



ADVANCING FAITH, FAMILY AND FREEDOM

PUBLIC COMMENT

Submitted in response to:

“Notice of Petition for Rulemaking and request for comments—Exclusion of Gender Alterations from the Medical Benefits Package.”

(*Federal Register* Vol. 83, No. 131, July 9, 2018, pp. 31711-31712.)

September 7, 2018

SYNOPSIS:

Family Research Council urges that the Department of Veterans Affairs *reject* the Petition for Rulemaking and *maintain* the current exclusion of “gender alterations” from the VA’s Medical Benefits Package, as listed in 38 CFR 17.38(c)(4).

VA benefits should be aimed at the direst, most life-threatening needs first. They should not go to surgery on physically healthy individuals who elect to alter their physically healthy bodies.

In 2016, the Centers for Medicare & Medicaid Services (CMS) issued a memo declining to issue a National Coverage Determination (NCD) mandating coverage for gender reassignment surgery. They declared that “there is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes.” What CMS was unwilling to do for Medicare recipients, the VA should not be doing for recipients of VA medical benefits.

Advocates for taxpayer funding of medical gender transition claim that it will reduce the mental health problems and risk of suicide that are known to exist at higher levels among those who identify as transgender. However, one of the strongest studies ever done on the subject, a 2011 study out of Sweden (Dhejne et al., *PLoS ONE*) did not support such a conclusion. The CMS memo stated:

The study identified increased mortality and psychiatric hospitalization compared to the matched controls. The mortality was primarily due to completed suicides (19.1-fold greater than in control Swedes), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well. . . . The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%).

Finally, the exorbitant cost of these procedures can hardly be justified for so little benefit. Data from the Philadelphia Center for Transgender Surgery suggests that a comprehensive package of male-to-female surgical procedures would cost \$110,450, and female-to-male procedures would cost \$89,050. That’s not to mention hormone treatment, which is required indefinitely and can cost as much as \$200 a month.

We urge you to reject the Petition for Rulemaking and retain the current exclusion of “gender alterations” from the VA’s medical benefits package.

BODY:

On behalf of Family Research Council, a non-profit public policy organization that addresses issues of family, human sexuality, and religious liberty, I write to urge that the Department of Veterans Affairs *reject* the Petition for Rulemaking and *maintain* the current exclusion of “gender alterations” from the VA’s Medical Benefits Package, as listed in 38 CFR 17.38(c)(4).

38 CFR 17:38(b) states:

Care referred to in the “medical benefits package” will be provided to individuals only if it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

Medical procedures which fall in the area of “gender alterations” (including cross-sex hormone therapy and gender reassignment surgery) do *not* “promote health” (“enhance the quality of life or daily functional level of the veteran”), “preserve health” (“maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span”), or “restore health” (“restore the quality of life or daily functional level that has been lost due to illness or injury”). Instead, such procedures interfere with, disrupt, or destroy the normal operation of body systems such as the endocrine and reproductive systems; and remove or destroy the functioning of otherwise normal and healthy body parts. This can hardly be considered “health care,” let alone “medically necessary.”

Furthermore, 38 CFR 17.38(a)(1)(x) says that the medical benefits package includes:

Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.

Gender reassignment surgery is not undertaken as a result of “disease or trauma,” and is plainly cosmetic in nature, in that its *only* purpose is to alter the *appearance* of the body, not to improve the physical functioning of any part of the body.

These are obvious but crucial facts to remember when considering medical forms of “gender alterations” such as hormone therapy and gender reassignment surgery. These treatments do *nothing* to improve the *physical* functioning of the body. The only reason it is asserted that they are ever deemed “medically necessary” or even in any way medically beneficial is because it is asserted that they improve the *mental* health of the individual who experiences the *mental health* condition known as gender dysphoria. The use of *surgical* procedures in an effort to improve the *psychological* functioning of an individual is itself extraordinary in the practice of medicine, and it requires the highest level of evidence to justify using taxpayer funds for this purpose.

