hereby finds:
2 I. That citizens living under the 138 percent of federal poverty level have greater medical
3 needs than elective cosmetic surgery and that the state of New Hampshire should prioritize critical
4 care costs over elective cosmetic surgeries for this population.
5 II. Extending coverage for these additional elective cosmetic surgeries will dramatically
6 increase the costs of the program for the taxpayers weakening the financial stability of the program.
7 III. Neither drug or hormone therapy, nor surgery are able to impart the reproductive
8 function of the objective sex, resulting in permanent sterility, possibly violating the Hippocratic
9 oath.
10 IV. Public funding for such procedures may violate the Constitution of the State of New
11 Hampshire regarding rights of conscience and religious liberty.
12 V. The narrow approval of the proposed rule allowing Medicaid provision of these
13 procedures underscores the necessity of public debate and general approval or disapproval of public
14 funding by the general court.
15 2 New Section; Sex Reassignment Surgery Excluded from Coverage Under State Medicaid
16 Plan. Amend RSA 167 by inserting after section 3-k the following new section:
17 167:3-l State Medicaid Plan; Sex Reassignment Excluded. Medical assistance provided under
18 the state Medicaid plan shall not include sex reassignment drug or hormone therapy or surgery.
19 3 Effective Date. This act shall take effect 60 days after its passage.

Committee Minutes

Senate Finance Committee

Deb Martone 271-4980

SB 331, prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Hearing Date: January 9, 2018

Time Opened: 1:41 p.m. **Time Closed:** 3:12 p.m.

Members of the Committee Present: Senators Daniels, Reagan, Giuda, Morse, D'Allesandro and Feltes

Bill Analysis: This bill provides that sex reassignment drug or hormone therapy or surgery shall not be covered under the state Medicaid plan.

Sponsors:
Sen. Daniels Rep. Weyler

Who supports the bill: Representatives Souza, Notter, Cordelli, Copp, McCarthy, Silber, Gauthier, Sullivan, Moore, Comeau, Scully, Gould, Burt and Hoell; Rene Hamilton; Shannon McGinley; Gabrielle Jette; Liz Gabert.

Who opposes the bill: Representative Wuelper; Jeanne Hruska; Marcia Garber; Dr. Laura Fry; Ken Norton; Sarah Mattson Dustin; Alex McEntee; Lisa Bunker; Tom Huckman; Dr. Paul Cody; Dalia Vidunas; Anthony Procik; Dr. Leonard Small; Atty. Rebecca Whitley; Dawn McKinney; Linda Rogers; J.J. Smith; Louise Spencer; Melissa Hinebauch; Susan Stearns; Benjamin Steiger.

Who is neutral on the bill: Robert Durnz.

Summary of testimony presented in support:

Senator Daniels, Prime Sponsor:

- Whether one chooses to go through transgender reassignment or not is a personal choice, and as such should be paid for with personal funds, not public funds.
- In this last budget we spent a lot of money trying to address the opioid crisis, improving access to mental health, and working to create and maintain a good economic environment so that people had jobs, as well as several other initiatives that benefit the people of New Hampshire. In spite of all this, a recent report indicated that we still have 161 people on the DD Waitlist, people who through no choice of their own truly need the assistance of government to meet their daily needs. If we are to continue down the path of publicly funded

gender reassignment, the money is coming from within the current budget, most likely to the detriment of those on the DD Waitlist who need the assistance the most.

- Gender reassignment is not an inexpensive process. Consider the following costs reported in _Teen Vogue_ magazine by someone who went through the process:
  Hormone Therapy: At Least $1,500/Year. It costs at least $1,500/year to have hormone levels checked and to renew medication prescriptions. The cost for this person had reached $13,500, and the plan was to continue for the rest of their life.
  Gender Reassignment Surgery: $30,000+. This step in the transition is very expensive, and the average cost is upwards of $30,000. In addition to the actual procedure, there are also travel costs and hotel accommodations if a good physician is not located in your area.
  Facial Feminization Surgery: $25,000-$60,000. There is also a high price to pay for this procedure. Board certified surgeons qualified to do these procedures will charge anywhere from $25,000 to $60,000 depending upon the amount of work they have to do.
  Breast Augmentation: $5,000-$10,000. Breast augmentation surgery will cost between $5,000 and $10,000. It all depends upon the surgeon you choose, where they are located, and what type of implant you want.
- When all is said and done, this is a procedure that could cost well over $100,000.
- We do not publicly fund elective abortions. We should not publicly fund gender reassignment.
- Senator Reagan remarked that Senator Daniels mentioned the millions of dollars we are currently spending on folks with substance misuse disorder, a self-directed activity. However, we don't want to pay for individuals suffering from gender dysphoria, a recognized medical condition, as somehow they are robbing disabled people of money. Senator Reagan cannot make that connection, and therefore, cannot support the bill. It is discriminatory against a group that is arbitrarily being singled out and blamed for budget shortfalls for other conditions, some of which are opted for by those with the disorder.

Rene Hamilton:

- Ms. Hamilton is a male-to-female transsexual, has been dealing with gender issues, and heavily involved in the gay and transsexual communities for half a century. She has been living as a woman for 40 years. She has experienced a sex change, breast augmentation and many other procedures.
- There appears to be some confusion around what exactly a sex change operation does. Gender affirmation surgeries, as some now call it, do not change a person's sex. That is an impossibility. Sex changes are simply a series of elective, plastic surgeries that attempt to help the gender-confused. It will mimic the appearance and sexual functioning of the opposite sex. This is done through one or more highly expensive and complicated plastic surgeries.
- It starts out with surgical sterilization. Based on the sex, either the penis and testicles are removed, or a complete hysterectomy is performed.
- The major component of sex reassignment surgery is around sexual functioning

in the bedroom. The surgery does little to improve functioning in society. To a lesser extent, it gives a degree of more comfort in dealing with people, but it's not a guarantee.

- The cause of this condition is unknown. You can't know if a procedure is life-saving, if you don't know what's causing it.
- The only time a government should use taxpayer funds for individual improvement is when those funds are proven to help the individual become a greater contributor to society. Such is the logic behind drug treatment programs, early prenatal health care and food stamps, for example.
- Sex reassignment surgery is primarily sexual in nature. Ms. Hamilton questions the rationale in the government paying for that.
- The cost of sex reassignment surgery is the last of 4 gateways designed to stop dysfunctional, psychotic and suicidal individuals from sexually mutilating themselves. The traditional high cost of sex reassignment surgery forced a transsexual to be functional in society *before* they even have the change. It insured they had to work through enough of their own demons to be able to hold down a 9-to-5 job and support themselves to afford the surgery. This gateway insured that the person could handle all of the tremendous stressors that exist post-operatively, before they took the final and irreversible step.
- With insurance companies paying for this cost, it guarantees that many suicidal and psychotic individuals will have a surgery, but should never have been considered for it.
- The current post-surgical suicide rate is between 40-50 percent, and will increase with insurance coverage.
- Individuals having incurred sex reassignment surgery have a long recovery period. Is the state willing to provide full-time disability pay?
- Some work colleagues find it difficult to accept an individual once he/she has had sex reassignment surgery.
- The desire to help transsexuals by paying for sex reassignment surgery, while humane and compassionate, is misguided at best. It is dangerous and extreme.
- Sex changes don't make transsexuals better and more productive citizens. They must be so, prior to the surgery, in order to have the surgery.
- Senator Feltes inquired if any group paid for Ms. Hamilton's trip here today from San Francisco. She stated NH Cornerstone paid for her flight.
- Senator D'Allesandro commented we spend a fortune to rehabilitate a person who is infected with drugs. We make that commitment because we want to make that person's life better. He inquired as to how you make the distinction between what this bill is prohibiting, and servicing those people's needs? It is costly. Ms. Hamilton agreed it is costly. But this issue is functional sexuality. The big cost of surgery is so she can have sex as close to being a woman as possible. The other costs are cosmetic, to help make you appear more presentable in public. Senator Giuda added that the outcomes need to be looked at, as well. Drug outcomes, for example, are dismal with a 90 percent failure rate. Senator Giuda is reluctant to duplicate that situation. Ms. Hamilton offered the success rate for transsexual surgeries is abysmal. The outcomes are not delivering on the tens of thousands of dollars of expense. Senator Giuda

inquired if there are current programs that could develop better outcomes without the surgery. Ms. Hamilton believes it must start with true science rather than with pseudo science. She suggests giving the University System money for a research grant to determine what the cause is.

- Post-operative transsexuals are attempting suicide at a greater rate than the suicide rate in the historic Nazi death camps. There is something here that is not working.
- Senator Feltes asked Ms. Hamilton if she had a medical degree. She does not. He asked if she had a law degree. She replied she does not.

Shannon McGinley, Executive Director, Cornerstone Action:

- Cornerstone is concerned with public policy regarding parental rights, children's welfare and conscience rights. All three are at issue with SB 331.
- A recent Medicaid rule change provides background to Cornerstone's position. In late July 2017, the New Hampshire Department of Health and Human Services sent letters to participants in the NH Healthy Families program, as well as Well Sense, informing them that as of July 1st, gender reassignment surgery would be covered. The letter was received at the end of July, but the public hearing was not taking place until August 20th. These letters went directly to the minors themselves. The public hearing was rescheduled until September. The day before the public hearing occurred a second letter went out to these families with the exact same wording but a different date, and was directed again to the minor. Thus, without advance notice, New Hampshire taxpayers were made financially responsible for gender reassignment procedures.
- DHHS treated Medicaid funding for gender reassignment as a done deal without oversight. The public hearing and subsequent JLCAR review could not change that fact. There was no opportunity for input from taxpayers.
- Since July, Cornerstone has heard from parents whose families are covered under NH Healthy Families and Well Sense, but whose children's chronic conditions are not covered in full under the program. They asked a question that has yet to be answered. With existing health needs yet unmet, why did DHHS expand Medicaid to cover gender reassignment, an elective, plastic surgery procedure?
- Letting the DHHS policy stand allows gender reassignment surgery for minors. If this is being done under the guise of non-elective medicine, what will happen if a minor covered under Medicaid were to seek a sex change, or gender reassignment surgery, against the wishes of their parents? Will DHHS seek custody of such a child on the grounds that parents are failing to provide medical treatment? Will legislators step in to prevent such a scenario from coming to pass?
- Cornerstone is concerned that taxpayer funding of gender reassignment is a violation of conscience rights. Just as people with sincerely-held religious beliefs about the right to life have been protected to a large degree from funding abortions thanks to the Hyde Amendment and similar provisions, people with sincerely-held moral objections to gender-altering procedures should not be forced into participating in those procedures via their taxes.

- With this rule change, DHHS ignored a federal court order. Their excuse for the proposed rule change mandating coverage for sex change procedures is that failure to do so equals discrimination under the terms of the Affordable Care Act. The Fifth Circuit of Appeals, in an action that applies nationwide, has enjoined that provision of the Act.
- Ms. McGinley related a personal experience she had recently at Children's Hospital at Dartmouth in Manchester, during which she discovered many copies of a pamphlet entitled, "Pediatric and Adolescent Transgender Care," which promotes services the hospital is providing to minors.
- Medicaid funding of gender reassignment is a political move, not driven by public health needs.
- Senator Feltes noted his reading of the Texas decision is that it is an injunction against the rules, not Provision 1557 of the Affordable Care Act, that makes the requirement. He asked Ms. McGinley to point out in the decision her legal conclusion that Texas enjoined that provision of the Act. Ms. McGinley stated she would follow up with Senator Feltes on his request. She indicated the state can get their reimbursement portion from the federal government, but they are not required to do so. Senator Feltes further inquired if Cornerstone has secured any attorney or supplied any brief that suggests that injunction applies to that provision. Ms. McGinley replied she has, and is happy to supply that information.

