PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

LETTER TO SENIOR PENTAGON OFFICIAL

May 8, 2016

Context: Those who opposed lifting military personnel bans often insisted that the Pentagon could not do so because of the complexity of implementing inclusive policy. In some cases, implementation concerns reflected well-intended questions about how to preserve readiness, while in others, they were tactics to delay policy change. In May 2016, we learned that a senior official responsible for military personnel policy had privately expressed concern that transgender military service was a complex issue. Defense Secretary Ash Carter had ordered the military to study how to lift the ban, and internal conversations at the Pentagon had coalesced around five implementation concerns. In this letter, the Palm Center explained on the basis of the latest research why implementation concerns were unfounded.

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

May 9, 2016

Mr. [redacted]

Dear Secretary [redacted],

I am writing in response to your observation that transgender military service is a complex issue, and to respectfully suggest that evidence-based best practices show that it is not. According to a careful implementation study that I sent you via LTC [redacted] after our meeting, and that was authored by retired General Officers and leading scholars and experts, "formulating and implementing inclusive policy [for transgender personnel] is administratively feasible and neither excessively complex nor burdensome."[1]

This is not just a matter of semantics or the definition of complexity. Experts who have studied implementation conclude that the most important principle of successful inclusion is to evaluate everyone under neutral rules and expectations. With transgender individuals, the default option should be to apply familiar and settled ways of managing medical risk. There should be an extremely strong presumption against special rules or procedures for transgender members.

In contrast to your point that more guidance is better than less, the evidence suggests that few new rules or guidelines are needed, and that over-regulation would be counterproductive. Please consider the ostensibly thorny questions that you raised at our meeting as examples of issues that, on close examination, do not require complex policy formulation or extensive new guidance.

1. Do the proposed UNLESS factors for evaluating gender dysphoria successfully screen out accession applicants who are "in the middle of" gender transition? What about applicants who have been treated for gender dysphoria or simply identify as transgender, but without a medical plan for surgery? They would qualify under the proposed factors, but they might need surgery already (and either not realize it, or fail to disclose it), or they might develop a need for surgery in the future. How should we handle that?

The Palm Center proposed the following factors be substituted for the blanket ban on transgender individuals in DODI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services:

> Neither transgender identity nor gender nonconformity is disqualifying, however a current or past diagnosis of gender dysphoria is disqualifying UNLESS 1) There

> no history of comorbid mental disorder that would be disqualifying under DODI 6130.03; 2) Maintenance hormone medications (if taken) are medically stable and effective for at least six months; 3) At least six months have elapsed since any transition-related surgical procedure and no complications or functional limitations persist; 4) If the applicant has transitioned gender, at least six months have elapsed since the applicant began living in his or her target gender; 5) If the applicant has started to transition gender or has a clinical treatment plan for gender transition, as documented by treatment records, and if the transition plan involves surgical procedures, those procedures are complete and the applicant meets (3) above; and (6) If the applicant has started to transition gender or has a clinical treatment plan for gender transition, as documented by treatment records, or the applicant has already transitioned gender, the applicant has obtained new identification in that gender.

The purpose of the proposed factors is to identity applicants with a history of gender dysphoria whose current physical or mental status may be too unstable for the stress of military service, including applicants who require surgical treatment for relief of gender dysphoria. The factors address various potential bases for lack of stability or lack of relief from gender dysphoria, including other mental-health issues, hormones, surgical recovery, recently completed gender transition, medical recommendation for surgery, and possession of appropriate identification. Applicants who meet all factors—like applicants who meet similar UNLESS standards used throughout DODI 6130.03—are medically stable at the time of accession.

DOD argues that some applicants who self-identify as transgender, or who have received any treatment for gender dysphoria, should be required to meet a higher burden of disproving a medical need for surgery in the future if their medical records do not clearly address the issue. Applicants determined to have such a future need would be disqualified. In contrast to the Palm UNLESS factors that identify the subset of transgender applicants who are "in the middle of" an active process of transitioning gender and are therefore more likely to be medically unstable at the time of accession, the DOD approach attempts to identify transgender applicants with a potential need for surgery at some undetermined time in the future, however small the risk. These individuals would have a higher burden of predicting future medical need than any other applicants bear.