Although the World Professional Association for Transgender Health (WPATH) and other professional organizations assert that hormone therapy and gender reassignment surgery may be beneficial and even “medically necessary” for some patients, this conclusion is “consensus-based”—*not* “evidence-based,” meaning reflecting the convincing findings of a large body of

well-constructed scientific studies.¹ Reliance on “consensus-based” guidelines and practices represents little more than politically correct groupthink, with the “consensus” having been engineered by threats of career destruction for those who do not conform.

More on what the actual scientific evidence shows regarding “gender alterations” is found in response to the questions below.

What evidence is available about the safety and effectiveness of gender alterations for the treatment of gender dysphoria and how reliable is that evidence?

As the request for comments stated, earlier in 2018, “the Department of Defense issued a report that considered the efficacy of gender alteration surgery as treatment for gender dysphoria. That report noted considerable scientific uncertainty and overall lack of high quality scientific evidence demonstrating the extent to which transition-related treatments such as sex reassignment surgery remedy the multifaceted mental health problems associated with gender dysphoria.”

Family Research Council recently (December 2017) published a paper summarizing the results of one of the most detailed surveys of the scholarly literature concerning outcomes of gender reassignment surgery.² It was conducted by the federal Centers for Medicare & Medicaid Services (CMS) in response to a formal request for a National Coverage Determination (NCD) *mandating* coverage of gender reassignment surgery under Medicare. After a thorough examination of the evidence, however, CMS *declined* to issue an NCD on this topic, “because *the clinical evidence is inconclusive*” (emphasis added).³

Here is more of what FRC wrote about this 2016 decision memo:

CMS declared that “*there is not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively*” (emphasis added).⁴

It is worth examining more closely what CMS concluded about the inadequacy of the currently available evidence.

¹ For example, in the American Psychological Association’s “Criteria for Evaluating Treatment Guidelines,” one criterion is “Guidelines consider clinical opinion, observation, and consensus among recognized experts representing the range of views in the field.” However, this is only one of at least *twenty-one* such criteria. See: American Psychological Association, “Criteria for Evaluating Treatment Guidelines,” *American Psychologist* (December 2002), 1052-1059. Online at: <http://www.apa.org/pubs/journals/features/evaluating.pdf>.

² Peter Sprigg, “Is Gender Reassignment Surgery ‘Medically Necessary?’” *Issue Analysis* (Washington, D.C.: Family Research Council, December 2017); online at: <https://www.frc.org/genderreassignmentsurgery>.

³ “Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N),” Centers for Medicare & Medicaid Services, August 30, 2016, accessed September 5, 2018, 65, <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282>.

⁴ *Ibid.*

First, the CMS staff did an extensive search of the medical literature for studies focusing on the outcomes of gender reassignment surgery. While there is an abundance of literature on the general topic of such surgery, much of it involves individual case reports or details of specific surgical procedures—neither of which are helpful in determining the safety or effectiveness of such procedures for the general population of individuals suffering from gender dysphoria.

Instead, it was necessary to seek out studies that reported on “functional outcomes.” Since the goal of gender reassignment surgery is to improve the patient’s *mental* rather than physical health, these studies rely on “psychometric instruments”—defined as “scientific tools to measure individuals’ mental capabilities and behavioral style.” Such tools must demonstrate both “validity” (“how well the tool actually measures what it was designed to measure”) and “reliability” (“how accurately results of the tool would be replicated” in identical research). The CMS description of why these concepts are important hints at the difficulty in establishing definitive evidence that such surgery is “medically necessary”:

Reliability and validity are important because when evaluating patients with gender dysphoria *most of the variables of interest (e.g., satisfaction, anxiety, depression) are latent in nature (not directly observed but are rather inferred) and difficult to quantify objectively* (emphasis added).⁵

“All studies reviewed had potential methodological flaws . . .”

CMS ended up analyzing 33 studies, published between 1979 and 2015, that met their standards for inclusion. In evaluating the quality of these studies, CMS immediately noted one red flag: “There was a single randomized study.”⁶ The use of random samples—or in this case, random assignment to a group that would receive surgery or a group that would not—is generally considered one of the criteria for “gold standard” research, yet it is a technique that has almost never been used in studying the outcomes of gender reassignment surgery.