Summary of testimony presented in opposition:

Jeanne Hruska, Policy Director, ACLU NH:

- This bill would discriminate against our LGBT friends and family by denying them life-saving medical care.
- Being transgender is not a choice. Many transgender people require medical care to bring their body, the expression of their gender, and/or their biochemistry into alignment with who they really are.
- Gender transition-related care, including the provision of gender-affirming surgical care and other treatments such as hormone therapy, are neither cosmetic nor elective.
- The American Medical Association has concluded that medical research demonstrates the necessity and effectiveness of hormone therapy and surgeries to treat many individuals diagnosed with gender dysphoria. As such, the AMA supports public and private health insurance coverage for these medically necessary treatments and opposes the kind of exclusions that SB 331 would create.
- Ms. Hruska addressed the false allegation in this bill that public funding for gender-affirming surgical care or hormone therapy implicates our New Hampshire Constitution's guarantees regarding rights of conscience and religious liberty. SB 331 is about access to insurance coverage, and does not impose any specific regulations on any providers. Providing Medicaid coverage for these medical procedures simply ensures that Granite Staters are able to access the life-saving care they need and deserve.

- Passage of this bill would result in New Hampshire falling out of compliance with state and federal law, which could open the state to legal action by those unlawfully denied coverage.
- A state public health plan that targets transgender persons to withhold coverage for medically necessary care discriminates on the basis of sex.
- New Hampshire courts have held that discrimination based on an individual's gender identity constitutes disability discrimination. In *Doe v. Electro-Craft*, the Superior Court noted that the inclusion of gender identity disorder in the Diagnostic and Statistical Manual of Mental Disorders supported inclusion of gender identity disorder as a "handicap" for purposes of New Hampshire antidiscrimination law.
- SB 331 would also violate Section 1557 of the Affordable Care Act, the antidiscrimination provision, which applies to "any program or activity that is administered by an Executive Agency." This would include New Hampshire's Medicaid program. This provision prohibits discrimination on bases addressed by federal civil rights laws, and includes protections based on gender identity, transgender status and sex stereotypes.
- Regulations implementing the ACA require that benefits established as essential not be subject to denial based on present or predicted disability, degree of medical dependency, or quality of life. A 2016 decision issued by a federal district court in Texas has not changed this legal analysis. The case was not a challenge to the nondiscrimination provision of the ACA, but rather a challenge to regulations issued by the US Department of Health and Human Services interpreting the nondiscrimination provision of the ACA. Until Congress says otherwise, Section 1557 remains a vehicle for Granite State transgender people to bring legal challenges for the denial of gender transition-related care.
- This bill would result in discrimination and would exclude a category of effective and widely utilized medical care. SB 331 would compromise the health and well-being of a whole class of persons in the state. It would also open the state to costly and protracted legal challenges.

Dr. Laura Fry, Associate Medical Director, Manchester Community Health Center:

- Dr. Fry has been a family physician for over 25 years.
- This bill would deny life-saving medical care to Granite Staters.
- Transgender people have well known barriers to health care due to multiple factors including medical stigma, lack of provider knowledge and education, simple lack of access due to likelihood of poverty, and lack of insurance. This lack of access to health care is the biggest barrier to both safe hormonal treatment and appropriate medical care, critical and often life-saving treatment of gender dysphoria.
- Health care needs are high for transgender people. They live in poverty--4 times the national average. Nineteen percent of transgender people lack health services. They suffer a high prevalence of depression, substance abuse to cope with mistreatment, and a suicide attempt rate that is 26 times higher than the general population.
- In addition, they suffer from legal barriers, stigma and discrimination. There is family rejection, violation of rights to education, employment and social

protections, resulting in higher rates of unemployment, poverty, housing insecurity and marginalization.

- Adolescents are particularly vulnerable as the beginning of puberty and the physical signs of gender become more pronounced, and are not desired by those children who identify with the other gender.
- Being transgender is not a choice nor a mental illness. It is a persistent and authentic disconnection between the sex assigned to a person at birth and the internal sense of who they are. It is long known and long lived, and can be expressed as young as 2 or 3 years old. Hormonal treatment and gender-affirmation surgery are not cosmetic or convenient. They are often life-saving medical procedures for transgender patients.
- Dr. Fry started treating transgender patients approximately 11 years ago. She has treated one dozen or so patients. She related her experiences with her first transgender patient and with an adolescent she treated.
- Most of the Manchester Community Health Center patients are not seeking multi-million dollar surgeries, but are moving toward being able to live comfortably as the gender with which they identify. A profound knowledge has been with these patients most of their lives. The process takes a lot of courage and support from a medical community that is understanding, knowledgeable and sympathetic. These patients' lives are not easy.
- Decisions about hormone therapy and gender affirmation surgery are best handled by doctors and their patients. By denying Medicaid coverage for these medical care options, this Legislature would be preventing doctors from caring for their patients by taking needed medical options off the table.
- Please leave decisions about medical care to doctors.

Ken Norton, Executive Director, NAMI New Hampshire:

- Mr. Norton focused on the high risk for suicide for transgender people. He distributed a chart of New Hampshire's Top Ten Leading Causes of Death during the years 2011 through 2015.
- Suicide is the second leading cause of death for ages 10-34 in New Hampshire, as well as nationally. It is the third leading cause of death for ages 35-44, and the fourth leading cause of death for ages 45-54.
- Suicide deaths are the tip of the iceberg in contrast to suicide attempts.
- There is an emerging body of research showing that transgender people are eight times more likely to attempt suicide than their peers in the general population. Young people who are gender-nonconforming are at a higher risk.
- A 2017 review of recent research on transgender suicide showed several unique risk factors contribute to the high rate of suicide in this population, including lack of family and social supports, gender-based discrimination, body-related shame, and difficulty undergoing gender reassignment.
- NAMI New Hampshire sees suicide and suicide prevention as a significant and preventable public health issue. The human and economic impact of suicide is severe. This issue is best left to doctors and patients to determine.
- Senator Feltes noted a suggestion was made earlier in the testimony that gender reassignment surgery leads to higher suicide rates. He asked Mr. Norton to respond. Mr. Norton replied that in the research he has found, that

issue was unclear. The statistics he found were lifetime prevalence, and did not distinguish between pre- or post-operative. Folks going through this have a very difficult journey to walk. That places them at higher risk in terms of choosing surgery, or a lesser option.

Alex McEntee:

- Ms. McEntee is a transgender, non-binary individual, meaning her gender identity falls somewhere between being a male or a female. She uses "they" and "them" pronouns.
- She is a New Hampshire Medicaid recipient. This bill would deny her critical, medical care.
- Her troubles began in her teens, when she made a few suicide attempts. In her 20s and 30s she was an active bulimic and morbidly obese. Ms. McEntee developed Type 2 Diabetes in her late 20s, and has endured over 10 surgeries to prevent her retinas from detaching. Could some of these costly treatments have been avoided had she understood back then that she was transgender?
- Ms. McEntee related a personal episode whereby a friend of hers asked her to castrate him with a sporting knife in an effort to have reassignment surgery.

Lisa Bunker:

- Ms. Bunker objects to SB 331 as it misrepresents the purpose of these treatments, and injects state control into private medical decisions.
- To a person suffering from gender dysphoria, hormone therapy and reassignment surgery are not "elective" or "cosmetic" as stated in the bill. They are medically necessary and can be life-saving. That was Ms. Bunker's experience when she underwent transition. Her gender dysphoria, the persistent sense of wrongness she felt in her body, was so acute she truly felt at the time that her other options besides transition were escape into substances or suicide.
- Ms. Bunker did have suicidal ideation before transitioning, but not since that time. It was not because she wanted to have sex as a woman, but that she wanted to be able to look herself in the mirror again without a feeling of horror. In fact, her dysphoria has largely been cured, and she has not thought of taking her own life since transitioning.
- Lisa's personal experience is backed up by broad consensus in the medical community. Dozens of mainstream medical organizations, including the American Medical Association, the American Psychiatric Association, and many others have recognized the medical necessity of these treatments and officially endorsed them.
- SB 331 also misrepresents the specific purpose of gender transition when it notes that surgery cannot impart reproductive function. That has never been the purpose of this surgery. Rather, the treatment alleviates crippling dysphoria. The loss of fertility is a sacrifice, but one many transgender people are willing to make in order to finally live as their true selves in the world.
- There are significant protocols in place to insure such decisions are never made lightly, especially where children are involved.
- Medical treatments should be determined by patients and their doctors, not categorically denied by the state. This bill is based on false assumptions, and

overreaches the authority of the Legislature in the private lives of New Hampshire residents. Its passage into law would represent real hardship for Granite Staters in need of a proven medical treatment.

Dr. Paul Cody, Equality Health Center:

- Dr. Cody is a licensed psychologist and gender specialist, who has provided therapy to transgender individuals since 1992. He is a member of the World Professional Association for Transgender Health ("WPATH"), which sets the standards of care for the health of transsexual, transgender and gender-nonconforming people.
- Transgender persons have come to Dr. Cody for assessments for eligibility and readiness for sex reassignment surgeries.
- Dr. Cody distributed WPATH's December 21, 2016 Position Statement on Medical Necessity of Treatment, Sex Reassignment and Insurance Coverage. In that statement he noted, "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 of the diagnosed condition. In some cases, such surgery is the only effective treatment for the condition, and for some people genital surgery is essential and life-saving."
- Dr. Cody hopes the committee will seek equity in coverage of medically, necessary procedures for transgender people.
- People in psychotic episodes are not allowed to have surgery.
- Gender dysphoria and its correction is not a matter about having a better sex life. It's a matter about having a body one can look at in the mirror, can shower and touch those parts without self-loathing.
- Minors are not having surgery without their parents' consent.
- Surgery has made a big difference in Dr. Cody's patients' lives. It has reduced their gender dysphoria, if not completely eliminated it. It has made them happier and better functioning.
- Senator D'Allesandro commented that our role in life is to make life better for people. And what he is hearing is that Dr. Cody shares that goal.
- Senator Daniels questioned parental consent. Is that just for this type of surgery, or all surgeries in general? Dr. Cody indicated he was referring to gender dysphoria.

Dalia Vidunas, Executive Director, Equality Health Center:

- The Equality Health Center has been providing transgender medical care to transgender and gender-nonconforming individuals for the past 5 years. These services include hormone replacement therapy, general health screening, behavioral health counseling services, and linkage to other critical health services.
- In 2017, they provided over 400 appointments to people within Merrimack County here in New Hampshire for gender services.
- Members of the Equality Health Center staff witness the positive impact of gender-affirming health care. These patients are in a better position to lead healthier, more productive lives. They can contribute to society as they feel

better about themselves.

- When transgender individuals are able to access appropriate trans-related health care, they take better care of their bodies. Overall, there is a decrease in medical expenses associated with hospitalizations for depression and suicidal ideation, treatment for substance misuse, as well as a decrease in the costs associated with the treatment of Hepatitis C and HIV infections. Other cost savings are associated with the increased productivity of transgender individuals who have been able to access appropriate transgender medical care, such as higher employment rates, less incarceration rates and reduced homelessness rates.

