First and Fourteenth

To: Minnesota State Legislature
From: L. Martin Nussbaum, esq.
Re: Minnesota HF 2607, the gender-affirming care health plan coverage mandate
Date: March 15, 2024

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Tradition wins.

Our law firm has been asked to comment regarding HF 2607, a bill that requires employee health plans to cover gender-affirming care. Because of our experience in public law and the law affecting religious institutions, we have closely followed developments with regard to the science, conscience issues, and legislation related to gender transition. Gender transition issues have become more problematic given the epidemic of teenage girls identifying as transgender and the growing evidence that the "science" supporting gender transition is deeply flawed.

HF 2607 Would Burden Religious Exercise for Many. Many religious employers, including Catholic, Evangelical Christians, Orthodox Jews, and Muslims, believe that God created humans male and female and that this is no divine mistake. *See, e.g.,* Gen. 5:2 ("Male and female he created them"), Mt. 19:4 ("he who made them from the beginning made them male and female"), Quran 49:13 ("We have created you male and female").

Transgender Medicine Is Not Settled. Its Practice Injures Many. Most religions also subscribe to the value at the core of the Hippocratic Oath: "first do no harm." This principle looms large given the growing scientific evidence that, with regard to gender transition procedures, minors are incapable of giving informed consent,[1] and the risks of adverse outcomes are substantial.[2]

[1] Recently leaked documents reveal that even the medical professional working with the World Professional Association of Transgender Health ("WPATH") "admit to the impossibility of getting proper informed consent for hormonal interventions from their young patients." Mia Hughes, *The WPATH Files: Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable Adults*, Environmental Progress (March 5, 2024); *see also Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274 (Admin.) (Engl. 2020).

[2] Adverse outcomes include: (a) from genital surgery: a suicide rate nineteen times the general population, Cecilia Dhejne, *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS ONE e16885 (2011); (b) from puberty blockers: adverse effects on social and emotional maturation and bone density, stunted maturation of genitals and reproductive organs, and impaired sexual functioning as an adult, Cecilia Dhejne, *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS ONE e16885 (2011); (c) from cross sex hormones: genital or vaginal atrophy, hair loss or gain, voice changes, impaired fertility, increased cardiovascular risks, and liver and metabolic changes, Stephen B. Levine, *Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults*,

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Religious Exemption from Morally-Controversial Legislation Is Consistent with the Finest Traditions of American and Minnesota law. It has long been the practice in Minnesota and elsewhere that legislators often provide religious exemption from morally controversial laws.[3] The do so because religious liberty is most distinctive aspect of the American experiment. This is why James Madison called it the "lustre of our country." In the First Amendment, the founders of our country forbade government action "prohibiting the free exercise" of religion. U.S. Const., amend. I. Minnesota's founders went further.[4] The preamble to the state constitution states that the people adopted Minnesota's constitution because they were "grateful to God for our civil *and religious liberty*." Then in article I, section 16, they stated that "[t]he right of every man to worship God according to the dictates of his own conscience shall never be infringed . . . *nor shall any* control or *interference with the rights of conscience be permitted* . . ." The Minnesota Legislature has, consistent with this high tradition, provided statutory religious exemptions.[5]

Why does religious freedom matter? It matters because the most distinctive aspect of the human condition is that every person is endowed with a conscience. As Aristotle taught long ago, conscience requires exercise. Exercise of conscience requires freedom. Without freedom to act according to one's conscience, we cannot become a virtuous people. Benjamin Franklin recognized that "only a virtuous people are capable of freedom.

There's more. Professor Elizabeth Clark has cited scores of studies showing that religious liberty promotes human flourishing.

> Religion is extensively documented to have a positive effect on individuals' well-being and health. This includes a sense of wellbeing, life satisfaction, mental health, and physical health levels, including lowered suicide rates and deaths of despair . . . Religiosity is correlated with reduced criminality [and] with lower recidivism rates and fewer disciplinary problems in prison. . . . The impact of religion in individuals is particularly noticeable in adolescents. Positive correlations with religiosity include physical and mental health, academic achievements, and community involvement.

