Greetings,

My name is Alex Fay and I am writing to ask that the ODH and OMHAS Rules on Gender Transition and Data Collection rules be invalidated as they violate criteria. These rules are unwanted and unnecessary and violates both the consent of patients and privacy laws by collecting extensive data on transgender patients. The rules are stated to protect the "life and health" of Ohioans, however, enacting these rules will negatively affect the health of transgender patients who are seeking gender affirming care to survive and thrive. Healthcare should be a decision between the patient and their provider, not the government. These rules are discriminatory and harmful to trans patients, and frustrating and confusing for healthcare providers and should be invalidated.

Thank you,
Alex Fay

To the JOINT COMMITTEE ON AGENCY RULE REVIEW,

JCARR must invalidate ODH and OMHAS rules 5122-14-12.1, 5122-26-19, 3701-3-17, 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61 because they violate the Joint Committee's criteria. These rules are unconstitutional, unnecessary, and unwanted; the government collection of extensive health information on every Ohio transgender patient WITHOUT THEIR CONSENT violates privacy laws. The Agencies did not demonstrate the "that the regulatory intent of the rule justifies its adverse impact on business," because no no fiscal analysis was submitted at all. The regulatory intent of these rules is to protect the "life and health" of Ohioans, but NO EVIDENCE WAS PRESENTED to show that Ohioans who receive gender-affirming care in Ohio are consistently being harmed. Conversely, these rules WILL CAUSE HARM as adult patients avoid doctors knowing that their "de-identified" data will be handed over to hostile Ohio legislators and made publicly available and needlessly delayed or withheld care from the small percentage of children who need it. Ohio's brand of Gender-affirming care improves lives. The Agencies received thousands of pages of testimony attesting to that fact and little, if any, to the contrary. Healthcare should be determined by doctors, parents and patients, not politicians. As a transgender patient in Ohio who would be adversely affected by these rules' implementation, I urge JCARR to hold these rules to the highest standards and recommend invalidation or removal from consideration entirely.

Thank you for your consideration,

Amelia M Murphy

The ODH & OMHAS Rules must be invalidated by JCARR because they violate JCARR Criteria. WHY?

They are UNCONSTITIONAL, UNNECESSARY, & UNWANTED

The GOVERNMENT COLLECTION of extensive health data on every Ohio transgender patient (both youth and adult) — WITHOUT THEIR CONSENT–violates privacy laws.

The Agencies did not demonstrate “that the regulatory intent of the rule justifies its adverse impact on business,” because no no fiscal analysis was submitted at all.

The regulatory intent of these rules is to protect the “life and health” of Ohioans, but NO EVIDENCE WAS PRESENTED to show that Ohioans who receive gender-affirming care in Ohio are consistently being harmed.

Conversely, these rules WILL CAUSE HARM as Adult patients avoid doctors knowing that their “de-identified” data will be handed over to hostile Ohio legislators and made publicly available and needlessly delayed or withheld care from the small percentage of children who need it.

Ohio’s brand of Gender-affirming care improves lives.

The Agencies received thousands of pages of testimony attesting to that fact and little, if any, to the contrary. Healthcare should be determined by doctors, parents and patients, not politicians.

With health and safety at stake we urge JCARR to hold these rules to the highest standards and recommend invalidation or removal from consideration entirely.

WITNESS FORM
REGULAR AGENDA

JOINT COMMITTEE ON AGENCY RULE REVIEW

Agenda Item # 14
(Only 1 item # per Witness Slip)

Please check if you are an Agency Representative? ■

Name: Liam Strausbaugh
(PLEASE PRINT LEGIBLY)

Name, address, and phone of Organization/Department that you represent:

National Association of Social Workers - Ohio Chapter
400 W Wilson Bridge Rd, Ste 103, Worthington, OH 43085
614-461-4484

Rule number(s): 3701-3-17, 3701-59-06, 3701-59-07, 3701-83-60, 3701-83-61

PROPONENT: ☐ **OPPONENT:** ■

Please check basis for opposition testimony:

Legislative intent X	Legislative authority
Conflict with other rule X	Incomplete/inaccurate RSFA X
Incorporation by reference	Adverse Business Impact Justification X
Regulatory Restriction Justification X	Implements federal law or rule that is more stringent or burdensome than federal law or rule requires

Are you submitting written testimony? Yes ■ No ☐

JCARR ODH Testimony

(A) The proposed rule or revised proposed rule exceeds the scope of its statutory authority.
No argument

(B) The proposed rule or revised rule conflicts with the legislative intent of the statute under which it was proposed.
ODH Revised Rules 3701-3-17 falls under the section of Ohio Administrative Code (OAC) that is used for reporting communicable diseases that are dangerous to public health. The legislative intent behind section 3701 of the OAC is to track illnesses and diseases that could impact public health, not to perpetuate stigmatization of transgender identities. There is no reason that a diagnosis of gender dysphoria should be comparable to and in the same section of rule as plague, botulism, rabies, Ebola, smallpox, or hepatitis to name only a few.

(C) The proposed rule or revised proposed rule conflicts with another proposed or existing rule.
Both proposed ODH and OMHAS rules conflict with each other in multiple areas, but also with existing language within the OAC.

Subject	OMHAS Language	ODH Language	Current Rule
Privacy		3701-3-17(C)(1)(c) requires healthcare providers to disclose "**specific information about the nature of any diagnosis**" 3701-3-17(C)(1)(d) will "lead to disclosure of individual identities" as the population being targeted by these rules is so miniscule that it may be **possible to combine demographic information with the "specific information about the nature of any diagnosis" to reveal an individual's identity**	4757-5-01(D) "social workers should **protect the confidentiality of all information obtained** in the course of professional service"

Referral	5122-26-19(B)(1) – (B)(2) "The provider employers or has available for referral **for the in-person, direct provision of services"** 5122-14-12.1(C)(1) "The provider employs or has available for referral"	3701-59-07(B)(1) – (B)(2) "Employs or has available for referral"	
Care Plan	5122-26-19(B)(3) Care plans must include specific services to be provided by the professionals specified in (B)(1) and (B)(2) and other professionals from appropriate disciplines, a process for acquiring **consent from each minor individual's parent/guardian/custodian,** and a detailed plan of action for individuals **seeking to detransition**	3701-59-07(B)(3) Care plans must include a demonstrably active role in the minor individual's care, sufficient informed consent for **both minor individuals receiving care AND parent/guardian/custodian,** and a detailed plan of action for individuals **seeking to detransition OR cease treatment** 3701-83-61(B)(3) Care plans must include a demonstrably active role in the minor individual's care, sufficient informed consent for **both minor individuals receiving care AND parent/guardian/custodian,** and a detailed plan of action for individuals **seeking to detransition OR cease treatment**	4757-5-01(D) "social workers should **protect the confidentiality of all information obtained** in the course of professional service" 5122-27-03 Care plans should include description of specific health services and support needs, anticipated goals, name of all services being provided, frequency of services, documentation of care plan review
Consent	Consent can be provided by each minor individual's parent, guardian, or custodian (5122-26-19(B)(3))	Consent must be obtained from the minor's parent, guardian, or custodian **AND from the minor** (3701-59-07(B)(3) and 3701-83-61(B)(3))	ORC 3129.03(A) states that consent is needed from **one** parent, guardian, or custodian ORC 4731.97 **If an individual is a minor, they lack the capacity to consent**

Hormones	5122-14-12.1 and 5122-26-19 State that providers cannot provide hormonal interventions for the purposes of gender transition unless certain requirements are met	3701-59-07 States that providers cannot provide hormonal interventions for the purposes of gender transition unless certain requirements are met	ORC 3129.02(A)(2) States that hormonal interventions may not be provided unless certain requirements are met, but **these requirements differ** from both ODH and OMHAS proposed rules
Surgery		3701-59-06 and 3701-83-60 It is impermissible for gender reassignment or genital gender reassignment surgeries or referrals for surgeries cannot be completed	ORC 3129.02(A)(1) Physicians cannot perform gender reassignment surgeries on minor individuals, so ODH rules are redundant and unnecessary