Atty. Rebecca Whitley, Policy Coordinator, NH Children's Behavioral Health Collaborative ("CBHC") and New Futures, Inc:

- The CBHC supports state-level policy changes to transform New Hampshire's children's mental health and substance use disorder system into an integrated, comprehensive system of care that is family driven and youth guided, community based, and culturally and linguistically competent.
- Cultural competence is a core value of the CBHC. Each youth comes to the CBHC with a different background. This includes their age, disability, national origin and gender identity. The CBHC opposes SB 331 because it removes medically necessary treatment options for children, youth and families and eliminates the ability of families and medical professionals to use flexible, culturally competent, and gender-affirming approaches and treatments.
- Every child is unique and treatment decisions should be between a parent, their child and the child's medical and mental health providers. The American Academy of Pediatrics ("AAP") strongly endorses the use of gender-affirming care when treating children. In support of this policy, the AAP emphasizes that "discouraging or shaming a child's gender identity or expression can harm a child's social-emotional health and well-being, and may have lifelong consequences.
- Failing to support medically necessary treatment for transgender youth and families could lead to more costs to the State in the long run. Rejecting a child's gender identity and denying them gender-affirming care leaves them at an increased risk for depression, self-harm, isolation, posttraumatic stress, incarceration, homelessness and suicidality. Suicidality is one of the most serious, elevated health risks facing transgender people.
- In 2013, the Diagnostic and Statistical Manual of Mental Disorders-5 ("DSM-5") was revised, and gender identity disorder was changed to gender dysphoria, a diagnostic criteria reflecting the psychological distress that occurs due to gender and sex discord. The condition of gender dysphoria is associated with clinically significant distress or impairment in social, school, or other areas of functioning. Puberty can be particularly difficult for gender-nonconforming adolescents and children with gender dysphoria. Early intervention and treatment using gender-affirming approaches may alleviate psychological harm associated with gender dysphoria and lead to better physical and psychosocial outcomes. On the other hand, untreated gender dysphoria can drive depression, anxiety, social problems, school failure, self-harm and even suicide.

- SB 331 would prohibit Medicaid from covering both gender-confirming surgeries and hormone therapy. Gender-affirming hormone therapy is the primary medical intervention sought by transgender individuals. We should be supporting our youth to achieve physical and mental well-being instead of creating barriers and restricting access to treatment for a particularly vulnerable population.
- The CBHC opposes this bill because the passage and implementation of the bill could put New Hampshire out of compliance with federal law, thus jeopardizing the federal match for New Hampshire's Medicaid program, which is generally 50 percent of the entire cost of the program.
- In New Hampshire, the Medicaid managed care organizations ("MCOs") manage the treatment for the state's Medicaid population. The 2016 regulations expressly prohibit discrimination based on gender identity, and require state Medicaid programs and MCOs to develop methods of ensuring that all beneficiaries are able to receive health care services in a culturally competent manner, regardless of factors such as gender, sexual orientation or gender identity. The passage of this bill would violate those regulations.
- A medical necessity determination would have to be authorized by the MCOs regarding hormone therapy or surgery to be covered.

Jennifer Joy Smith, Policy Advocacy, New Hampshire Public Health Association:

- The Association is yet to take a position on SB 331.
- Dr. Smith is a retired, family physician and a transgender individual who has had counseling.
- This is not about sexuality; it is about identity.
- Many have been confused about their sexual identity for much of their lives.
- Once he came out, Dr. Smith became a much happier person.
- There is no downside to Medicaid covering transgender surgery. Why shouldn't Medicaid cover procedures that all other insurance carriers cover?
- Senator D'Allesandro asked Dr. Smith to comment on the value of self-worth. Dr. Smith gave personal examples that have contributed to his self-worth, including having an identity publicly that "feels right".

Dr. Leonard Small:

- Dr. Small is a retired pediatrician having practiced for 34 years.
- Both the NH Pediatric Society and the NH Medical Society oppose SB 331.
- The decision for gender-affirming therapy is complex and difficult, involving the patient, parents, physicians and mental health providers. Once the decision is made, delay is detrimental. There is only harm in waiting until one is an adult, and then can possibly afford insurance other than Medicaid.
- Restricting access to care because one is poor and on Medicaid increases the risks of anxiety, depression and suicide in an already vulnerable population. One should not be denied medically necessary treatment because of the parents' inability to pay.
- The American Academy of Pediatrics endorses gender-affirming therapy.

Linda Rogers:

- Ms. Rogers is a fully transitioned, transgender woman. She waited until retirement to do so, primarily due to valid economic reasons.

- It took 8 years from when she initially sought treatment, both in the mental health and medical professions, to complete the transition. She was heavily "vetted" to make sure it was the correct decision.
- In 2016, Medicare eliminated their blanket exclusion against transgender surgery. Ms. Rogers' insurance carrier, Harvard Pilgrim, was very supportive. The cost of her transition was approximately $45,000.
- It takes a period of time to determine which procedures work well for each individual.
- Out of 225,000 Harvard Pilgrim subscribers, Ms. Rogers is the only subscriber to complete this process. Over a 2-year period, she calculated and found it came out to one cent per month per subscriber. She doesn't feel she has deprived anyone of anything.
- Ms. Rogers has never been happier.
- Sex was the last thing on her mind when making the determination to go on this journey. She decided she had to do this to become complete as a person. Ms. Rogers is deeply involved in her community.

Tom Huckman:

- Mr. Huckman is a parent of a transgender child. His 17-year old daughter sensed at the age of 3 that there was something wrong with being born a male. She ultimately came out transgender to the community in 7th grade, and has never looked back. She is on hormone therapy, and had a surgical procedure that stopped male puberty in its tracks. It was augmented with estrogen therapy, and was an absolute "game changer".
- Mr. Huckman's daughter is a honor student, 3-season athlete, holds down 2 jobs, and is a lay eucharistic minister at church. She also teaches ski lessons, and is a member of the Legislative Youth Advisory Committee.
- There is a visible change in Mr. Huckman's child. She is out there, vivacious, doing everything, and enjoying life.
- Don't take these tools off the table for others, especially Medicaid coverage. The Huckmans paid for their daughter's treatment themselves, and it was not cheap.

Future Action: Pending

dm
Date Hearing Report completed: January 10, 2018

Speakers

SENATE FINANCE COMMITTEE

Date: 01/09/2018 Time: 1:40 p.m. Public Hearing on SB 331

Prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

(Please check box(es) that apply)

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☐	☒	☐	Rep. Kathleen Souza	
☐	☒	☐	Rep. Jeanine Notter	Hills 21
☑	☐	☑	Jeanne Hruska	ACLU-NH
☐	☐	☑	Marcia Garber	self 5 Hills End Way Manchester 03104
☑	☑	☐	Rene Hamilton	(self) - transgender from San Fran (happy to go last)
☑	☑	☐	Shannon McGinley	Cornerstone Action
☒	☐	☒	Laura Fry	MCHC
☐	☒	☐	Rep Glenn Cordelli	Carroll 4
☒	☐	☒	Ken Norton	NAMI NH
☐	☒	☒	Rep Anne Copp Dan Freuding	Merr #1
☐	☒	☐	Rep. Frank McCarthy	
☐	☒	☐	Rep. Norman Silber	Belknap #2
☐	☐	☑	Sarah Mattson Dustin	NH Women's Foundation
☐	☑	☐	Rep. Francis Gauthier	Claremont Ward 1
☐	☒	☐	Rep. Victoria Sullivan	Hills Dis 16
☐	☒	☐	Rep Josh Moore	Hills Dis 21
☐	☒	☐	Rep Ed Comeau	Edward C Comeau U.C.C. 1-308 Without Prejudice
☐	☒	☐	Rep Kevin Scully	Hills 33
☒	☐	☒	Alex McEntee	Concord, NH
☐	☒	☐	Rep Linda Gould	Dist 7

SENATE FINANCE COMMITTEE

Date: 01/09/2018 Time: 1:40 p.m. Public Hearing on SB 331

Prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Please check box(es) that apply:

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☑	☐	☑	Lisa Bunker	Exeter
☐	☒	☐	Rep John Burt	Goffstown
☐	☒	☐	Gabrielle Jette	Self / NH
☐	☒	☐	Liz Gabert	Self / Bedford
☑	☐	☒	Tom Huckman	Self / Ossipee
☑	☒	☑	Dr. Paul Cody	Equality Health Ctr.
☑	☐	☑	Dalia Vidunas, MSW	Equality Health Ctr
☐	☐	☑	Anthony Procik	Rights & Democracy
☐	☐	☐	Robert M. Dunn	NAMI NH
☑	☐	☑	Leonard Small	NHPS / NHMS
☑	☐	☐	Sen Gary Daniels	Dist 11 (sponsor)
☑	☐	☑	Becky Whitley	CBHC / New Futures
☑	☐	☑	Dawn McKinney	NH Legal Assistance
☑	☐	☑	Linda Rogers	Self / Epsom
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SENATE FINANCE COMMITTEE

Date: 01/09/2018 Time: 1:40 p.m. Public Hearing on SB 331

Prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Please check box(es) that apply:

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☑	☐	☑	J.J. Smith	Self
☐	☐	☑	Louise Spencer	self
☐	☐	☑	Melissa Hinebauch	Self
☐	☐	☑	Susan Stearns	Self
☐	☐	☑	Benjamin Steiger	Self
☐	☒	☐	JR Hoell	Merr 23
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Testimony

SB331 - prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.. (Finance)

Good afternoon, Mr. Chairman,

For the record my name is Gary Daniels and I am the State Senator for District 11, representing the towns of Amherst, Merrimack, Milford and Wilton. I am also the prime sponsor of SB331, which prohibits Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

I'd like to start by saying that whether one chooses or not to go through transgender reassignment is a personal choice and as such should be paid for with personal funds, not public funds.

In this last budget we spent a lot of money on trying to address the opioid crisis, improving access to mental health, working to create and maintain a good economic environment so that people had jobs, as well as several other initiatives that benefit the people of NH. In spite of all that, a recent report indicated that we still have 161 people on the disability waiting list, people who through no choice of their own, truly need the assistance of government to meet their daily needs

If we are to continue down the path of publically funded gender reassignment, the money is coming from within the current budget, most likely to the detriment of those on the DD wait list who need the assistance most.

Gender reassignment is not an inexpensive process. Consider the following costs reported in Teen Vogue magazine by someone who went through the process:

Hormone Therapy: At Least $1,500/Year
It costs at least $1,500/year to have hormone levels checked and to renew medication prescriptions. The cost for this person had reached **$13,500**, and the plan was to continue at $1,500/month for the rest of their life.

Gender Reassignment Surgery: $30,000-Plus
This step in the transition is very expensive, and the average cost is upwards of $30,000. In addition to the actual procedure, there are also travel costs and hotel accommodations if a good physician does not live in your vicinity.

Facial Feminization Surgery: $25,000-$60,000
There's also a high price to pay for this procedure. Board certified surgeons that are qualified to do these procedures will charge anywhere from $25,000 to $60,000 depending on the amount of work they have to do.

Breast Augmentation: $5,000-$10,000
Breast augmentation surgery will cost between $5,000 and $10,000, and it all depends on the surgeon you choose, where that person is located, and what type of implant you want.

When all is said and done, this is a procedure that could cost well over $100,000.

I have talked to others who would be here to testify for this bill, but they are having to travel to PA today to get their disabled child the care that is needed, but for which funding is not available in NH.

We do not publically fund elective abortions. We should not publically fund gender reassignment. I respectfully ask that the committee support SB331 as "Ought to Pass".