This argument, however, is based on two flawed assumptions. The first flawed assumption is that a high percentage of transgender persons will undergo gender transition during their military service and live in another gender. The second flawed assumption is that, within the subset of transgender persons who actually transition to life in another gender during military service, all of them will require surgical procedures as part of that transition. Being transgender is not the same thing as transitioning gender, and it does not make surgical treatment inevitable or even likely.[2] Transgender identity is defined as an incongruence between gender identity and gender assigned at birth, and any distress (if there is distress) arising from that lack of congruence can be relieved in a number of different ways short of either gender transition or gender-transition surgery: 1) adoption of policies that prohibit discrimination and harassment; 2) mental health counseling addressing ways of managing gender identity; and/or 3) use of hormone treatment without gender transition or without surgical treatment.

How do we know that these assumptions about the role of surgery in addressing gender dysphoria are drastically flawed? We know because medical utilization evidence from civilian medical insurers clearly demonstrates they are flawed, even when medical coverage for gender transition is fully available and *even when the employer has not screened applicants for gender dysphoria*. A study[3] published in the *New England Journal of Medicine* reported as follows:

> As for the expected utilization of transition-related care, the latest research suggests that among large civilian employers whose insurance plans offer transition-related care including surgery and hormones, an average of 0.044 per thousand employees (one of every 22,727) file claims for such care annually.
>
> . . .
>
> If transgender people are twice as likely to serve in the military as to work for the civilian firms from which the 0.044 figure was derived, then an estimated 188 transgender service members would be expected to require some type of transition-related care annually. It is not possible, on the basis of the available data, to estimate how many will require hormones, only, surgery only, or hormones plus surgery.
>
> As an accuracy check, consider the Australian military, which covers the cost of transition-related care: over a 30-month period, 13 Australian troops out of a full-time force of 58,000 underwent gender transition—an average of 1 service member out of 11,154 per year. If the Australian rate were applicable to the U.S. military, the Pentagon could expect 192 service members to undergo gender transition annually.

The *New York Times* recently reported that a RAND study commissioned by DOD forecasted similarly low utilization of transition-related medical services in the military: "The study, which has not yet been publicly released, predicted that between 29 and 129 service members would seek transition-related medical care annually."[4] Based on an estimated 12,800 transgender personnel now serving, the available research makes clear that only a small percentage will undergo gender transition in any form while in the military, and fewer still will require surgery as part of that transition. Any personnel policy that is based on the expected consequences for a few dozen service members is very close to a ban based on anecdote. It is regulation on the basis of fear and obstruction, not medicine.

Military policy should not presume or encourage over-treatment of gender dysphoria by adopting policies that equate being transgender with surgical intervention, contrary to medical standards of care. Courses of action proposed by some of the Services insist on medically unnecessary treatment as the price of enlistment, such as a requirement for surgery that would make an individual physically "match" gender identity in all respects. The expectation that surgical rates will be high may also be driven by an institutional preference for treatment that makes transgender persons completely "pass" and be indistinguishable from non-transgender persons of the same sex. This is not medicine; it is personal preference for how transgender individuals should appear to others.

2. Would a special Service evaluation outside the MEPS qualification process be more accurate than the proposed UNLESS factors in predicting medical fitness or medical need for surgical treatment? Would a referral for specialist consultation within the MEPS process help in determining medical need?

Some working group members advocated that transgender applicants be separately approved or rejected by an individual Service outside the usual MEPS process (a "special Service evaluation"), a procedure that is similar to the current process for requesting a waiver of medical standards. This would be counterproductive—and reminiscent of "don't ask, don't tell"—because it rests on the assumption that transgender applicants are so medically different they cannot be evaluated in the same manner as other applicants. The better approach is to use the MEPS process for all applicants and allow MEPS examiners to make familiar UNLESS-based assessments in the same manner they already do.

MEPS examiners have a variety of tools to obtain additional information to assist them in making medical assessments. They can require records of civilian medical care and disqualify applicants if they do not produce them. They can rely on the medical judgment of the applicant's primary care or specialist provider, or require applicants to submit outside evaluations, or refer cases for review by outside specialists. Each of these tools is designed to help MEPS examiners apply a specific qualification standard in DODI 6130.03, such as an UNLESS factor. For applicants who have received medical care for gender dysphoria, their treatment records will be the best evidence of need for surgery. If those records are unclear, examiners can require they be clarified. For applicants who self-identify as transgender but have not received treatment—in some cases because they have not needed any treatment—MEPS examiners always have the option to refer to an outside specialist if a history of gender dysphoria raises questions.