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48 J. Sex & Marital Therapy 706 (2022); *Gender-Affirming Hormone in Children and Adolescents*, BJM EBM Spotlight (Feb. 25, 2019).

[3] *See, e.g.,* George Washington's January 29, 1777 letter to Pennsylvania Council of Safety calling for imposition of a draft so long as it exempted the "conscientiously scrupulous" like Amish and Mennonites.

[4] *See State v. Hershberger*, 462 N.W.2d 393, 397 (Minn. 1990) (explaining that "Minnesotans are afforded greater protection for religious liberties against governmental action under the state constitution than under the first amendment of the federal constitution").

[5] *See, e.g.,* Minn. Stat. §§ 363A.26 (religious organization exemption from Human Rights Act's prohibition on religious discrimination); 253B.03 (protecting patient's right to practice religion).

> Frequent attenders at religious services engage in fewer risky behaviors such as illegal drug and alcohol use.
>
> Religious beliefs can anchor and inspire communities, promote intergenerational norm transfer, and develop democratic values such as tolerance, reflective thinking, generosity, altruism, and law-abidingness. Religion and religious organizations also promote peacemaking through non-violent democratic movements, mediation . . . and shaping of transitional justice by religious actors. Faith-based associations also provide enormous support for humanitarian, educational, and medical care.

Elizabeth A. Clark, *The Impact of* Religion *and Religious Organizations*, 49 BYU L. Rev. 1, 5-6, 20 (2023).

The Re-Definition of "Medical Assistance" to Include Standards of Care Pronounced by Radicalized Medical Societies Will Only Hurt the Poor. Section 2 of HF2607 redefines "gender affirming care" as a subset of "medical assistance" provided for needy persons to include the "procedures and criteria . . . recognized by prevailing professional standards." If the prevailing medical standards are those of medical societies like the World Professional Association of Transgender Health, the Endocrine Society, and the American Academy of Pediatrics, this provision incorporates pseudo-science and ideology into Minnesota law to the detriment of the poor.[6]

HF 2607 Will Trigger Two Types of Lawsuits Requiring the State to Incur Unnecessary Expense. If passed without religious exemption, conscientious religious employers are likely to sue the State for religious exemption as required by Minn. Const. art. 1, § 16 and U.S. Const., amend. I. In addition, there is a growing number of medical malpractice lawsuits being filed for facilitating pediatric gender transition due to the frequency of adverse outcomes from such procedures.[7] Such lawsuits create unnecessary strife and expense.

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[6] *See* Leor Sapir, *'Trust the Experts' Is Not Enough: U.S. Medical Groups Get the Science Wrong on Pediatric 'Gender Affirming' Care*, Manhattan Institute Memo (Winter 2022); Mia Hughes, *The WPATH Files: Pseudoscientific Surgical and Hormonal Experiments on Children, Adolescents, and Vulnerable Adults*, Environmental Progress (March 5, 2024); Leor Sapir, *The American Academy of Pediatrics' Dubious Transgender Science*, Wall Street Journal (August 17, 2022).

[7] *See, e.g.,* the law firm, Campbell Miller Payne that specializes in "Justice for the Detransitioner Community," here: https://cmppllc.com/, Dan Hart, *'Only the Beginning': Lawsuits from Detransitioners Are on the Rise*, The Washington Stand (December 7, 2023).

GENDER JUSTICE

663 UNIVERSITY AVENUE WEST
SUITE 200
SAINT PAUL, MN 55104
PHONE 651.789.2090

RE: Support for HF2607

April 4, 2024

To Chair Tina Liebling and members of the Health Finance and Policy Committee:

Gender Justice is a legal and policy advocacy organization dedicated to advancing gender equity through the law. We believe that all people, no matter their gender, deserve affordable access to the healthcare they need, and that best practice medical care for transgender people should be no exception as a crucial aspect of transgender people's health and livelihood.