Thank you, Mr. Chairman

To: New Hampshire Senate Finance Committee
From: Ms. Rene Hamilton
Representing Self, Transexual with Regret at invitation of NH Cornerstone Action
renejaxiwritebooks@gmail.com
San Francisco, CA
Date: Tuesday, January 9, 2018
RE: Please vote OTP on SB 331

First, let me say that from my perspective as a post-operative transsexual, there appears to be some confusion around what exactly a sex change operation does. Sex change operations, or what some are now calling gender affirmation surgeries, do not change a person's sex. That is an impossibility.

Sex changes are simply a series of elective, plastic surgeries that attempt to help the gender confused individual mimic the look and sexual functionality of the opposite sex. This is done through one or more highly complicated plastic surgeries. They all start with surgical sterilization, whereby the person's penis and testicles are removed and or a complete hysterectomy is performed. as is the case of female to males.

Since the major component of Sex Reassignment Surgery (SRS) is around sexual functioning in the bedroom, the surgery does little to improve the individual's functioning in society, with the sole exception of their personal comfort levels.

I am in good company when I say that the only time a government should spend taxpayer funds for individual improvement is when those funds will ultimately help the individual become a greater contributor to our society. Such is the logic behind drug treatment programs, early prenatal healthcare, food stamps, and the like.

But since SRS is primarily sexual in nature, I sincerely question the rationale of the government paying for it.

More importantly, you should understand that the cost of SRS is the last of four gates designed to stop suicidal, psychotic and delusional individuals from sexually mutilating themselves.

The traditionally high cost of SRS forced transsexuals to be functional in society before they had the change. It ensured they had worked through enough of their demons to be able to hold down a 9-5 job, and support themselves post-surgically. This gateway ensured, as best as it could, that the person could handle the tremendous stress associated with the sex change *before* they took that one final and irreversible step.

The state paying this cost guarantees that some surgeries will be perfomed on suicidal and psychotic individuals, for whom this type of surgery should never have been considered. State funding for SRS ensures that the current 40-50% attempted suicide rate of post-operative transsexuals will go through the roof. If this procedure were a life-saving surgery as others suggest, why are its recipients more likely to try killing themselves?

In addition, if your goal is to help transsexuals be more productive citizens, then you must be aware that one does not have a sex change on Saturday and go back to work on Monday.
In my own case, I was 35 years old when I had the surgery. I was in the prime of my life, and yet following the surgery I was physically unable to work for nearly a year. During that time, I went through all of my substantial savings, sold my cars, and ultimately pawned everything of value I owned to survive.

Another male to female transsexual I knew underwent her surgery the following year and was unable to return to work for two years. A female to male friend of mine had to undergo four separate surgeries over an 18-month period. He had multiple medical complications that kept him from working, and ultimately he went on permanent disability.

Is the state of New Hampshire willing to provide full time disability pay for those transsexuals receiving publicly funded surgery?

Further, there are many people who after a sex change will never be fully accepted back in their old place of employment. Just as my own mother could never get around to calling me she and her, the same holds true for work colleagues. The state cannot use laws to force people to change their own view of reality. So, it then becomes extremely necessary for the state to be willing to pay for new job training programs with the transsexual individual in mind.

In closing, I would ask that you to forego your own limited preconceptions around this issue, and understand that your desire to help transsexuals by paying for the surgery is misguided at best, and dangerous in the extreme.

Sex changes don't make transsexuals better and more productive citizens. They must be so in the first place, in order to have this life-changing surgery - not the other way around. And if the pre-operative transsexual is a functioning and productive person, then why would the state pay for their elective surgery?

I urge you to not allow the great state of New Hampshire to pay for these surgeries.

Mr Chairman and committee members.

I am Dr. Leonard Small. I am a retired Pediatrician, having practiced in Dover for 34 years.

I speak for both the NH Pediatric Society and the NH Medical Society, both of which oppose SB 331. The NHPS has 256 members, representing the majority of Pediatricians in the State, and is a chapter of the American Academy of Pediatrics. Likewise, the NHMS is a chapter of the American Medical Association and represents the physicians of the State.

The executive committee of the NHPS and the legislative committee of the NHMS each voted unanimously, with essentially no discussion, to oppose this bill.

Transgender youth have significantly elevated rates of anxiety, depression, and suicide. Gender-affirming therapy, as recommended by the American Academy of Pediatrics, has been shown to greatly reduce these problems, and improve quality of life. Therapy, including counseling, hormones, and surgery, is preventative and medically necessary, not cosmetic.

The decision for gender-affirming therapy is complex and difficult, involving the patient, parents, physicians, and mental health providers. Once the decision is made, delay is detrimental. There is only harm in waiting until one is an adult and then can possibly afford insurance other than Medicaid.

Restricting access to care because one is poor and on Medicaid increases the risks of anxiety, depression, and suicide in an already vulnerable population. One should not be denied medically necessary treatment because of the parents' ability to pay.

On a personal note, in my 34 years of practice, I do not recall having to tell a parent or patient that they could not access medically necessary and mainstream treatment because Medicaid denied it. This bill could have put me in that situation. I would have been very distressed.

To summarize:

The American Academy of Pediatrics endorses gender-affirming therapy.
This bill denies medically necessary treatment to a population at high risk for anxiety, depression, and suicide.
Therapy is medically necessary and preventative. It is not cosmetic.
The NHPS and the NHMS strongly oppose this bill.

Thank you for your time.

January 9, 2018

The Honorable Gary Daniels, Chair
Senate Finance Committee
New Hampshire State House, Room 103
107 North Main Street
Concord, NH 03301

Re: CBHC's opposition to Senate Bill 331, prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery

Dear Chairman Daniels and Honorable Members of the Committee:

The New Hampshire Children's Behavioral Health Collaborative ("CBHC") appreciates the opportunity to provide testimony in opposition to SB 331, prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

The CBHC is a collaboration of over 60 organizations and hundreds of families and youth dedicated to transforming the way we support children with behavioral health needs. In 2014, New Futures was selected to serve as the backbone organization for the CBHC. New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all Granite Staters. In my role as Children's Behavioral Health Policy Coordinator for New Futures, I provide strategic support and expertise to advance CBHC's policy priorities. In that capacity, I offer the comments below.

The CBHC supports state-level policy changes to transform New Hampshire's children's mental health and substance use disorder system into an integrated, comprehensive system of care that is family driven and youth guided, community-based, and culturally and linguistically competent. Cultural competence, a core value of the CBHC, involves understanding and appropriately responding to the unique combination of cultural variables and the full range of diversity youth and families bring to the behavioral health system. Cultural diversity can include a variety of factors, including but not limited to age, disability, ethnicity, national origin, race, religion, sex, sexual orientation, and gender identity.

The CBHC opposes SB 331 because it removes medically necessary treatment options for children, youth and families and eliminates the ability of families and medical professionals to use flexible, culturally competent, and gender-affirming approaches and treatments.

Every child is unique and treatment decisions should be between a parent, their child and the child's medical and mental health providers. The American Academy of Pediatrics (AAP)

strongly endorses the use of gender-affirming care when treating children.[1] In support of this policy, the AAP emphasizes that "discouraging or shaming a child's gender identity or expression can harm a child's social-emotional health and well being, and may have lifelong consequences.[2]

Failing to support medically necessary treatment for transgender youth and families could lead to more costs to the State in the long run. Rejecting a child's gender identify and denying them gender-affirming care leaves them at an increased risk for depression, self-harm, isolation, posttraumatic stress, incarceration, homelessness, and suicidality.[3] Suicidality is one of the most serious elevated health risks facing transgender people.

In 2013, the Diagnostic and Statistical Manual of Mental Disorders-5 ("DSM-5") was revised and gender identity disorder was changed to gender dysphoria, a diagnostic criteria reflecting the psychological distress that occurs due to gender and sex discord.[4] The condition of gender dysphoria is associated with clinically significant distress or impairment in social, school, or other areas of functioning.[5] Puberty can be particularly difficult for gender non-conforming adolescents and children with gender dysphoria. Early intervention and treatment using gender-affirming approaches may alleviate psychological harm associated with gender dysphoria and lead to better physical and psychosocial outcomes. On the other hand, untreated gender dysphoria can drive depression, anxiety, social problems, school failure, self-harm and even suicide.[6]

This far-reaching bill would prohibit Medicaid from covering both gender-confirming surgeries *and* hormone therapy. Gender affirming hormone therapy is the primary medical intervention sought by transgender individuals.[7] We should be supporting our youth to achieve physical and mental well-being instead of creating barriers and restricting access to treatment for a particularly vulnerable population.

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[1] See American Academy of Pediatrics Policy Statements available at https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Statement-in-Support-of-Transgender-Children-Adolescent-and-Young-Adults.aspx.
[2] "Supporting & Caring for Transgender Children," American College of Osteopathic Pediatricians, American Academy of Pediatrics, and Human Rights Campaign Foundation, available at https://assets2.hrc.org/files/documents/SupportingCaringforTransChildren.pdf.
[3] "Understanding Gender Nonconformity in Childhood and Adolescence," Gender & Sex Development Program, Lurie Children's Hospital of Chicago, available at https://www.aap.org/en-us/Documents/solgbt_webinar_transition_garofalo.pdf.
[4] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Washington, DC: American Psychiatric Association; 2013.
[5] Id.
[6] *See* note 3 above.
[7] Center of Excellence for Transgender Health, University of California San Francisco. *See* http://transhealth.ucsf.edu/trans?page=guidelines-overview.

NH Children's Behavioral Health Collaborative

Lastly, the CBHC opposes SB 331 because the passage and implementation of the bill could put New Hampshire out of compliance with federal law, thus jeopardizing the federal match for New Hampshire's Medicaid program, which is generally 50% of the entire cost of the program. New Hampshire's Medicaid program must comply with federal nondiscrimination laws, including regulations promulgated under the federal Medicaid statute prohibiting arbitrary restrictions on Medicaid coverage on the basis of diagnosis or health condition;[8] Section 1557, the nondiscrimination provision of the Affordable Care Act; and regulations governing the activities of Medicaid managed care organizations ("MCOs") which expressly prohibit discrimination based on gender identity[9] and require state Medicaid programs and MCOs to develop methods of ensuring that all beneficiaries are able to receive health care services in a culturally competent manner, regardless of factors such as gender, sexual orientation, or gender identity.[10]

For the reasons presented above, the CBHC strongly urges the committee to vote SB 331 inexpedient to legislate.

Respectfully,

Rebecca G. Whitley, Esq.
Children's Behavioral Health Policy Coordinator
New Futures, Inc.

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[8] *See* 42 CFR § 440.230(c)
[9] *See* 42 CFR § 438.3(d)(4)
[10] *See* 42 CFR § 438.206(c)(2)

January 9, 2018
Senate Finance Committee
Testimony on SB 331

Thank you for reading the following testimony. My name is Dalia Vidunas. I am the Executive Director of Equality Health Center. I am here to let you know that I do not support SB331, relative to prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Equality Health Center is proud to provide quality transgender medical care to transgender and gender non-conforming individuals. These services include hormone-replacement therapy, general health-screening, behavioral health counseling services and linkage to other critical health services (ie: assisting in finding supportive primary care providers, endocrinologists, and surgeons that provide gender-affirming surgeries.)

Medical interventions such as hormone replacement therapy and surgical procedures for transgender patients aim to decrease gender dysphoria, "the clinically significant distress that, for many transgender people, accompanies a profound misalignment between gender identity and assigned sex at birth." On a daily basis our staff have the privilege of witnessing the positive impact gender-affirming health care services has on individuals who have been living with gender dysphoria. What our clinic sees is an affirmation of what scientific evidence-based research informs us: Individuals who are able to access these critical medical services are in a better position to lead healthier, more productive lives, contributing more to their communities and society at large.