The Palm Center suggests that its proposed UNLESS factor (5) be reasonably read to flag not only applicants with treatment records documenting a need for surgical procedures, but also applicants who would have been advised of a need for surgical procedures if properly evaluated by a specialist. It is within the authority of MEPS to require such an evaluation if one is necessary under the circumstances. However, UNLESS factor (5) must be assessed as a matter of professional medical judgment, not by lay opinion of the applicant, in the same way that every other qualification standard in DODI 6130.03 is assessed.

There is nothing a special Service evaluation can accomplish that is not already informed by the proposed UNLESS factors, except to give unreasonable weight to the medically uninformed opinion of applicants as to whether or not they believe they should undergo surgery at some time in the future. Stated intention to receive medical care is an unreliable measure of medical necessity, in exactly the same way that lay intention to receive medical treatment of any kind is an unreliable measure of medical necessity. For example, some persons may insist that they need reconstructive surgery for an ailing knee. They may have an extremely firm, yet medically uninformed, belief that they require this surgery in order to be fit. However, a doctor will often determine that a different range of options is medically indicated, such as intensive physical therapy or loss of weight. It is not the patient's choice of what is medically necessary among a range of potential options; doctors make a professional medical judgment as to what is medically

necessary. Medical care is not self-directed by the patient, and that will be the case for transgender medical care in the military as well.

Transgender applicants should not be, and need not be, required to meet a unique burden of disproving future medical need if professional medical judgment determines that such a need does not currently exist. No amount of individual verification through special Service review will accurately screen for transgender persons who may have a future need for surgical treatment. Research tells us that this percentage will be extremely small, but it cannot tell us who that small number of people will be. As a comparison, a small percentage of applicants who have played football are at risk of developing a concussion-related loss of fitness at some time. There is no way to accurately predict who those persons will be. All the system can do is determine whether applicants are currently fit, medically stable, and do not require additional treatment. But we do not automatically exclude from accession every person who has played football because a small percentage of them may become unfit, nor do we send them through a separate process of evaluation.

The only predictable effect of special Service evaluation for transgender applicants is a negative one. It creates a separate-but-equal system of evaluation for all transgender applicants even when they are fully fit for service. This is stigmatizing and demeaning, and it will undermine the military's efforts to make inclusive policy work.

3. Don't the Palm Center's proposed UNLESS factors create an incentive for transgender applicants to lie or game the system?

Some working group participants have expressed concern that an UNLESS-based model for transgender accession will incentivize lying. This argument assumes that transgender applicants will hide their medical histories or falsely deny an intention to have surgery in the future, and therefore they cannot be evaluated by the same MEPS process using the familiar UNLESS model. Instead, transgender applicants would be processed separately by the Services under "black box" standards that could vary from case to case, rather than standard, publicly available UNLESS factors administered by MEPS.

This concern is unfounded. Any defined factor of UNLESS qualification potentially invites an effort by a few to evade that factor, but this must not be an insurmountable problem because DODI 6130.03 uses a variety of UNLESS-based qualification standards throughout. There is no reason to believe that transgender applicants are more likely to withhold information than non-transgender applicants. The incentives—and the risks—of that less-than-forthcoming approach are the same for all applicants.

The strongest incentive to withhold information arises under the current transgender accession ban. A "black box" system of special Service review also discourages disclosure because applicants have no idea what could trigger disqualification, and so they might believe it would be best to say nothing. Enumerated UNLESS factors are the best option because they clarify what it will take to demonstrate medical fitness and stability, providing applicants with a fair, transparent standard to meet.

4. What if a transgender service member has a medical need to transition gender while in a deployed setting? How would real-life experience (RLE) work in that setting?