CMS concluded:

Overall, the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . , small sample sizes, lack of validated assessment tools, and considerable lost to follow-up (emphasis added).⁷

Not only were “the quality and strength of evidence” low, but the results were mixed:

Of the 33 studies reviewed, published results were conflicting – some were positive; others were negative. Collectively, the evidence is inconclusive for the

⁵ Ibid., 8.

⁶ Ibid., 10.

⁷ Ibid., 62.

Medicare population. The majority of studies were non-longitudinal, exploratory type studies (i.e., in a preliminary state of investigation or hypothesis generating), or did not include concurrent controls or testing prior to and after surgery.⁸

CMS concluded that only a handful of the studies were even useful for their evaluation—and they showed little demonstrable benefit from gender reassignment surgery (GRS):

After careful assessment, we identified six studies that could provide useful information (Figure 1). Of these, the four best designed and conducted studies that assessed quality of life before and after surgery using validated (albeit non-specific) psychometric studies *did not demonstrate clinically significant changes* or differences in psychometric test results after GRS (emphasis added).⁹

In addition to the 2016 CMS decision memo (which addressed only surgery, not hormone therapy), the February 2018 *Department of Defense Report and Recommendations on Military Service by Transgender Persons*¹⁰ summarized a number of other reviews of the research on the outcomes of gender reassignment surgery, hormone therapy, or both:

According to the Hayes Directory, which conducted a review of 19 peer-reviewed studies on sex reassignment surgery, the “evidence suggests positive benefits,” including “decreased [gender dysphoria], depression and anxiety, and increased [quality of life],” but “because of serious limitations,” these findings “permit only weak conclusions.”¹¹ It rated the quality of the evidence as “very low” due to the numerous limitations in the studies and concluded that there is not sufficient “evidence to establish patient selection criteria for [sex reassignment surgery] to treat [gender dysphoria].”¹²

With respect to hormone therapy, the Hayes Directory examined 10 peer-reviewed studies and concluded that a “substantial number of studies of cross-sex hormone therapy each show some positive findings suggesting improvement in well-being after cross-sex hormone therapy.”¹³ Yet again, it rated the quality of the evidence as “very low” and found that the “evidence is insufficient to support patient selection criteria for hormone therapy to treat [gender dysphoria].”¹⁴ . . .

In 2010, Mayo Clinic researchers conducted a comprehensive review of 28 studies on the use of cross-sex hormone therapy in sex reassignment and concluded that there was “very low quality evidence” showing that such therapy “likely improves gender

⁸ Ibid.

⁹ Ibid.

¹⁰ *Department of Defense Report and Recommendations on Military Service by Transgender Persons*, February 2018; online at: <https://permanent.access.gpo.gov/gpo90292/MILITARY-SERVICE-BY-TRANSGENDER-INDIVIDUALS.PDF>.

¹¹ Hayes Directory, “Sex Reassignment Surgery for the Treatment of Gender Dysphoria,” p. 4 (May 15, 2014).

¹² Id. at 3.

¹³ Hayes Directory, “Hormone Therapy for the Treatment of Gender Dysphoria,” pp. 2, 4 (May 19, 2014).

¹⁴ Id. at 4.

dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.”¹⁵ . . .

Even the RAND study, which the [previous Defense Secretary Ash] Carter policy is based upon, confirmed that “[t]here have been no randomized controlled trials of the effectiveness of various forms of treatment, and most evidence comes from retrospective studies.”¹⁶ . . . “In the absence of quality randomized trial evidence,” RAND concluded, “it is difficult to fully assess the outcomes of treatment for [gender dysphoria].”¹⁷

As noted in the publication by FRC, the CMS 2016 decision memo “searched for other sources of data on the effectiveness of gender reassignment surgery—and found them to be sparse.”

The search included “External Technology Assessments” and found:

There were no AHRQ [Agency for Healthcare Research and Quality] reviews on this topic.