Gender affirming medical care drastically improves quality of life for transgender people, with 98% of transgender people reporting increased life satisfaction after receiving it. Gender affirming care is supported widely by major medical organizations including the American Medical Association and American Academy of Family Physicians.

Since 2015, Minnesota Departments of Commerce and Health have maintained a practice of ensuring coverage of this care for transgender people, and the passage of HF 2607 would codify those practices, increasing predictability for insurers, consumers, and providers. Additionally, the bill adds a definition of Gender Affirming Care in line with medical best practices, to provide clarity and security for patients and providers, and ensure that legislators and insurers don't get between patients and their care team.

This step is needed now to protect healthcare access for trans Minnesotans and trans people from around the midwest seeking care here. Forty-seven percent of transgender people in the US have thought about moving states because of their own state government considering or passing legislation targeting them for unequal treatment according to the new results of the 2022 US Trans Survey. Meanwhile, clinics in Minnesota are reporting surges of new transgender patients seeking care. Last year, the Minnesota legislature passed the Trans Refuge Act to protect Minnesota providers and visiting patients from persecution by other states. To ensure the promise of refuge for new and residing trans Minnesotans, we must ensure trans people can access the care they need.

Please support the Gender Affirming Care Act for the many transgender people who call this state home.

GENDER JUSTICE

663 UNIVERSITY AVENUE WEST
SUITE 200
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PHONE 651.789.2090

Thank you for your support,

Megan Peterson
Executive Director, Gender Justice

Asian American Organizing Project (AAOP)

1821 University Ave West, Suite 202
St. Paul, MN 55104

April 04, 2024

Chair Tina Liebling
477 State Office Building
St Paul, MN 55155

Dear Chair Liebling and members of the House Health and Finance Policy Committee,

Asian American Organizing Project (AAOP), connects nonpartisan grassroots organizing efforts within our community and with coalition partners across the Twin Cities, together with community allies, to create a more just and equitable democracy. Our mission at AAOP is to empower young Asian Minnesotans to create systemic change for an equitable, conscious, and just society.

AAOP is passionate about equipping young Minnesotans with the tools and resources they need to survive and thrive. In the last 3 years, AAOP has been engaging with our base of young Asian Minnesotans (ages 18 - 35) on Reproductive Justice and had over 500 conversations on accessing reproductive care. It's clear that our community needs are not met. We are therefore in support of HF 2607, which mandates insurance coverage for gender affirming care. This is an issue that impacts all Minnesotans, but it affects some communities disproportionately, so we must fight to close this disparity gap by ensuring equity in health services for all. Laws that protect gender justice rights are under attack at the national level and so Minnesota has a duty to act now in protecting these rights for its citizens and set a precedent for future legislation around healthcare and life-saving resources. With stronger, more inclusive healthcare policy, our democracy can grow and become truly representative of all Minnesotans.

So, AAOP is voicing our support for HF 2607, the Gender Affirming Care Act, because this is an issue that embodies our personal commitment to increasing visibility for gender and reproductive justice within and for marginalized communities. We urge the members of the House Committee for Health and Finance Policy to vote in favor of this critical legislation

Sincerely,

Linda Lelis-Her
Executive Director
Asian American Organizing Project

April 2, 2024

Dear Chair Liebling and Members of the Health Finance and Policy committee:

OutFront Minnesota writes in support of HF 2607 (Finke) - Health plans clarified to require coverage of gender-affirming care. OutFront Minnesota, founded in 1987, is the state's largest LGBTQ+ advocacy organization that has sought to build power within Minnesota's LGBTQ+ communities and address inequities through intersectional organizing, advocacy, education, and direct support services. We believe that this legislation is important to fostering a Minnesota that protects *all* of its residents.

Today, we support the Gender Affirming Care Insurance bill (HF 2607) which would ensure that Minnesotans have the full access to the health care they need and deserve. While gender affirming care encompasses a range of supportive care services that are governed by the standards of care outlined by the World Professional Association for Transgender Health (WPATH); despite increasing political rhetoric this care is supported by all major medical associations including the American Medical Association, American Psychological Association, American Association of Pediatrics, and others.