The multitude of professional organizations that support the provision of transgender medical care and insurance coverage of such care include the following well-respected entities:

- American Medical Association;
- American Psychiatric Association;
- American Academy of Family Physicians;
- American College of Obstetricians and Gynecologists;
- American Academy of Physician Assistants;
- American College of Nurse Midwives;
- American Public Health Association;
- American Academy of Child and Adolescent Psychiatry;
- National Association of Social Workers;
- National Commission on Correctional Health Care; and
- World Professional Association for Transgender Health.

All of these entities agree that transgender medical interventions, including surgical intervention, are a vital part of providing medically necessary health care. These services should not be classified as elective cosmetic services akin to botox, face lifts, or liposuction. WPATH states: "The medical procedures attendant to sex reassignment are not 'cosmetic' or 'elective' or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed patient."**(1)**

Many insurers have anticipated that allowing coverage for transgender related health care, including surgical interventions would create a financial burden. Evidence-based research conducted by The Williams Institute, UCLA and John Hopkins University does not back up these claims.(**2**) In fact, the evidence shows that just the opposite is true. When transgender individuals are able to access appropriate trans-related health care they take better care of their bodies. Overall there is a decrease in medical expenses associated with hospitalizations for depression and suicidal ideation, treatment for substance misuse as well as a decrease in the costs associated with the treatment of Hepatitis C and HIV infections. Other cost-savings are associated with the increased productivity of transgender individuals who have been able to access appropriate transgender medical care (ie: higher employment rates and less incarceration rates; reduced homelessness rates)

I thank you all for your time and your consideration and ask you to please vote not on SB331 which would exclude transgender individuals to access vitally necessary medical care.

Dalia Vidunas, MSW
Executive Director
Equality Health Center
603-225-2739
dalia@equalityhc.org

1. http://www.lambdalegal.org/sites/default/files/publications/downloads/ll_trans_professional_statements.rtf_.pdf
2. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf

(Formerly Concord Feminist Health Center)

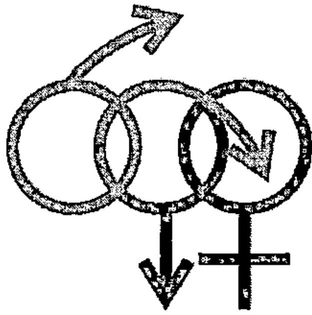
January 9, 2018

NH Senate Finance Committee
Re: Senate Bill 331

Hello,
I am Dr. Paul Cody, a licensed psychologist and gender specialist who works at Equality Health Center in Concord. Since 1992 I have provided therapy to transgender individuals. Transgender persons have come to me for assessments for eligibility and readiness for gender confirmation surgeries, also called sex reassignment surgeries. My letters of referral have been accepted by surgeons in the United States, Canada, and Thailand. I am a full member of the World Professional Association for Transgender Health, known as WPATH. It is "an international, interdisciplinary, professional association devoted to the understanding and treatment of individuals with Gender Dysphoria." (WPATH, 2016). WPATH sets the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. Statements of support of the WPATH Standards of Care have been made by the American Medical Association, the Endocrine Society, the American Psychiatric Association, the American Psychological Association, the American Academy of Family Physicians, the National Commission of Correctional Health Care, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology, the American Society of Plastic Surgeons, and the World Health Organization (WPATH, 2016).
Attached to my statement is the *WPATH 21 December 2016 Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage*. I call your attention especially to the next-to-last paragraph on the third page, which I will read aloud.
[Read quote.]
Thank you for listening to my statement. I hope the committee makes the decision to support equity in coverage of medically necessary procedures for transgender people.

Paul Cody, Ph.D.
NH License #555

38 South Main St, Concord, NH 03301 • www.equalityhc.org • 603-225-2739(ph) • 603-228-6255(fax)



WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

21 December 2016

Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.

The World Professional Association for Transgender Health (WPATH) is an international, interdisciplinary, professional association devoted to the understanding and treatment of individuals with Gender Dysphoria (GD). Founded in 1979, and currently with over 1500 medical, mental health, social scientist, and legal professional members, all of whom are engaged in clinical practice and/or research that affects the lives of transgender and transsexual people, WPATH is the oldest professional association in the world that continuously has been concerned with this clinical specialty.

Gender Dysphoria (GD), often associated with transsexualism, is a condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5, 2013), published by the American Psychiatric Association. Previous nomenclature for gender dysphoria includes transsexualism and gender identity disorder (GID), conditions which are also recognized in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, published by the World Health Organization, of which the United States is a member. Nomenclature is subject to changes, and new terminology and classifications may be arrived at by various medical organizations or administrative bodies, but these events shall not in themselves change the meaning or intent of this WPATH statement.

The criteria currently listed for GD are descriptive of many people who experience dissonance between their sex as assigned at birth and their gender identity. Gender identity is common to all human beings, is developed in early childhood, and is thought to be firmly established in most people—transgender or not—by age 4,[1] though for some transgender individuals, gender identity may remain somewhat fluid for many years,[2] while for others, conditions specific to individual lives may constrain a person from acknowledging or even recognizing any gender dysphoria they may experience until they

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[1] American Academy of Pediatrics, 1999.

[2] Fraser L and De Cuypere G, 2016.

are well into adulthood. The various The DSM-5 descriptive criteria for gender dysphoria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment that is frequently, though not universally, associated with transsexual and transgender conditions.

The WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (SOC) were first issued in 1979, and articulate the "professional consensus about the psychiatric, psychological, medical and surgical management of GD." Periodically revised to reflect evolution in evidence-based clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary. The most recent version of the SOC (Version 7) was published in 2012.[3] WPATH recommends that medical and mental health providers and administrators check www.wpath.org regularly to ensure they are working with the most up-to-date revision of the SOC.

MEDICAL NECESSITY is a term common to health care coverage and insurance policies in the United States. A common definition of medical necessity as used by insurers is:

> "[H]ealth care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
>
> "Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors."[4]

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. Treatment includes legal name and sex or gender change on identity

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[3] Coleman E, Bockting W, Botzer M, et al. 2012.

[4] Definition from Blue Cross Blue Shield Settlement (Section 7.16(a)) available at www.hmosettlements.com

documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures required to effectively treat an individual's gender dysphoria. Neither genital appearance nor reconstruction is required for social gender recognition, and so no surgery should be a prerequisite for identity document or record changes; changes to documentation so that identity documents reflect the individual's current lived expression and experience are crucial aids to social functioning, and can be a necessary component of the social transition and/or pre-surgical process. Delay of document changes may have a deleterious impact on a patient's social integration and personal safety.

In addition to hormonal balancing, medically necessary gender affirming/confirming surgical procedures are described in section XI of the SOC. These procedures include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient, including nipple resizing or placement of breast prostheses, as necessary; genital reconstruction by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, scrotoplasty, and penile and testicular prostheses, as necessary; facial hair removal, certain facial plastic reconstruction, voice therapy and/or surgery, and gender affirming counseling or psychotherapeutic treatment, as appropriate to the patient.

> "Non-genital surgical procedures are routinely performed... notably, subcutaneous mastectomy in female-to-male transsexuals, and facial feminization surgery, and/or breast augmentation in male-to-female transsexuals. These surgical interventions are often of greater practical significance in the patient's daily life than reconstruction of the genitals."[5]

It is important to understand that every patient will not have a medical need for identical procedures. Clinically appropriate treatments must be determined on an individualized and contextual basis, in consultation with the patient's medical providers.

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 of the diagnosed condition.[6] In some cases, such surgery is the **only** effective treatment for the condition, and for some people genital surgery is essential and life-saving.

These medical procedures and treatment protocols are not experimental: Decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient. For example, a recent study of female-to-male transsexuals

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[5] Monstrey S, De Cuypere G, Ettner R (eds). (2007).

[6] Victoria L. Davidson v. Aetna Insurance. (1979). Judicial finding that "...the treatment and surgery...is of a medical nature and is feasible and required for the health and well-being of the patient."

found significantly improved quality of life following cross-gender hormonal therapy.[7] Moreover, those who had also undergone chest reconstruction had significantly higher scores for general health, social functioning, as well as mental health.[8]

> "[Hormone therapy and surgical] SRS [sex reassignment surgery] is an effective treatment for transsexualism and the only treatment that has been evaluated empirically with large clinical case series."[9]

Available routinely in the United States and in many other countries, these treatments are cost effective rather than cost prohibitive. In the United States, numerous large employers (e.g., City and County of San Francisco, University of California, Emory University, University of Michigan, IBM, Johnson & Johnson, Bank of America, Apple, and hundreds more[10]) have negotiated contracts with their insurance carriers to enable medically necessary treatment for transsexualism and/or GD to be provided to covered individuals. As more carriers realize the validity and effectiveness of treatment (Aetna, Cigna, United Healthcare, and many others now have medical guidelines for transgender care), coverage is being offered, often at very low or no additional premium cost.[11] More than 15 states currently have regulations in place prohibiting insurance carriers from offering policies that contain exclusions restricting transgender people from accessing needed healthcare.[12] Further, in a decision rendered 30 May 2014, the US Department of Health and Human Services Departmental Appeals Board found that "transsexual surgery" should not be considered experimental or dangerous as it has been proven to be an effective treatment for gender dysphoria when properly diagnosed and administered, lifting a longstanding Medicare program ban on this treatment.[13] More recently, in June, 2016, the Department of Defense lifted its ban on transgender military service, and will offer medically necessary hormone and surgical therapies for transgender active duty and reserve servicemen and women.[14]

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[7] Keo-Meier C L, et al. (2014).

[8] Newfield E, et al. (2006).

[9] Gijs L & Brewaeys A. (2007).

[10] See the latest Corporate Equality Index, maintained by the Human Rights Campaign Workplace Project at www.hrc.org for the list of companies that have scored 100% in current and past years (since 2002).

[11] Herman JL. (2013).

[12] See http://www.transequality.org/blog/pennsylvania-makes-17-states-dc-banning-trans-health-exclusions-hawaii-likely-next-0 for further information.

[13] www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf; last accessed 11-03-2016.

[14] Department of Defense Instruction (DoDI) 1300.28, "In-Service Transition for Transgender Service Members," June 30, 2016, and Directive-Type Memorandum (DTM) 16-005, "Military Service of Transgender Service Members," June 30, 2016.

"Professionals who provide services to patients with gender conditions understand the necessity of SRS, and concur that it is reconstructive, and as such should be reimbursed, as would any other medically necessary treatment."[15]

Professional associations that have issued statements in support of the WPATH Standards of Care include the American Medical Association, the Endocrine Society, the American Psychiatric Association, the American Psychological Association, the American Academy of Family Physicians, the National Commission of Correctional Health Care, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology, the American Society of Plastic Surgeons, and the World Health Organization.

The WPATH Board of Directors urges health insurance carriers and healthcare providers in the United States to eliminate transgender or transsexual exclusions from their policy documents and medical guidelines, and to provide coverage for transgender patients; also to include in their policy documents and medical guidelines the medically prescribed sex reassignment or gender affirming/confirming services necessary for subscribers' treatment and well-being; and to ensure that ongoing healthcare, both routine and specialized, is readily accessible and affordable to all their subscribers on an equal basis.

[15] Monstrey S, De Cuypere G, Ettner R (eds). (2007).