There are no Blue Cross/Blue Shield Health Technology Assessments written on this topic within the last three years. . . .

There were no National Institute for Health and Care Excellence (NICE) reviews/guidance documents on this topic.

They did find, “There was a technology assessment commissioned by the New Zealand Ministry of Health . . .,” asking whether there was “evidence of effectiveness” for gender reassignment surgery (GRS) for “particular subgroups of people with transsexualism,” and “what subgroups would benefit from GRS?” However, “The authors concluded that there was not enough evidence to answer either of the research questions.”¹⁸

They examined “Evidence-Based Guidelines” and found:

ACOG [American College of Obstetricians and Gynecologists] did not have any evidence-based guidelines on this topic . . .

The American Psychiatric Association (APA) was unable to identify any Randomized Controlled Trials (RCTs) [sic] regarding mental health issues for transgender individuals.

¹⁵ Mohammad Hassan Murad, Mohamed B. Elamin, Magaly Zumaeta Garcia, Rebecca J. Mullan, Ayman Murad, Patricia J. Erwin & Victor M. Montori, “Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes,” *Clinical Endocrinology*, Vol. 72, p. 214 (2010).

¹⁶ RAND National Defense Research Institute, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, p. 7 (RAND Corporation 2016); available at:

https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1530/RAND_RR1530.pdf.

¹⁷ *Id.* at 10.

¹⁸ “Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N),” 42-44.

The Endocrine Society published a “Clinical Practice Guideline” focused primarily on endocrine (i.e., hormone) treatment of those who identify as transgender, but including a section on surgery as well. However, they cautioned about the quality of evidence available:

This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system to describe the strength of recommendations and the quality of evidence, which was low or very low.¹⁹

As for “Pending Clinical Trials,” they found the government clearinghouse website ClinicalTrials.gov reported that there is only one “currently listed and recently active trial directed at assessment of the clinical outcomes pertaining to individuals who have had gender reassignment surgery.”²⁰

The limited evidence available, and the poor quality of most of that evidence, make it impossible to conclude that “gender alterations” have been proven to be either safe or effective in reducing or eliminating the wide range of mental health problems associated with gender dysphoria.

Given the challenge of the high rates of Veteran suicide, what does the evidence, including peer-reviewed evidence, suggest about the impact of gender alterations on the rates of suicide and suicide ideation among those suffering from gender dysphoria?

This is an important question, since the elevated risk of suicide among those who identify as transgender is often cited as a reason to support medical gender transition (“gender alterations”). When activists refer to such treatments not only as “medically necessary” but as potentially “life-saving,” what they mean is that the treatments may prevent suicides that otherwise might have taken place. Is there evidence to support this claim?

Several of the sources cited in the *Department of Defense Report and Recommendations* (quoted above in answer to the first question) also address the suicide issue:

Importantly, the Hayes Directory also found: “Hormone therapy and subsequent [sex reassignment surgery] failed to bring overall mortality, suicide rates, or death from illicit drug use in [male-to-female] patients close to rates observed in the general male population. It is possible that mortality is nevertheless reduced by these treatments, but that cannot be determined from the available evidence.”²¹

¹⁹ Ibid., 44-46.

²⁰ Ibid., 49.

²¹ Hayes Directory, “Hormone Therapy for the Treatment of Gender Dysphoria,” p. 3; cited in *Department of Defense Report and Recommendations on Military Service by Transgender Persons*, p. 26.

The Mayo Clinic study said that “[s]uicide attempt rates decreased after sex reassignment but stayed higher than the normal population rate.”²²

As for the RAND study:

Although noting that “[m]ultiple observational studies have suggested significant and sometimes dramatic reduction in suicidality, suicide attempts, and suicides among transgender patients after receiving transition-related treatment,” RAND made clear that “none of these studies were randomized controlled trials (the gold standard for determining treatment efficacy).”²³

One of the outcome studies concerning gender reassignment surgery that was of the highest quality—a 2011 study out of Sweden—also had some of the *least* encouraging news regarding suicide rates. FRC summarized the 2016 CMS decision memo regarding the Swedish study:

One of the studies that did assess “functional endpoints,” conducted in Sweden, was perhaps the strongest study on the outcome of gender reassignment surgery. It is worth quoting the CMS summary of this study at length (emphasis added throughout):

Although the data are observational, they are robust because the Swedish national database is comprehensive (including all patients for which the government had paid for surgical services) and is notable for uniform criteria to qualify for treatment and financial coverage by the government. . . .