This is best practice medical care that should be available to those who need it. As noted in a state review in 2023 "covering medically necessary transition procedures was a cost-effective intervention" and withholding or delaying gender affirming care can have dramatic impacts on the mental health of individuals who need it. Rates of depression, suicide, and substance abuse are dramatically higher in transgender and gender expansive individuals who lack support and access to care. Those who receive care and support have dramatically improved health outcomes; and we believe that the state has an opportunity to clarify existing policy and help reduce cost and insurance barriers to this care.

Minnesota insurers are already prohibited from discriminating against trans Minnesotans by denying Gender Affirming Care, however the regulatory framework and prohibition on discrimination would be clarified for all by adding the requirement to the insurance statutes, and including a definition of Gender Affirming Care as offered in the author amendment.

While existing guidance from the state provides a strong framework for access under state plans and through private insurers, we believe that clarifying these expectations in law will help to ensure that individuals and their care providers face fewer barriers throughout the process. Minnesota has a long history of ensuring that LGBTQ+ individuals have the full protections and support of our state's laws; and HF 2607 will further Minnesota's leader as a national leader in LGBTQ+ rights and health care access.

OutFront Minnesota seeks to support and empower *all* residents in becoming their best and healthiest selves. The passage HF 2607 will advance those goals; and show our trans and gender expansive communities that they belong here. OutFront Minnesota respectfully urges your support for HF 2607 the Gender Affirming Care Insurance bill.

Sincerely,

Kat Rohn
Executive Director
OutFront Minnesota

My name is Camille Kiefel, and I am President of Detrans Help, a non-profit organization representing detransitioners. I've come here today as a detransitioner asking to pass the amendment for detransitioner coverage and to bring awareness to the difficulty we face getting access to proper medical care. Just like trans individuals, detransitioners have distinct health care needs. Because of the stigma around detransition, our needs are going unaddressed.

While transitioning, we were treated with respect and sensitivity. When we detransitioned, we noticed a shift. We feel unsupported. Part of this is that we are now cisgender. Privileged. Many of us were struggling with internalized homophobia, histories of sexual violence, mental illness, and mental disabilities. We saw transition as an answer. There is nothing privileged about being a detransitioner. I am shocked by the discrimination I and other detransitioners have faced as trauma survivors. It would be unacceptable for any other minority to be treated this way. Why is it ok to treat detransitioners so poorly?

Our providers became dismissive, and receiving the necessary care we need became difficult. We do not feel safe going back to our medical care providers who are not trained in how to care for us. I know one detransitioner who got pregnant after going on birth control when she thought she was infertile. We do not know the long-term impacts of these surgeries and HRT. There is so much we don't know and isn't being explored. There is no support for us.

We have reached out to World Professional Association for Transgender Health, WPATH, and the World Health Organization, WHO, expressing our concerns. Our request for dialogue was met with silence. While trans individuals are on the boards of these organizations, there is not one detransitioner to represent our needs. In addition to this, the WHO manages the ICD-10 codes that are used for billing. There is no ICD-10 medical code for detransition. Because detransitioners do fit the definition of gender variance, billing detransitioners under gender affirming care puts providers at risk for medical fraud and erases detransitioners from being medically documented. The goal should always be to provide better health care, but detransitioner needs have been ignored and silenced.

Many individuals who want to detransition can't because their insurance won't cover it. In one case, a detransitioner no longer identified as a woman. He had to wait 2 years to get his implants removed. Some detransitioners are forced to live as the sex they no longer identify with because they are unable to medically detransition. No one should be forced to live as the sex they don't identify with. It's crucial to understand that providing care for detransitioners does not detract from the care provided to transgender individuals. Detransitioners are a minority and need better access to medical care. Medical care should be within reach of everyone.