This position statement constitutes the professional and clinical opinions of the signers below, comprising all members of the WPATH Board of Directors and Executive Officers as of this date, 21 December 2016.

Gail Knudson, M.D. (Canada) President
Vin Tangpricha, M.D., Ph.D. (USA) President Elect
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Katherine Rachlin, Ph.D. (USA)
Loren Schechter, M.D. (USA)
Sam Winter, Ph.D. (Australia)

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Victoria L. Davidson v. Aetna Life & Casualty Insurance Co. 101 Misc.2d 1, 420 N.Y.S. 2d 450 (Sup. Ct., 1979).

Hard copy of email version of testimony given to the Senate Finance Committee with reference to SB 331 on Jan. 9, 2018, by Lisa Bunker.

Dear Senator,

I am emailing you before today's Senate Finance Committee hearing to provide you with an advance version of the testimony I intend to give you in person this afternoon regarding SB 331, the bill to prohibit Medicaid from covering gender affirmation surgery and hormone therapy. I object to this legislation on the grounds that it misrepresents the purpose of these treatments, and injects state control into private medical decisions.

To a person suffering from gender dysphoria, hormone therapy and reassignment surgery are not "elective" or "cosmetic" as stated in the bill. They are medically necessary and can be life-saving. That was certainly my personal experience when I underwent transition. My gender dysphoria - the persistent sense of wrongness I felt in my body - was so acute, I truly felt at the time that my other options besides transition were escape into substances, or suicide. (Info from the American Psychiatric Association on the diagnosis of gender dysphoria here.) https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

My personal experience is backed up by broad consensus in the medical community. Dozens of mainstream medical organizations, including the American Medical Association, the American Psychiatric Association, and many others, have recognized the medical necessity of these treatments and officially endorsed them. A list of some of these organizations is here. https://transcendlegal.org/medical-organization-statements

(I will note that proponents of this bill may cite Dr. Paul McHugh, formerly affiliated with John Hopkins, and/or the American College of Pediatricians, which Dr. McHugh helped found. Despite its impressive-sounding name, the ACP is a small, ideologically driven radical fringe entity that has been designated a hate group by the Southern Poverty Law Center. More info here.)
https://www.splcenter.org/hatewatch/2016/04/07/anti-lgbt-hate-group-releases-anti-trans-position-statement

SB 331 also misrepresents the specific purpose of gender transition when it notes that surgery cannot impart reproductive function. That has never been the purpose of this surgery. Rather, the treatment alleviates crippling dysphoria, that officially diagnosable sense of wrongness I mentioned before. The loss of fertility is a sacrifice, but one many trans people are willing to make in order to finally live as their true selves in the world. And I will note that there are protocols in place to make sure such decisions are never made lightly, especially where children are involved. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351

Finally, even if this bill was based based on accurate information, which it is not, I respectfully submit that medical treatments should be determined by patients and their doctors, not categorically denied by the state. SB 331 is based on false assumptions, and over-reaches the authority of the legislature in the private lives of New Hampshire residents. Its passage into law would represent real hardship for Granite Staters in need of a proven medical treatment. I urge the committee not to move this legislation forward any further.

Thank you for your kind attention.

Best regards,

~Lisa~
ehbunker@gmail.com

NEW HAMPSHIRE LEGAL ASSISTANCE

Working for Equal Justice Since 1971

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TTY: 1-800-735-2964

January 9, 2018

Senate Finance Committee
NH State Senate
107 North Main Street
Concord, NH 03301

Dear Senators:

I write on behalf of New Hampshire Legal Assistance (NHLA) to convey NHLA's opposition to SB 331.[1] NHLA is a non-profit law firm. We represent low-income and elderly clients in civil cases impacting their basic needs, including healthcare.

We previously testified at the Department of Health and Human Services in support of the rule change to remove "Sex change operations" from the list of Medicaid "non-covered" services in He-W.06. Medicaid coverage for treatment related to a person's gender transition should no longer be categorically excluded from Medicaid coverage, in fact it is mandated by federal law. Medicaid coverage includes hospital and physician services, such as those required by a Medicaid beneficiary in medical need of gender transition services. Under the nondiscrimination section of the Affordable Care Act, Section 1557, Medicaid cannot discriminate against individuals who need medical care for gender transition.

In addition to surgery, SB 331 proposes to exclude drug and hormone therapy. Medicaid should cover whatever is medically necessary. These services are mandated by federal law. If New Hampshire was to pass a law such as SB 331, Medicaid recipients could rely on federal law to claim a right to gender reassignment or hormone treatment therapy. The State will likely be subject to litigation and found liable to individuals denied care under existing He-W 531.06(g).

Thank you for the opportunity to comment. Please call me at (603) 206-2228 if you have any questions.

Sincerely,

Dawn McKinney
Policy Director

[1] NHLA submits these comments without prejudice to the right of our law firm and/or our current or future clients to make any claims in any current or future litigation. Absence of comment regarding any proposed changes to the law should not be construed as support for those proposed changes nor agreement that they are lawful.

NAMI | New Hampshire

National Alliance on Mental Illness

January 9, 2018

Honorable Senator Gary Daniels Chairman
Senate Finance Committee
North Main Street – SH Room 103
Concord, NH 03301

Dear Senator Daniels and Members of the Committee,

Thank you for the opportunity to testify today. My name is Kenneth Norton and I serve as Executive Director of NAMI NH, the National Alliance on Mental Illness. On behalf of NAMI NH, I am here to speak in opposition to SB 331.

Specifically, I am here to talk about the high risk for suicide for trans people. By way of background, I led the development of NAMI NH's Connect Suicide Prevention Program which was designated as a National Best Practice in suicide prevention, intervention and postvention. The Connect Program has trained in over 40 states and 35 tribal nations. In my role, I have done briefings related to mental health and suicide prevention at the Pentagon, provided training for the Department of Defense and presented in four countries. I have also served on numerous national workgroups and committees, including the National Suicide Prevention Lifeline.

As the chart below indicates, suicide is the second leading cause of death for ages 10-34 in NH (as well as nationally). It is the third leading cause of death ages 35-34, and fourth leading cause of death for ages 45-54. Suicide deaths are the tip of the iceberg in contrast to suicide attempts. The human and economic impact of suicide deaths and attempts is significant. A small but important subgroup of these statistics are people who are dealing with gender identity issues. There is an emerging body of research showing that trans people are eight times more likely to attempt suicide than their peers in the general population. Young people who are gender non-conforming are at higher risk. A 2017 review of recent research on trans-gender suicide showed several unique risk factors contribute to the high rate of suicide in this population: including lack of

NH Top Ten Leading Causes of Death
2011-2015

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 44	Unintentional Injury 10	Malignant Neoplasms —	Malignant Neoplasms 11	Unintentional Injury 252	Unintentional Injury 458	Unintentional Injury 381	Malignant Neoplasms 993	Malignant Neoplasms 2,572	Heart Disease 10,179	Malignant Neoplasms 13,455
2	Short Gestation 41	Congenital Anomalies —	Unintentional Injury —	Suicide —	Suicide 109	Suicide 143	Malignant Neoplasms 207	Heart Disease 578	Heart Disease 1,155	Malignant Neoplasms 9,581	Heart Disease 12,125
3	Maternal Pregnancy Comp. 29	Heart Disease —	Homicide —	Unintentional Injury —	Malignant Neoplasms 20	Malignant Neoplasms 76	Suicide 166	Unintentional Injury 453	Unintentional Injury 355	Chronic Low. Respiratory Disease 2,935	Chronic Low. Respiratory Disease 3,377
4	Placenta Cord Membranes 17	Homicide —	Cerebro-vascular —	Benign Neoplasms —	Heart Disease 14	Heart Disease 28	Heart Disease 119	Suicide 281	Chronic Low. Respiratory Disease 329	Cerebro-vascular 2,082	Unintentional Injury 3,276
5	SIDS 11	Influenza & Pneumonia —	Congenital Anomalies —	Congenital Anomalies —	Homicide 14	Congenital Anomalies 14	Liver Disease 37	Liver Disease 165	Liver Disease 250	Alzheimer's Disease 1,924	Cerebro-vascular 2,319
6	Circulatory System Disease 10	Malignant Neoplasms —	Heart Disease —	Heart Disease —	Cerebro-vascular —	Homicide 12	Diabetes Mellitus 23	Diabetes Mellitus 106	Diabetes Mellitus 248	Unintentional Injury 1,349	Alzheimer's Disease 1,966
7	Respiratory Distress —	Benign Neoplasms —	Suicide —	Homicide —	Chronic Low. Respiratory Disease —	Diabetes Mellitus —	Homicide 17	Chronic Low. Respiratory Disease 65	Suicide 209	Diabetes Mellitus 1,083	Diabetes Mellitus 1,473
8	Necrotizing Enterocolitis —				Benign Neoplasms —	Chronic Low. Respiratory Disease —	Cerebro-vascular 13	Cerebro-vascular 64	Cerebro-vascular 144	Influenza & Pneumonia 1,022	Influenza & Pneumonia 1,119
9	Neonatal Hemorrhage —				Congenital Anomalies —	Liver Disease —	Chronic Low. Respiratory Disease 13	Viral Hepatitis 27	Septicemia 73	Nephritis 782	Suicide 1,060
10	Unintentional Injury —				Diabetes Mellitus —	Complicated Pregnancy —	Two Tied —	Influenza & Pneumonia 24	Viral Hepatitis 69	Parkinson's Disease 582	Nephritis 869

Causes of Death Printer-Friendly Version

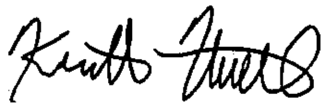
NAMI New Hampshire • 85 North State Street • Concord, NH 03301
InfoLine: 800-242-6264 • Tel. 603-225-5359 • Fax 603-228-8848 • info@naminh.org / www.NAMINH.org

family and social supports, gender-based discrimination, transgender-based abuse and violence, gender dysphoria and body-related shame, difficulty while undergoing gender reassignment, and being a member of another or multiple minority groups.

NAMI NH is committed to addressing suicide as a public health issue and reducing the incidence of suicide death in NH. We support the decision by the NH Department of Health and Human Services to offer Medicaid recipients the option of hormone therapy or sex reassignment surgery based on the recommendations and consultation with their health care providers. It is our opinion that denying these medical treatments will result in increased risk for suicide.

We respectfully request that you vote this bill inexpedient to legislate. I am happy to answer any questions which you may have.

Respectfully,



Kenneth Norton, LICSW
Executive Director

Testimony by Dr. Laura Fry
Senate Finance Committee
Senate Bill 331
January 9, 2018

1) Good afternoon. My name is Dr. Laura Fry and I am the Associate Medical Director for the Manchester Community Health Center.
2) I appreciate the opportunity to testify today in opposition to this bill, which would deny life-saving medical care to Granite Staters.
3) Let me start by reminding you of statistics you probably are very well acquainted with:
   a. Transgender people have well known barriers to health care due to multiple factors including medical stigma, lack of provider knowledge and education, simple lack of access due to likelihood of poverty and lack of insurance. This lack of access to health care is the biggest barrier to both safe hormonal treatment and appropriate medical care, which are critical, and often life-saving, treatment of gender dysphoria.
   b. Health care needs are high! Trans people live in poverty, in fact they experience poverty at 4 X the national average, and 19 % lack health services (NY study). They suffer a high prevalence of depression, substance abuse to cope with mistreatment, and a suicide attempt rate that is 26 times higher than the general population;
   c. There are also legal barriers, stigma and discrimination.
   d. We know there is family rejection, violation of their rights to education, employment and social protections and thus higher rates of unemployment, poverty, housing insecurity and marginalization.
   e. Adolescents are particularly vulnerable as the beginning of puberty and the physical signs of gender become more pronounced and are not desired by those children who identify with the other gender
4) What may be most important with regards to this bill is understanding that being Transgender is not a choice, nor a mental illness., It is a persistent and authentic disconnection between the sex assigned to a person at birth and the internal sense of who they are. It is long known and long lived, and can be expressed as young as two or three years old. Hormonal treatment

and gender affirmation surgery are not cosmetic or convenient. They are often are life-saving medical procedures for transgender patients.