(D) The proposed rule or revised proposed rule incorporates a text or other material by reference and:
No argument

(E) The agency has failed to prepare a complete and accurate rule summary and fiscal analysis of the proposed rule or revised proposed rule as required by section 106.024 of the Revised Code.
CSI Business Impact Analysis (BIA) page 2 for rule 3701-3-17 states that the rule is likely to directly reduce the revenue or increase the expenses of businesses to which the rule applies, while the Rule Summary and Fiscal Analysis (RSFA) states on page 2 that the change is revenues or expenditures due to this rule will be $0.00 and that the rule will have no impact. The BIA and RSFA does not take into account the necessary diversion of staff time and other resources that will need to be used in order to comply with these proposed rules. The above also applies to ODH rules 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61.

Additionally, both 3701-59-07 and 3701-83-61both state "There are no fees, penalties will only exist in cases of non-compliance, staff time will be required for submission of reports. Required care plans and staff should not add additional costs because we have been told these resources are already in place. However, providers may have increased cost if they hire or contract with additional staff to ensure compliance with the multi-disciplinary quality of care components.". This statement does not take into account the lack of staff that are needed to be hired or contracted with per these rules. There may also be additional costs associated with care plan requirements as requirements outlined in ODH rules, OMHAS rules, and current Ohio rule are not identical so further design of systems may need to be implemented.

On page 4 of CSI BIA of rule 3701-83-60 and 3701-83-61, there was also a comment left in the digital version from the Director of Ohio Department of Health, Lance Himes, that states "hospital said this [that the resources are already in place], but I am not sure ASFs or physicians have these resources. See proposed sentence". By this statement from the head of ODH himself, he cannot be

sure if the language submitted to CSI is true and accurate. Per his comment, he suggested alternative language to the document that was not submitted to CSI for review. If Lance Himes is correct and only hospitals currently have these resources available, there will be a large cost to private physicians and ambulatory surgical facilities that has not been evaluated in the BIA or RSFA.

All proposed ODH rules reference "medical expertise of ODH physicians" as their scientific data for developing these rules. This does not qualify as scientific data as there is no mention of the amount of physicians, who the physicians are, and no known areas of expertise from these physicians. Additionally, if they only spoke to physicians within ODH, how can we be sure of any objectivity? ODH rules are also duplicative of ORC 3129.02(A)(1) – (A)(2), though the BIA states there is no rule duplication.

(F) The agency has failed to demonstrate through the business impact analysis, recommendations from the common sense initiative office, and the memorandum of response that the regulatory intent of the proposed rule or revised proposed rule justifies its adverse impact on business in this state.
Neither the ODH nor the OMHAS rules contemplate or take into consideration the significant expenses, additional workload, and potential for new or further designed systems for care plan implementation in order to comply with all of these rules. Because the business impact analysis does not even adequately analyze the implications on business expenses, they cannot realistically justify these expenses.

(G) If the state agency is subject to sections 121.95, 121.951, 121.952, and 121.953 of the Revised Code, the agency has failed to justify the proposed adoption, amendment, or recission of a rule containing a regulatory restriction.
ODH is a state agency subject to the ORC sections listed above.

The scientific data that ODH has presented in the BIA as justification for these rules is simply "medical expertise of ODH physicians". As previously noted, there is no way to verify, scrutinize, or evaluate said "data" as these physicians are anonymous, of an unknown quantity, with unknown expertise, and cannot prove objectivity if they are own staff of the department creating these rules.

Proposed ODH rules are also unnecessary given ORC 3129.02(A)(1) and (A)(2).