Planned Parenthood®
Minnesota, North Dakota, South Dakota Action Fund

April 3, 2024

Members of the House Health Finance and Policy Committee
Via Electronic Delivery

Re: Letter in Support of House File 2607

Chair Liebling and Members of the Health Finance and Policy Committee:

Planned Parenthood North Central States (PPNCS) provides a full range of sexual and reproductive health care to Iowa, Minnesota, Nebraska, North Dakota, and South Dakota at 25 health centers, serving nearly 100,000 patients in the fiscal year 2023. They are proud to provide gender affirming care – including hormone therapy – at all of their health centers.

Founded in 1992, the Planned Parenthood Minnesota, North Dakota, South Dakota Action Fund is an independent, non-partisan, non-profit organization that advocates for the policy and support needed to make PPNCS's care possible. We work with supporters of all parties to defend and increase access to family planning services, fact based, medically accurate sexuality education, and healthcare abortion access. To that end, we're writing today in support of House File 2607 and insurance coverage for gender-affirming care.

Gender affirming care is just that – affirming and supportive of each patient's goals. It is also lifesaving. Comprehensive, gender-affirming care, and supportive social and family environments lead to health outcomes for gender diverse teens that are similar to their cisgender peers. With proven critical health outcomes, its crucial insurance providers cover gender affirming care.

We know transgender and gender expansive people share the same fundamental need for quality health care as all Minnesotans, and the promise of access cannot be fulfilled unless all people can afford care. Minnesotans need to be able to make decisions knowing that they are not going to be stuck with out-of-pocket payments they cannot afford. Insurance coverage is essential for real access and health equity.

Now is the time to expand access and reduce barriers to health care. Please support House File 2607.

Sincerely,

Tim Stanley
Executive Director

671 Vandalia Street • Saint Paul, MN 55114

WOMEN'S FOUNDATION OF MINNESOTA

April 3, 2024

Representative Liebling
Chair, House Health Finance & Policy Committee
House Office Building
St. Paul, MN

Dear Chair Liebling and Members,

As the President and CEO of the Women's Foundation of Minnesota, I write to express our support for HF4053 and HF2607, to expand access to health care coverage, including abortion and gender-affirming health care for Minnesotans. Our research with the Center on Women, Gender, & Public Policy at the University of Minnesota's Humphrey School shows that affordable access health care is not truly available for many patients in Minnesota.

Minnesota has distinguished itself as a place where bodily autonomy and human rights are protected. Now, we need to ensure coverage for the care that makes these rights real. Lack of access to care – including coverage for care – has significant consequences for the people most affected, especially our most marginalized Minnesotans – Black, Indigenous, refugees and immigrants, rural, and people with lower incomes.

HF4053 will ensure that all forms of health care insurance cover abortion and abortion-related care. Abortion is an essential component of women's health care and each person's ability to determine when, if, and how they become a parent. Safe, accessible abortion services save lives because pregnant people do not have to seek illegal, unsafe alternatives.

HF2607 will help Minnesotans access gender-affirming care by ensuring health insurance coverage. Prohibiting insurance companies from denying coverage for gender-affirming care will ensure health care decisions are made between patients and their medical professionals.

Living a safe and healthy life in Minnesota must include access to all types of health care including abortion and gender-affirming health care. We urge the committee to move these bills to make Minnesota a place where women, girls, and gender-expansive people from all backgrounds across the state can thrive.

Thank you,

Gloria Perez
President and CEO
Women's Foundation of Minnesota

Written Testimony in Opposition to HF 2607
Minnesota House Health Finance and Policy Committee
April 4, 2024

Dear Chair Liebling and Members of the Health Finance and Policy Committee:

I oppose requiring health insurance plans to cover medical transition treatments as would be mandated if HF 2607/SF 2209 passes. The evidence base for these treatments is very poor, particularly for minors.

Before approving legislation like HF 2607/SF 2209, Minnesota should commission a systematic review of the research literature to be completed by an independent party regarding the safety and efficacy of these treatments. We should know that people benefit from treatments and not be harmed before requiring health plans to cover them.