5) For me, this bill is personal. I started treating transgender patients about 11 years ago, when Jill, a relatively new patient of mine, asked me to start hormonal treatment because she said: "I'm a woman living in a man's body and I can't take it anymore." She was 55, and had multiple chronic medical problems. Soon after, a speaker at a medical conference who is a transwoman herself, told me this: "By providing hormonal treatment, you will be doing the one thing that will save her life". Since then I've been treating a dozen or so patients both M-F and F-M. Jill has had numerous more medical issues and I've agonized over her, but we've worked most of them out, and she has had some surgery done, remains on hormones, has done legal work to change her official gender assignment and is an advocate in our office for using proper pronouns!

   Another patient of mine came to us at age 16 with a "mental health crisis," including anxiety and depression. At that time, she was a male in our system and on her chart, but revealed already long standing knowledge of identifying as female, and had not told her mother. We facilitated her telling her mom her story; because of the young age, we did make a referral to a specialist, but since have started hormones, and the anxiety and depression have melted away. She is a happy confident young woman, now 19, who has plans to continue with gender reassignment surgery.

   Most of our patients are not seeking multi-million dollar surgeries, but are moving toward being able to live comfortably as the gender with which they identify. This is not cosmetic surgery or a poorly-thought out whim by these patients. This is life affirming and often life saving care. These are not patients who think that it's fashionable or convenient to change gender, but for whom a profound knowledge has been with them most of their lives, from when they understood the world to be divided into Boys and Girls. Their lives are not easy, and are certainly not made easier by being Transgender, and the process takes a lot of courage, and support from a medical community that is understanding, knowledgeable and

sympathetic. Denial of medically necessary treatments puts an already vulnerable population more at risk for severe emotional and physical sequelae.

Decisions about hormone therapy and gender affirmation surgery are best handled by doctors and their patients. By denying Medicaid coverage for these medical care options, this legislature would be preventing doctors from caring for their patients by taking needed medical options off the table. I am here today to ask you to leave decisions about medical care to doctors. I ask you to recommend to the Senate floor that SB311 be ruled "inexpedient to legislate."

The NHAFP supports my presence here and our stance is in line with the AAFP's non discrimination policy.

Statement by Jeanne Hruska, ACLU-NH
Senate Finance Committee
Senate Bill 331
January 9, 2018

I appreciate the opportunity to testify today in opposition to this bill, which would discriminate against our LGBT friends and family by denying them life-saving medical care.

A Transgender person is someone whose sex as designated at birth is different from who they know they are on the inside. So, for example, a transgender woman is a woman who was designated male at birth but is a woman. Many Transgender people require medical care to bring their body, the expression of their gender, and/or their biochemistry into alignment with who they really are. Gender transition-related care, including the provision of gender-affirming surgical care and other treatments such as hormone therapy, are neither cosmetic nor elective. This care is recognized by the medical and scientific communities as medically necessary for the treatment of gender dysphoria.[1]

Gender dysphoria is a real and serious medical condition experienced by many transgender people.[2] The condition is marked by clinically significant distress that stems from the misalignment of a person's gender identity (one's internalized sense of being a particular sex-i.e., male or female) and his or her assigned birth sex. Without treatment, this misalignment and the distress associated with it predictably leads to serious medical and mental health consequences, including clinical depression, loss of self-esteem, and in some cases, self-harm including genital self-surgery and suicide.[3]

The American Medical Association (AMA) has concluded that medical research demonstrates the necessity and effectiveness of hormone therapy and surgeries to treat many individuals diagnosed with gender dysphoria. As such, the AMA supports public and private health insurance coverage for these medically necessary treatments and opposes the kind of exclusions that SB331 would create.[4]

There is no substitute for this effective and life-saving treatment for gender dysphoria. Although there are a variety treatment options for gender dysphoria, for many individuals, surgical

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[1] *See* notes 5 and 6, below.

[2] *See* American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 5th ed., (American Psychiatric Publishing, 2013); American Medical Association House of Delegates (hereinafter "AMA"), "Removing Financial Barriers to Care for Transgender Patients" (2008), available at http://www.tgender.net/taw/ama_resolutions.pdf; and The World Health Organization's International Statistical Classification of Diseases and Related Health Problems, version 10 (ICD-10) includes "gender identity disorder," *available at* http://apps.who.int/classifications/icd10/browse/2010/en#/F64.

[3] AMA, above at 1.

[4] *See* note 7, above.

treatment is medically necessary.[5] Based on numerous studies tracking post treatment outcomes of individuals who have undergone gender-affirming surgical treatment, the AMA confirms that delaying treatment for gender dysphoria "can cause and/or aggravate additional serious and expensive health problems, such as stress-related physical illnesses, depression, and substance abuse problems, which further endanger patients' health and strain the health care system."[6] Follow-up studies have also shown the undeniable beneficial effect of this surgical care on postoperative outcomes.[7] SB331 would deny life-saving care for a serious medical condition and prevent doctors from determining the best care for their patients.

I also want to directly address the false allegation in the bill that public funding for gender-affirming surgical care or hormone therapy implicates our state constitution's guarantee regarding rights of conscience and religious liberty. That allegation is simply false. This law is about access to insurance coverage, and does not impose any specific regulations on any providers. Providing Medicaid coverage for these medical procedures simply ensures that Granite Staters are able to access the life-saving care they need and deserve.

Moreover, passage of this bill would result in New Hampshire falling out of compliance with state and federal law, which could open the state to legal action by those unlawfully denied coverage.

A state public health plan that targets transgender persons to withhold coverage for medically necessary care discriminates on the basis of sex. Federal courts have found that discrimination against transgender individuals is impermissible sex discrimination under the United States Constitution and federal laws prohibiting discrimination on the basis of sex, including Title VII.[8] New Hampshire courts have held that in matters of first impression under New Hampshire antidiscrimination law, New Hampshire will look to federal Title VII precedent, and thus, discrimination against transgender individuals is also impermissible sex discrimination under New Hampshire comparable antidiscrimination law.[9]

In addition, New Hampshire courts have held that discrimination based on an individual's gender identity constitutes disability discrimination. In Doe v. Electro-Craft, the Superior Court noted

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[5] Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. Plastic and Reconstructive Surgery, 105(3), 1222-1227.

[6] American Medical Association House of Delegates, Resolution 122, A-08, supra note 7.

[7] See, e.g. De Cuypere, G., & Vercruysse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH standards of care. International Journal of Transgenderism, 11(3), 194-205.; Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to-male transsexuals. European Urology, 57(4), 715-722; Klein, C., & Gorzalka, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME). The Journal of Sexual Medicine, 6(11), 2922-2939.

[8] Both federal courts and executive agencies have repeatedly indicated that sex-based protections cover transgender people through a definition of the term "sex" that includes gender identity and nonconformity with sex stereotypes. The U.S. Equal Employment Opportunity Commission recently issued a formal ruling that gender identity discrimination is *per se* sex discrimination. Macy v. Eric Holder, Atty. General, U.S. Dept. of Justice, EEOC Appeal No. 0120120821 (April 24, 2012).. *See, e.g.*, Glenn v. Brumby, 665 F.3d 1312 (11th Cir. 2011); Barnes v. City of Cincinnati, 401 F.3d 729 (6th Cir. 2005); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000); and Schroer v. Billington, 577 F. Supp. 2d 293 653 (D.D.C. 2008).

[9] Madeja v. MPB Corp., 149 N.H. 371, 378, 821 A.2d 1034, 1042 (citing N.H. Dep't of Corrections v. Butland, 147 N.H. 676, 680).

that the inclusion of gender identity disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) supported inclusion of gender identity disorder as a "handicap" for purposes of New Hampshire antidiscrimination law,[10] 1988 WL 1091932 (N.H.Super.). Since that decision in 1988, it is even more clear that transgender individuals would be covered under the state's disability laws, because, as noted above, not only the DSM but also every major medical association, including the American Medical Association and American Psychiatric Association agree that gender dysphoria is a medical condition for which there is an established course of treatment and that hormone therapy and surgical care are medically necessary for many individuals with the condition. By excluding such treatment from Medicaid coverage, New Hampshire would impermissibly discriminate on the basis of disability under state and federal law.

SB331 would also, by creating a categorical exclusion for all surgeries to treat gender dysphoria, violate federal law. The Federal Medicaid Act, 42 U.S.C. §1396a, mandates that the medical assistance made available to one person not be less in amount, duration, or scope than the medical assistance made available to any other individual. The Office of Medicaid "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 420.230(c). Specifically excluding coverage for all surgical care or hormone therapy related to gender transition regardless of individual medical need would do exactly that - arbitrarily deny coverage for treatment based exclusively on a Medicaid recipient's gender dysphoria.

SB331 would also violate the Affordable Care Act (ACA). Section 1557 of the ACA, the antidiscrimination provision, applies to "any program or activity that is administered by an Executive Agency," which includes New Hampshire's Medicaid program. This provision prohibits discrimination on bases addressed by federal civil rights laws, including Title IX of the Education Amendments of 1972 and Title VI of the Civil Rights Act of 1964. Through this non-discrimination law, §1557 incorporates nondiscrimination protections on the basis of sex, which includes protections based on gender identity, transgender status, and sex stereotypes. The law's implementing regulations make explicit that Section 1557 prohibits discrimination based on gender identity or sex stereotyping.[11]

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[10] RSA 354:A-2 defines disability as "(a) A physical or mental impairment which substantially limits one or more of such person's major life activities; (b) A record of having such an impairment; or (c) Being regarded as having such an impairment. Provided, that "disability" does not include current, illegal use of or addiction to a controlled substance as defined in the Controlled Substances Act (21 U.S.C. 802 sec. 102).

[11] Office for Civil Rights, *Questions and Answers on Section 1557 of the Affordable Care Act*, http://www.hhs.gov/ocr/civilrights/resources/laws/section1557_questions_answers.html (last accessed July 17, 2013); Letter from Leon Rodriguez, Director of the Office for Civil Rights, U.S. Department of Health and Human Services. July 12, 2012. Available at: http://hrc.org/files/assets/resources/HHSResponse8612.pdf. Not only has the Office for Civil Rights clarified that discrimination on the basis of gender identity is sex discrimination; both federal courts and executive agencies have repeatedly indicated that sex-based protections cover transgender people through a definition of the term "sex" that includes gender identity and nonconformity with sex stereotypes. The U.S. Equal Employment Opportunity Commission recently issued a formal ruling that gender identity discrimination is *per se* sex discrimination, Macy v. Eric Holder, Atty. General, U.S. Dept. of Justice, EEOC Appeal No. 0120120821 (April 24, 2012).. *See, e.g.*, Glenn v. Brumby, 665 F.3d 1312 (11th Cir. 2011); Barnes v. City of Cincinnati, 401 F.3d 729 (6th Cir. 2005); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000); and Schroer v. Billington, 577 F. Supp. 2d 293 653 (D.D.C. 2008).