(H) The proposed rule or revised proposed rule implements a federal law or rule in a manner that is more stringent or burdensome than the federal law or rule requires.
No argument

ODH 3701-3-17

ACTION: Original

DATE: 02/15/2024 4:38 PM

Common Sense Initiative

Mike DeWine, *Governor* Joseph Baker, *Director*
Jon Husted, *Lt. Governor*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Health

Rule Contact Name and Contact Information: Tyler Herrmann, tyler.herrmann@odh.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Reporting requirements for diagnosis and treatment of gender-related conditions

Rule Number(s): 3701-3-17

Date of Submission for CSI Review: 01/24/24

Public Comment Period End Date: 2/5/24

Rule Type/Number of Rules:

New/ X rules — No Change/___ rules (FYR? ___)

Amended/___ rules (FYR? ___) — Rescinded/___ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   The draft regulation imposes reporting requirements for the diagnosis and treatment of gender-related conditions.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   3701.13, 3701.23

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

5. **If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   N/A

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Preservation of the life and health of the people of Ohio, including children.

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The draft regulation requires deidentified reporting regarding the diagnosis, treatment, and cessation of treatment for gender-related conditions.

9. **Does the rule incorporate material by reference?** No

10. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

Not Applicable

11. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

Not Applicable

II. Fiscal Analysis

12. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

This will have no impact on revenues or expenditures.

0.00

Not Applicable.

13. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

Not Applicable.

14. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

15. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

16. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

Not Applicable.

III. Common Sense Initiative (CSI) Questions

17. **Was this rule filed with the Common Sense Initiative Office?** Yes

18. **Does this rule have an adverse impact on business?** Yes

A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

Though the text of this rule does not itself impose a penalty or sanction, ODH does have authority to take action for failure to comply.

C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** Yes

Requires reporting regarding the diagnosis, treatment, and cessation of treatment for gender-related conditions.

D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restriction Requirements under S.B. 9. Note: This section only applies to agencies described in R.C. 121.95(A).

19. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

A. **How many new regulatory restrictions do you propose adding to this rule?**

Not Applicable

B. **How many existing regulatory restrictions do you propose removing from this rule?**

Not Applicable

C. **If you are not removing existing regulatory restrictions from this rule, please list the rule number(s) from which you are removing restrictions.**

ODH 3701-59-06

Common Sense Initiative

Mike DeWine, *Governor* Jon Husted, *Lt. Governor* Joseph Baker, *Director*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Health

Rule Contact Name and Contact Information: Tyler Herrmann, tyler.herrmann@odh.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Quality Standards for Gender Transition Treatment at Hospitals

Rule Number(s): 3701-59-06

Date of Submission for CSI Review:

Public Comment Period End Date: 2/5/24

Rule Type/Number of Rules:

New/ X rules — No Change/___ rules (FYR? ___)

Amended/___ rules (FYR? ___) — Rescinded/___ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ Requires a license, permit, or any other prior authorization to engage in or operate a line of business.

   b. ☒ Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.

   c. ☒ Requires specific expenditures or the report of information as a condition of compliance.

   d. ☒ Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   The draft regulation disallows gender reassignment surgery and genital gender reassignment surgery for minors.

3. Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.

   3701.13, 3722.06

4. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

5. If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   N/A

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Preservation of the life and health of the people of Ohio, including children.

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The draft regulation prohibits gender reassignment surgery or genital gender reassignment surgery for minors.

9. **Does the rule incorporate material by reference?** No

10. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

Not Applicable

11. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

Not Applicable

II. Fiscal Analysis

12. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

This will have no impact on revenues or expenditures.

0.00

Not Applicable.

13. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

Not Applicable.

14. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

15. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

16. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

Not Applicable.

III. Common Sense Initiative (CSI) Questions

17. **Was this rule filed with the Common Sense Initiative Office?** Yes

18. **Does this rule have an adverse impact on business?** Yes

A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

Though the text of this rule does not itself impose a penalty or sanction, ODH does have authority to take action for failure to comply.