Even the medical associations that endorse medical transition treatments acknowledge there is minimal research supporting their endorsements. In their 2022 Standards of Care, the World Professional Association for Transgender Health (WPATH) conceded that the number of studies of pediatric transition treatments is low, and that few outcome studies have followed youth into adulthood.[i] In regard to puberty blockers, the Standards of Care state that:

- "…the long-term effects on bone mass have not been well established." (page S114)
- "The potential neurodevelopmental impact of extended pubertal suppression in gender diverse youth has been specifically identified as an area in need of continued study." (page S65)
- Providers should discuss with families, "…the future unknowns related to surgical and sexual health outcomes." (page S64)

The Endocrine Society documented in its 2017 clinical practice guidelines for the endocrine treatment of gender dysphoric persons that all but one of its recommendations regarding the treatment of adolescents are based on low or very low-quality evidence. [ii]

WPATH, the American Academy of Pediatrics (AAP), and the Endocrine Society all acknowledge that following puberty blockers with cross sex hormones, a common treatment pathway, threatens patients' fertility. This is because children begin blockers in very early puberty[iii] before gametes (i.e. sperm or ova) have matured.[iv] For cross sex hormones to be effective, patients must continue to suppress their own endogenous hormones after stopping puberty blockers.[v] [vi] [vii] Under these conditions, the gametes will not mature, with a likely future consequence of sterility.[viii] [ix] What WPATH, the AAP and the Endocrine Society fail to acknowledge is that almost all children who take puberty blockers (between 93% and 98%) go on to take cross-sex hormones (CSHs) [x] [xi] [xii] Effectively, children and their families are making choices about future fertility during the very early stages of puberty.

In the last several years, health authorities in Finland, Sweden, and England have performed systematic reviews of the research literature to determine the safety and efficacy of pediatric medical transition treatments. They are rethinking the use of puberty blockers and cross-sex hormones as a result. Finland's 2020 treatment recommendations warn that "…gender reassignment of minors is an experimental practice," and recommend psychosocial support, therapy and treatment of comorbid psychiatric disorders as "the first-line intervention".[xiii] Swedish health authorities say the risks of treatment likely outweigh possible benefits,[xiv] and along with England's NHS now recommend that puberty blockers and cross sex hormones be given only in the context of research programs. [xv] [xvi]

The media often report that pediatric transition treatments are needed to prevent suicide. The evidence does not support this claim. A Systematic review of the literature published by the Endocrine Society could not find sufficient evidence to "…draw a conclusion about the effect of hormone therapy on death by suicide."[xvii] Finnish researchers published a large study just last month that found,

- Gender dysphoria does not seem predictive of suicide deaths.
- Medical gender reassignment does not have an impact on suicide risk.
- The main predictor of mortality in the gender dysphoric population is psychiatric morbidity…." When researchers controlled for psychiatric treatment needs, subjects in the control group versus the gender dysphoric group did not have statistically significant different levels of death by suicide.[xviii]

Please put this bill on hold and commission a systematic review of the evidence. If the sponsor of this bill is correct that these treatments are safe and beneficial, a systematic review will only strengthen the sponsor's position. If European countries are correct that these treatments are experimental and have serious side effects, then kids are getting hurt. I would surely hope you would want to know that before you pass this bill.

Sincerely,

Susan Illg
1243 James Avenue
Saint Paul, MN 55105

[i] Coleman, E., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health*, 2022, pp. S1 – S258, Standards of Care - WPATH World Professional Association for Transgender Health (Page S46). *Quote:* "Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow

youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead."

[ii] Hembree, Wylie C, et al. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline." *The Journal of Clinical Endocrinology & Metabolism*, vol. 102, no. 11, 13 Sept. 2017, pp. 3869–3903, https://academic.oup.com/jcem/article/102/11/3869/4157558 (pages 3871-3872). A description of the evidence grading system is found on page 3872 in the section titled, *Method of Development of Evidence-Based Clinical Practice Guidelines*. Recommendations and suggestions for treating adolescents may be found on page 3871: sections 1.4, 1.5 and sections 2.1 through 2.6; and page 3872: sections 5.5 & 5.6. At the end of each recommendation or suggestion, the supporting evidence is graded. The supporting evidence for seven recommendations has a grade of "low quality," and the supporting evidence for three recommendations has a grade of "very low quality." The evidence for one recommendation to give adolescents information on options for fertility preservation has a grade of "moderate quality."