A bill that would permit coverage of a procedure, for example, a hysterectomy, when medically necessary for a non-transgender woman but that would deny coverage of this same procedure to a transgender man for whom it is also medically necessary treatment for gender dysphoria discriminates based on sex, gender identity, and sex stereotyping.

Regulations implementing the ACA require that benefits established as essential not be subject to denial based on present or predicted disability, degree of medical dependency, or quality of life.[12] Gender dysphoria is a health condition, as discussed above, and therefore, state Medicaid programs may not lawfully exclude all treatment for a medical condition just because of the disability, medical condition or identity of the individual requiring the essential benefit.

A 2016 decision issued by a federal district court in Texas has not changed this legal analysis. *See* Franciscan Alliance v. Burwell, no. 7:16-cv- 00108-o (N.D. Tex. Dec. 31, 2016). That decision did not change the scope of the non-discrimination provision of the ACA as set forth in Section 1557 nor could it. Only Congress can do that. The case was not a challenge to the non-discrimination provision of the ACA, but rather a challenge to regulations issued by the U.S. Department of Health and Human Services (USHHS) interpreting the non-discrimination provision of the ACA. The Court's ruling prevents USHHS from investigating and acting on complaints of discrimination brought by transgender people challenging denials of health care. Until Congress says otherwise, Section 1557 remains a vehicle for Granite State transgender people to bring legal challenges for the denial of gender transition-related care.

In sum, transgender people need and deserve health care, just like everyone else. This bill would result in discrimination and would exclude a category of effective and widely utilized medical care. The bill has no sound basis in science or medicine, and would compromise the health and well-being of a whole class of persons in the state. It would also open the state to costly and protracted legal challenges. I urge this committee to vote against SB331.

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[12] 42 U.S.C. 18022(b)(4)

TO: Senate Finance Committee

FROM: Shannon McGinley, Cornerstone Action
603-228-4794, smcginley@nhcornrstone.org

DATE: Tuesday, January 8, 2018

RE: please vote OTP on SB 331, prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Cornerstone is concerned about public policy regarding parental rights, children's welfare, and conscience rights. All three are at issue with SB 331. Cornerstone Action [and its supporters] support the bill.

A recent Medicaid rule change provides background to our position. Late last July, the New Hampshire Department of Health and Human Services sent letters to participants in the Healthy Families program, informing them that as of July 1, "gender reassignment" would be a covered service. **The letters were addressed to the minors** and went out long before the scheduled public hearing about amending Medicaid rules to allow payment for such procedures. A **second letter** with identical language was sent to minors before the rescheduled hearing as well.

Thus without advance notice, New Hampshire taxpayers were made financially responsible for gender reassignment procedures. **DHHS treated Medicaid funding for gender reassignment as a done deal without oversight.** The public hearing and subsequent JLCAR review could not change that fact.

Since July, Cornerstone has heard from parents whose families are covered under Healthy Families, but whose children's chronic conditions are not covered in full under the program. They asked a question that has yet to be answered: with existing health needs yet unmet, why did DHHS expand Medicaid to cover gender reassignment, an elective plastic surgery procedure?

The lack of transparency alone by DHHS in this matter should be enough to prompt you to pass SB 331. At this point, **allowing last July's Medicaid rule change to stand rewards DHHS for its done-deal behavior**.

Letting the DHHS policy stand allows gender reassignment for minors. If this is being done under the guise of "non-elective" medicine, I have to ask what will happen if a minor covered under Medicaid were to seek sex-change - or 'gender reassignment' - against the wishes of parents. Will DHHS seek custody of such a child on the grounds that parents are failing to provide medical treatment? Will you, as legislators, step in to prevent such a scenario from coming to pass? You can, by supporting SB 331.

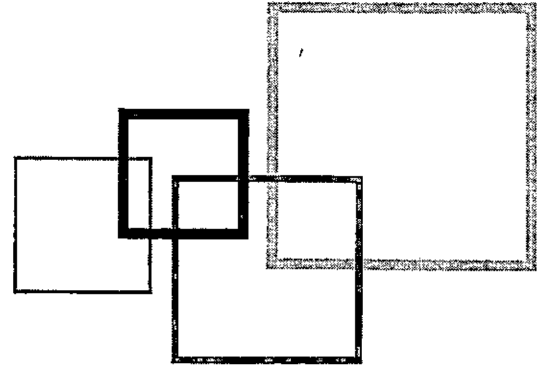
We are concerned that taxpayer funding of gender reassignment is a violation of conscience rights. Just as people with sincerely-held religious beliefs about the right to life have been protected to a large degree from funding abortions thanks to the Hyde Amendment and similar provisions, people with sincerely-held moral objections to gender-altering procedures should not be forced into participating in those procedures via their taxes.

Furthermore, with last year's done-deal rule change, **DHHS ignored a federal court order.** The DHHS's excuse for the proposed rule change mandating coverage for sex-change procedures is that failure to do so equals discrimination under the terms of the federal Affordable Care Act (Obamacare). The Fifth Circuit Court of Appeals, in an action that applies nationwide, has enjoined that provision of Obamacare.

Medicaid funding of gender reassignment is a political move, not driven by public health needs. **Please vote Ought to Pass on SB 331,** and tell DHHS to keep political moves away from Healthy Families.

Strong Families for a Strong New Hampshire

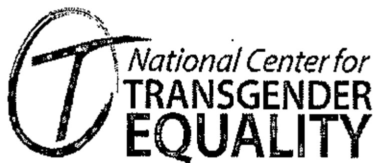
P.O. BOX 4683, MANCHESTER, NH 03108 | PH (603) 228-4794
WWW.NHCORNERSTONE.ORG



2015 U.S. Transgender Survey

New Hampshire State Report

January 2017



The full report and Executive Summary of the 2015 U.S. Transgender Survey are available at www.USTransSurvey.org.

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Updated October 2017

USTransSurvey.org | TransEquality.org

New Hampshire State Report

The 2015 U.S. Transgender Survey (USTS) is the largest survey examining the experiences of transgender people in the United States, with 27,715 respondents nationwide. The USTS was conducted by the National Center for Transgender Equality in the summer of 2015. Of respondents in the USTS, 225 were New Hampshire residents.[1] This report discusses the experiences of respondents living in New Hampshire.

Income and Employment Status

- 7% of respondents in New Hampshire were unemployed.[2]
- 18% were living in poverty.[3]

Employment and the Workplace

- 15% of respondents who have ever been employed reported losing a job in their lifetime because of their gender identity or expression.
- In the past year, 20% of those who held or applied for a job during that year reported being fired, being denied a promotion, or not being hired for a job they applied for because of their gender identity or expression.
- Respondents who had a job in the past year reported being verbally harassed (11%), physically attacked (1%), and sexually assaulted (1%) at work because of their gender identity or expression.
- 17% of those who had a job in the past year reported other forms of mistreatment based on their gender identity or expression during that year, such as being 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, or having a boss or coworker share private information about their transgender status with others without their permission.
- Overall, 21% of respondents who had a job in the past year reported being fired, being denied a promotion, or experiencing some other form of mistreatment related to their gender identity or expression during that past year.

Education

- 74% of those who were out or perceived as transgender at some point between Kindergarten and Grade 12 (K–12) experienced some form of mistreatment, such as being verbally harassed, prohibited from dressing according to their gender identity, disciplined more harshly, or physically or sexually assaulted because people thought they were transgender.
  - 65% of those who were out or perceived as transgender in K–12 were verbally harassed, 26% were physically attacked, and 21% were sexually assaulted in K–12 because of being transgender.

- 12% faced such severe mistreatment as a transgender person that they left a K–12 school.

- 27% of respondents who were out or perceived as transgender in college or vocational school were verbally, physically, or sexually harassed because of being transgender.

Housing and Homelessness

- 23% of respondents experienced some form of housing discrimination in the past year, such as being evicted from their home or denied a home or apartment because of being transgender.
- 28% have experienced homelessness at some point in their lives.
- 10% experienced homelessness in the past year because of being transgender.

Public Accommodations

- Respondents reported being denied equal treatment or service, verbally harassed, or physically attacked at many places of public accommodation—places that provide services to the public, like retail stores, hotels, and government offices.
- Of respondents who visited a place of public accommodation where staff or employees thought or knew they were transgender, 22% experienced at least one type of mistreatment in the past year. This included 13% who were denied equal treatment or service, 13% who were verbally harassed, and 2% who were physically attacked because of being transgender.

Restrooms

- 9% of respondents reported that someone denied them access to a restroom in the past year.
- In the past year, respondents reported being verbally harassed (9%), physically attacked (2%), and sexually assaulted (1%) when accessing a restroom.
- 54% of respondents avoided using a public restroom in the past year because they were afraid of confrontations or other problems they might experience.
- 27% of respondents limited the amount that they ate or drank to avoid using the restroom in the past year.

Police Interactions

- Respondents experienced high levels of mistreatment and harassment by police. In the past year, of respondents who interacted with police or other law enforcement officers who thought or knew they were transgender, 47% experienced some form of mistreatment. This included being verbally harassed, repeatedly referred to as the wrong gender, physically assaulted, or sexually assaulted, including being forced by officers to engage in sexual activity to avoid arrest.
- 48% of respondents said they would feel uncomfortable asking the police for help if they needed it.

Health

- 24% of respondents experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender.
- 27% of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender. This included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.
- In the past year, 18% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 25% did not see a doctor when needed because they could not afford it.
- 35% of respondents experienced serious psychological distress in the month prior to completing the survey (based on the Kessler 6 Psychological Distress Scale).[4]
- 13% of respondents reported that a professional, such as a psychologist, counselor, or religious advisor, tried to stop them from being transgender.

Identity Documents

- Only 13% of respondents reported that *all* of their IDs had the name and gender they preferred, while 60% reported that *none* of their IDs had the name and gender they preferred.
- The cost of changing IDs was one of the main barriers respondents faced, with 28% of those who have not changed their legal name and 25% of those who have not updated the gender on their IDs reporting that it was because they could not afford it.
- 23% of respondents who have shown an ID with a name or gender that did not match their gender presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted.

ENDNOTES | NEW HAMPSHIRE STATE REPORT

1. The number of respondents in New Hampshire (n=225) is an unweighted value. All reported percentages are weighted. For more information on the methodology and weighting procedures used to report 2015 U.S. Transgender Survey data, see the full survey report, available at www.USTransSurvey.org.
2. For reference, the U.S. unemployment rate was 5% at the time of the survey, as reported by the Bureau of Labor Statistics. See the full report for more information about this calculation.
3. For reference, the U.S. poverty rate was 12% at the time of the survey. The research team calculated the USTS poverty measure using the official poverty measure, as defined by the U.S. Census Bureau. USTS respondents were designated as living in poverty if their total family income fell under 125% of the official U.S. poverty line. See the full report for more information about this calculation.
4. For reference, 5% of the U.S. population reported experiencing serious psychological distress during the prior month as reported in the 2015 National Survey on Drug Use and Health. See the full report for more information about this calculation.

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Monday, March 12, 2018

THE COMMITTEE ON Finance

to which was referred **SB 331**

AN ACT prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.

Having considered the same, the committee recommends that the Bill

IS INEXPEDIENT TO LEGISLATE

BY A VOTE OF: 3-3

Senator John Reagan
For the Committee

Deb Martone 271-4980

FINANCE

SB 331, prohibiting Medicaid from paying for sex reassignment drug or hormone therapy or surgery.
Inexpedient to Legislate, Vote 3-3.
Senator John Reagan for the committee.