Dhejne et al., (2011)²⁴ tracked all patients who had undergone reassignment surgery (mean age 35.1 years) over a 30 year interval and compared them to 6,480 matched controls. *The study identified increased mortality and psychiatric hospitalization compared to the matched controls. The mortality was primarily due to completed suicides (19.1-fold greater than in control Swedes), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well.* We note, mortality from this patient population did not become apparent until after 10 years. *The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%).* The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control. Further, *we cannot exclude therapeutic interventions as a cause of the observed excess morbidity and mortality.*²⁵

In this “robust” study, the consequences of gender reassignment surgery are startling, and appear to be uniformly negative. They encompass not only higher rates of mental illness

²² Murad, et al., 216; cited in *Department of Defense Report and Recommendations on Military Service by Transgender Persons*, 26.

²³ RAND Study at 10 (citing only to a California Department of Insurance report); cited in *Department of Defense Report and Recommendations on Military Service by Transgender Persons*, 27.

²⁴ Cecilia Dhejne, et al., “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden,” *PLoS ONE* 6 (2011), accessed November 14, 2017, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>.

²⁵ “Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N),” 62.

(as indicated by psychiatric hospitalization) than in the general Swedish population, but higher rates of physical illness—cancer (“neoplasm”) and heart disease—as well.

Most shocking of all, however, was the rate of completed suicides—which was over *19 times higher* than in the general Swedish population. Transgender activists often insist that the reason gender reassignment surgery is “medically necessary” is in order to *prevent* the suicides which might otherwise occur among those who identify as transgender but are frustrated in their desire to surgically alter their bodies. Yet the Swedish study shows that extraordinary rates of suicide persist *after* surgery.

Not only that, but the study “cannot exclude therapeutic interventions as a *cause* of the observed excess morbidity and mortality” (emphasis added). In other words, not only does gender reassignment surgery (and other “therapeutic interventions” such as hormone therapy) not demonstrably benefit those who identify as transgender—*it may actively harm them*. Not only are such interventions not “medically necessary”—they may be dangerous.

The Department of Defense also cited the Swedish study:

A sixth study, which came out of Sweden, is one of the most robust because it is a “nationwide population-based, long-term follow-up of sex-reassigned transsexual persons.”²⁶ The study found increased mortality and psychiatric hospitalization for patients who had undergone sex reassignment surgery as compared to a healthy control group.²⁷

The DoD report added a footnote elaborating on the findings of the Swedish study:

It bears noting that the outcomes for mortality and suicide attempts differed “depending on when sex reassignment was performed: during the period 1973-1988 or 1989-2003.” . . . Even though both mortality and suicide attempts were greater for transsexual persons than the healthy control group across both time periods, this did not reach statistical

²⁶ Dhejne, et al., 6; see also “Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)” (“Strengths of this study include nationwide representativity over more than 30 years, extensive follow-up time, and minimal loss to follow-up. . . . Finally, whereas previous studies either lack a control group or use standardised mortality rates or standardised incidence rates as comparisons, we selected random population controls matched by birth year, and either birth or final sex.”)