[iii] Coleman, E., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health*, 2022, pp. S1 – S258, Standards of Care - WPATH World Professional Association for Transgender Health (page S112). *Note*: WPATH provides the following guidance for determining when to start puberty blockers, "When a child reaches an age where pubertal development would normally begin (typically from 7-8 to 13 years for those with ovaries and from 9 to 14 years for those with testes), it would be appropriate to screen the child more frequently, perhaps at 4-month intervals, for signs of pubertal development (breast budding or testicular volume > 4 cc)."

[iv] Finlayson, Courtney, et al. "Proceedings of the Working Group Session on Fertility Preservation for Individuals with Gender and Sex Diversity." *Transgender Health*, vol. 1, no. 1, 2016, pp. 99–107, https://www.liebertpub.com/doi/10.1089/trgh.2016.0008 (page 100). *Quote:* "Pubertal suppression treatment, prescribed to youth with gender dysphoria as early as Tanner state 2 of puberty, pauses the development of undesired puberty, including some irreversible secondary sexual characteristics, but also prevents maturation of primary oocytes and spermatogonia to mature oocytes and sperm."

[v] Coleman, E., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health*, 2022, pp. S1 – S258, Standards of Care - WPATH World Professional Association for Transgender Health (page S115, Statement 12.6). *Quote:* "We recommend health care professionals measure hormone levels during gender-affirming treatment to ensure endogenous sex steroids are lowered and administered sex steroids are maintained at a level appropriate for the treatment goals for transgender and gender diverse people…."

[vi] Hembree, Wylie C, et al. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline." *The Journal of Clinical Endocrinology & Metabolism*, vol. 102, no. 11, 13 Sept. 2017, pp. 3869–3903, https://academic.oup.com/jcem/article/102/11/3869/4157558 (pages 3885-3886).

The Endocrine Society Guidelines state that one of the major goals of cross sex hormone therapy is "…to reduce endogenous sex hormone levels, and thus reduce the secondary sex characteristics of the individual's designated gender…."

[vii] Coleman, E., et al. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health*, 2022, pp. S1 – S258, Standards of Care - WPATH World Professional Association for Transgender Health (page S115). *Note:* This page in the SOC explains that in addition to taking estrogen to develop female secondary sex characteristics, natal males must also take medication to block endogenous testosterone production to prevent development of male secondary sex characteristics. Testosterone both blocks the production of endogenous estrogen and develops male secondary sex characteristics, so natal females do not need a second medication to block estrogen production.

[viii] Mayhew, Allison C, and Veronica Gomez-Lobo. "Fertility Options for the Transgender and Gender Nonbinary Patient." *The Journal of Clinical Endocrinology & Metabolism*, vol. 105, no. 10, 14 Aug. 2020, pp. 3335–3345, https://academic.oup.com/jcem/article/105/10/3335/5892794?login=false (page 3337). *Quote:* "….significant concerns have been raised regarding the viability of fertility options for gonads that have not undergone puberty."

[ix] Joyce, Helen. *Trans: When Ideology Meets Reality*, Oneworld Publications, London, 2021 (page 91). *Quote:* "But there is no doubt about an indirect harm that will be suffered by any children who start taking them [puberty blockers] young enough to avoid puberty altogether: sterility. Cross-sex hormones cause the secondary sex characteristics of the desired sex to develop – breasts, beards, and so on – but only a person's own sex's hormones can cause their ovaries or testicles to mature."

[x] "The Cass Review Independent Review of Gender Identity Services for Children and Young People: Interim Report." NHS England and NHS Improvement, Feb. 2022, The Cass Review - Independent review of gender identity services for children and young people: Interim Report (page 38. section 3.31). *Quote:* "The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminate in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. Data from both the Netherlands and the study conducted by GIDS demonstrated that almost all children and young people who are put on puberty blockers go on to sex hormone treatment (96.5% and 98% respectively)."