A medically indicated gender transition is not a medical emergency. What does create the possibility of medical emergency is the current policy that completely denies medical care and mandates secrecy under threat of discharge, not the orderly plan for gender transition. That plan can be scheduled in a manner that does not interfere with deployment calendars, in the same way that other non-emergency medical care is now scheduled. For example, a need for surgical orthopedic repair is not necessarily a medical emergency. Athletes often schedule such a repair for the off-season so it will not result in downtime during the competitive season. Similarly, military personnel who may eventually require surgical care, but who are presently medically stable and fit to perform duty, need not disrupt a deployment calendar. The issue will be a matter of consultation between doctor and commander, not a veto by the service member. The key with respect to transgender policy is to handle the decision in the same way non-emergency medical care is handled for all other conditions, not to create a special rule for transgender medical care.

While gender transition is not a medical emergency and can be scheduled around deployment, aspects of transition could in fact take place during deployment. For example, even if real-life experience (RLE) overlapped with deployment in a small minority of cases, there is no reason to assume that RLE is incompatible. There is a common misunderstanding that RLE must be secretive, furtive behavior that takes place outside the view of a transgender person's work colleagues. The reality is that RLE can and should be open and known to others, and it does not create workplace issues that are any different from workplace issues related to gender transition in general. Even in the deployed setting, all RLE means is that colleagues would be informed that an individual intends to transition gender for medical reasons. (It's not as if the clothing will change in any noticeable way—everyone is wearing largely gender-neutral attire.)

A military that accommodates transgender service will have instances in which deployed individuals are known as a gender other than their birth gender. RLE is therefore not different in nature from gender transition in general. The impact on work colleagues is exactly the same, and so it need not be a complicating factor for deployment.

5. How can the military distinguish between surgeries that are medically necessary and those that are merely "optional"?

The rest of the federal government is now subject to rules[5] that require insurers to provide all medically necessary transition-related care, and as a result those insurers are, or will be, making determinations of medical necessity. There is no reason that TRICARE and its network of similarly major insurers cannot make the same determinations for service members within DOD. If the rest of the federal government can apply a definition of medical necessity, DOD can as well. Widely accepted medical standards of care govern these determinations.[6]

What should the military say to an individual who wants "optional" surgery? Precisely the same thing it would say to any service member who wants cosmetic surgery that is not medically necessary: 1) this treatment will not be covered by the military healthcare system (unless it qualifies as approved cosmetic surgery under standard guidelines);[7] and 2) the member accepts the risk that cosmetic surgery will result in unfitness for duty and also accepts the consequences of that unfitness. This is not a new concept for military healthcare, and the issue should be handled under existing rules that apply to everyone.

Conclusion

In sum, research and evidence demonstrate that the best practices for managing issues related to transgender personnel will be consistent with the best practices already in use for everyone else. Neutral rules and expectations are the path to successful implementation, and that principle has been endorsed by retired General Officers and leading scholars and experts. Inclusive policy is "administratively feasible and neither excessively complex nor burdensome," provided that medical risk is managed according to familiar and settled standards, medical care is provided according to the same standards that apply to all personnel, and medical regulation avoids the temptation of over-regulation and separate-but-equal divisions.

Thank you for your consideration.

Aaron Belkin

Aaron Belkin
Director

---

[1] Major General Gale S. Pollock & Shannon Minter, Report of the Planning Commission on Transgender Military Service (Palm Center 2014).
[2] Eli Coleman et al. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism*, 13:165-232, at 171, http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf.
[3] Aaron Belkin, Caring for Our Transgender Troops—The Negligible Cost of Transition-Related Care, New England Journal of Medicine (2015), 373:1089-1092, http://www.nejm.org/doi/full/10.1056/NEJMp1509230.
[4] The Military's Transgender Policy, Stalled, New York Times, Apr. 6, 2016.
[5] U.S. Office of Personnel Management (Healthcare and Insurance), FEHB Program Carrier Letter No. 2015-12, Covered Benefits for Gender Transition Services, June 23, 2015. "Effective January 1, 2016, no carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs or supplies related to gender transition or 'sex transformations.' This letter clarifies OPM's earlier guidance recognizing the evolving professional consensus that treatment may be medically necessary to address a diagnosis of gender dysphoria."
[6] Coleman, Standards of Care.
[7] See, e.g., U.S. Army Medical Command, OTSG/MEDCOM Policy Memo 12-076, Policy for Cosmetic Surgery Procedures and Tattoo/Brand Removal/Alteration in the Military Healthcare System (MHS), Oct. 2, 2012 (scheduled for expiration Oct. 2, 2014).