²⁷ Id. at 7; see also at 6 (“Mortality from suicide was strikingly high among sex-reassigned persons, also after adjustment for prior psychiatric morbidity. In line with this, sex-reassigned persons were at increased risk for suicide attempts. Previous reports suggest that transsexualism is a strong risk factor for suicide, also after sex reassignment, and our long-term findings support the need for continued psychiatric follow-up for persons at risk to prevent this. Inpatient care for psychiatric disorders was significantly more common among sex-reassigned persons than among matched controls, both before and after sex reassignment. It is generally accepted that transsexuals have more psychiatric ill-health than the general population prior to the sex reassignment. It should therefore come as no surprise that studies have found high rates of depression, and low quality of life, also after sex reassignment. Notably, however, in this study the increased risk for psychiatric hospitalisation persisted even after adjusting for psychiatric hospitalisation prior to sex reassignment. This suggests that even though sex reassignment alleviates gender dysphoria, there is a need to identify and treat co-occurring psychiatric morbidity in transsexual persons not only before but also after sex reassignment.”).

significance during the 1989-2003 period. One possible explanation is that mortality rates for transsexual persons did not begin to diverge from the healthy control group until after 10 years of follow-up, in which case the expected increase in mortality would not have been observed for most of the persons receiving sex reassignment surgeries from 1989-2003. Another possible explanation is that treatment was of a higher quality from 1989-2003 than from 1973-1988.²⁸

In summary, it seems clear that persons who identify as transgender have higher suicide rates than the general population—the DoD Report said that “among people who are transgender . . . lifetime rates of suicide attempts [are] reported to be as high as 41% (compared to 4.6% for the general population).”²⁹ It also seems clear that the suicide risk for those who identify as transgender remains higher than the general population even after a medical gender transition. While some of the research seems to indicate it is possible that suicide rates are lower after such treatment than before, the quality of the evidence is poor. And note that while the data from the National Transgender Discrimination Survey suggests a general rate of suicide attempts among transgender-identified persons that is nine times higher than among the general population, the Swedish study showed a rate of completed suicides *after gender reassignment surgery* that is *nineteen* times higher—calling into doubt whether these treatments result in even an incremental improvement in suicide rates.

Given that any addition to the medical benefits package will have an associated cost and burden on existing specialists, especially urological and vascular surgeons and other highly trained specialists who are already in short supply nationwide, what is the potential impact of adding “gender alterations” on Veterans' access to care, particularly for Veterans facing life-threatening medical conditions waiting to see surgical specialists?

Family Research Council analyzed the cost of providing gender transition medical care to members of the military in 2017.³⁰ Here are excerpts:

Although some sources estimate that only about a third of those who identify as transgender actually seek gender reassignment surgery,³¹ a large part of the reason is because of the high cost and the fact that it is often not covered by insurance. . . . [W]e relied on the National Transgender Discrimination Survey to calculate the percentage of people in the general population who either have had or wish to have the average surgical

²⁸ *Department of Defense Report and Recommendations on Military Service by Transgender Persons*, footnote 87, p. 25.

²⁹ Ann P. Haas, Philip L. Rodgers & Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, p. 2 (American Foundation for Suicide Prevention and The Williams Institute, University of California, Los Angeles, School of Law 2014), available at <https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf>; cited in *Department of Defense Report and Recommendations on Military Service by Transgender Persons*, 21.

³⁰ Peter Sprigg, “Transgender Policy Could Cost Military Billions Over Ten Years,” *Issue Brief* (Washington, D.C.: Family Research Council, July 2017); online at: <https://downloads.frc.org/EF/EF17F52.pdf>.

³¹ Parker Marie Molloy, “WATCH: Debunking the ‘Surgery is a Top Priority for Trans People’ Myth,” *The Advocate*, March 13, 2014; online at: <https://www.advocate.com/politics/transgender/2014/03/13/watch-debunking-surgery-top-priority-trans-people-myth>

intervention, and concluded it is 82 percent of biological males who identify as female and 64 percent of biological females who identify as male.³²

. . . The Philadelphia Center for Transgender Surgery has published one of the most comprehensive lists of different surgical options and their prices, including the cost of hospitalization and anesthesia.³³ FRC has calculated that a comprehensive package of male-to-female surgical procedures would cost \$110,450, and female-to-male procedures would cost \$89,050.³⁴ . . .