[xi] Biggs, Michael. "The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence." *Journal of Sex & Marital Therapy*, 19 Sept. 2022, pp. 1–21, https://www.tandfonline.com/doi/full/10.1080/0092623X.2022.2121238 (page 5). *Quote:* "Subsequent experience in the Netherlands and other countries confirms the fact that 96%-98% of children who undergo puberty suppression continue to cross-sex hormones."

[xii] Van der Loos, Maria ATC, et al. "Children and adolescents in the Amsterdam Cohort of Gender Dysphoria: trends in diagnostic and treatment trajectories during the first 20 years of the Dutch Protocol." *The Journal of Sexual Medicine*, vol. 20, Issue 3, March 2023, pp. 398-409, https://academic.oup.com/jsm/article/20/3/398/7005631?login=false (page 407). *Note:* In this document, the Dutch researchers who popularized the use of puberty blockers acknowledge that most children who take puberty blockers continue to cross sex hormones. *Quote:* "The

majority of adolescents (93%) using GnRHa go on to start with GAH [gender-affirming hormones]. This finding may imply that GnRHa treatment is used as a start of transition rather than an extension of the diagnostic phase."

[xiii] *Recommendation of the Council for Choices in Health Care in Finland (PALKO/COHERE Finland) Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors* – unofficial translation. Palveluvalikoima Tjänsteutbudet, 2020, pp 1-11 https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf (page 8). *Note*: I found the link for this report at the bottom of this webpage: https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors

[xiv] *Care of Children and Adolescents with Gender Dysphoria Summary of National Guidelines*. Socialstyrelsen The National Board of Health and Welfare, Dec. 2022, pp. 1-6 https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf (page 3). *Quote:* "At group level (i.e. for the group of adolescents with gender dysphoria, as a whole), the National Board of Health and Welfare currently assesses that the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits of these treatments."

[xv] *Interim Service Specification: Specialist Service for Children and Young People with Gender Dysphoria (Phase 1 Providers) Publication Reference: PR1937_i*. NHS England, 20 Oct. 2022, pp. 1-26, https://www.engage.england.nhs.uk/specialised-commissioning/gender-dysphoria-services/user_uploads/b1937-ii-specialist-service-for-children-and-young-people-with-gender-dysphoria-1.pdf (page 16). *Quote:* "Consistent with advice from the Cass Review highlighting the uncertainties surrounding the use of hormone treatments, NHS England is in the process of forming proposals for prospectively enrolling children and young people being considered for hormone treatment into a formal research programme with adequate follow up into adulthood, with a more immediate focus on the questions regarding GnRHa. On this basis NHS England will only commission GnRHa in the context of a formal research protocol."

[xvi] *Care of Children and Adolescents with Gender Dysphoria Summary of National Guidelines*. Socialstyrelsen The National Board of Health and Welfare, Dec. 2022, pp. 1-6, https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf (page 4). *Quote:* "The Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) concludes that existing scientific evidence is insufficient for assessing the effects of puberty suppressing and gender-affirming hormone therapy on gender dysphoria, psychosocial health and quality of life of adolescents with gender dysphoria [2]. Knowledge gaps need to be addressed and the National Board of Health and Welfare recommends that these treatments be provided in the context of research."

[xvii] Baker, Kellan E., et. al. "Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review." *Journal of the Endocrine Society*, 19 February 2021, pp. 1-16, https://doi.org/10.1210/jendso/bvab011 (page 13, Table 6).

[xviii] Ruuska, Sami-Matti, et al., "All-cause and suicide mortalities among adolescents and young adults who contacted specialised gender identity services in Finland in 1996–2019: a register

study." *BMJ Mental Health*, 17 February 2024, pp. 1-6, https://mentalhealth.bmj.com/content/ebmental/27/1/e300940.full.pdf (pages 1 and 5).