However, surgery is not the only cost associated with medical “gender transition.” The website CostHelper.com has estimated some of these costs. For example, the cost of counseling just in the year prior to surgery can run as high as \$5,000, and hormone therapy in the year before surgery can cost as much as \$2,400.³⁵ . . .

Following surgery, those who have undergone gender reassignment require ongoing hormone therapy. (In addition, some individuals who identify as transgender seek hormone treatments even if they opt not to have surgery. . . .) This *hormone treatment is required indefinitely*, and can cost as much as \$200 a month.³⁶

The DoD’s *Report and Recommendations* also indicated that transgender medical care “imposes disproportionate costs”:

Transition-related treatment is also proving to be disproportionately costly on a per capita basis, especially in light of the absence of solid scientific support for the efficacy of such treatment. Since implementation of the [former Defense Secretary Ash] Carter policy [on July 1, 2016], the medical costs for Service members with gender dysphoria have increased nearly three times—or 300%—compared to Service members without gender dysphoria.³⁷

Although the numbers are probably much higher now as the transgender movement has grown rapidly, there is reason to doubt that there would be enough surgeons experienced with gender reassignment surgery to meet the demand, if federal funding for such procedures becomes widely available. Ten years ago, Dr. Marci (formerly Mark) Bowers, a biologically male surgeon who

³² Jaime M. Grant, Ph.D., Lisa A. Mottet, J.D., Justin Tanis, D.Min., with Jack Harrison, Jody L. Herman, Ph.D., and Mara Keisling, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* (Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011), p. 79. Online at: http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

³³ “Male To Female Price List,” online at: <http://www.thetransgendercenter.com/index.php/mtf-price-list.html>; and “Female to Male Price List,” online at: <http://www.thetransgendercenter.com/index.php/price-list.html>; The Philadelphia Center for Transgender Surgery (accessed June 24, 2017).

³⁴ Some sources have added up all the items on the price list and come up with a total of \$140,450 for male-to-female surgery and \$124,400 for female-to-male, See: Alyssa Jackson, “The high cost of being transgender,” *CNN*, July 31, 2015; online at: <http://www.cnn.com/2015/07/31/health/transgender-costs-irpt/index.html>. However, a careful examination of the list shows that some of the items are alternative options rather than additives. FRC’s estimate eliminates these redundancies.

³⁵ “Sex Reassignment Surgery Cost,” *CostHelper Health*, accessed June 24, 2017; online at: <http://health.costhelper.com/sex-reassignment-surgery.html>

³⁶ *Ibid.*

³⁷ Minutes, Transgender Review Panel (Nov. 21, 2017).

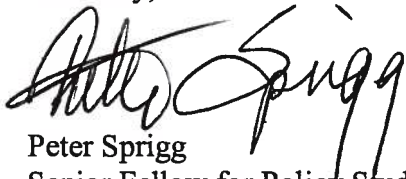
now identifies as female and performs gender reassignment surgery, estimated that there may be 25 doctors in the entire country who have *ever* performed such surgery, “But in terms of one who [does] them on a regular basis, I would say, fewer than six.”³⁸

Conclusion

Gender reassignment surgery is, on the face of it, elective and cosmetic in nature, since it does nothing to enhance the physical functioning of the body. This alone makes it unsuitable for the VA to provide. While hormone therapy and gender reassignment surgery may have some effect in alleviating the narrow symptoms of “gender dysphoria,” there is insufficient quality evidence to prove that such procedures actually improve the overall mental health of patients, including the risk of suicide, in the long run. These procedures are very costly and would divert resources—both money and the time and expertise of physicians—away from more important priorities.

Family Research Council urges the Department of Veterans Affairs to reject the Petition for Rulemaking and retain the current exclusion of “gender alterations” from the VA’s medical benefits package.

Sincerely,



Peter Sprigg
Senior Fellow for Policy Studies
Family Research Council
Washington, D.C.

³⁸ Seth Doane, “The Sex Change Capital of the U.S.,” *CBS News*, September 7, 2008; online at: <http://www.cbsnews.com/news/the-sex-change-capital-of-the-us/>