C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restriction Requirements under S.B. 9. Note: This section only applies to agencies described in R.C. 121.95(A).

19. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

A. **How many new regulatory restrictions do you propose adding to this rule?**

Not Applicable

B. **How many existing regulatory restrictions do you propose removing from this rule?**

Not Applicable

C. **If you are not removing existing regulatory restrictions from this rule, please list the rule number(s) from which you are removing restrictions.**

Not Applicable

ODH 3701-59-07

Common Sense Initiative

Mike DeWine, *Governor* Joseph Baker, *Director*
Jon Husted, *Lt. Governor*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Health

Rule Contact Name and Contact Information: Tyler Herrmann, tyler.herrmann@odh.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Quality Standards for Gender Transition Treatment at Hospitals

Rule Number(s): 3701-59-07

Date of Submission for CSI Review: 1/24/24

Public Comment Period End Date: 2/5/24

Rule Type/Number of Rules:

New/ X rules — No Change/____ rules (FYR? ___)

Amended/____ rules (FYR? ___) — Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ Requires a license, permit, or any other prior authorization to engage in or operate a line of business.

   b. ☒ Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.

   c. ☒ Requires specific expenditures or the report of information as a condition of compliance.

   d. ☒ Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.

Regulatory Intent

2. Please briefly describe the draft regulation in plain language.
   Please include the key provisions of the regulation as well as any proposed amendments.

   The draft regulation imposes quality standards for the provision of care for gender-related conditions.

3. Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.

   3701.13, 3722.06

4. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

5. If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

   N/A

6. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

   Preservation of the life and health of the people of Ohio, including children.

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The draft regulation imposes quality standards for the provision of care for gender-related conditions for minors.

9. **Does the rule incorporate material by reference?** No

10. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

Not Applicable

11. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

Not Applicable

II. Fiscal Analysis

12. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

This will have no impact on revenues or expenditures.

0.00

Not Applicable.

13. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

Not Applicable.

14. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

15. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

16. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

Not Applicable.

III. Common Sense Initiative (CSI) Questions

17. **Was this rule filed with the Common Sense Initiative Office?** Yes

18. **Does this rule have an adverse impact on business?** Yes

A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

Though the text of this rule does not itself impose a penalty or sanction, ODH does have authority to take action for failure to comply.

C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restriction Requirements under S.B. 9. Note: This section only applies to agencies described in R.C. 121.95(A).

19. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

A. **How many new regulatory restrictions do you propose adding to this rule?**

Not Applicable

B. **How many existing regulatory restrictions do you propose removing from this rule?**

Not Applicable

C. **If you are not removing existing regulatory restrictions from this rule, please list the rule number(s) from which you are removing restrictions.**

Not Applicable

ODH 3701-83-60

Common Sense Initiative

Mike DeWine, *Governor* Joseph Baker, *Director*
Jon Husted, *Lt. Governor*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Health

Rule Contact Name and Contact Information: Tyler Herrmann, tyler.herrmann@odh.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Quality Standards for Gender Transition Treatment at Health Care Facilities

Rule Number(s): 3701-83-60

Date of Submission for CSI Review: _____

Public Comment Period End Date: 2/5/24

Rule Type/Number of Rules:

New/X rules — No Change/____ rules (FYR? ___)
Amended/____ rules (FYR? ___) — Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   The draft regulation disallows gender reassignment surgery and genital gender reassignment surgery for minors.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   3701.13, 3702.30

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

5. **If the regulation implements a federal requirement, but includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   N/A

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Preservation of the life and health of the people of Ohio, including children.

The draft regulation prohibits gender reassignment surgery or genital gender reassignment surgery for minors.

9. **Does the rule incorporate material by reference?** No

10. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

Not Applicable

11. **If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.**

Not Applicable

II. Fiscal Analysis

12. **Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.**

This will have no impact on revenues or expenditures.

0.00

Not Applicable.

13. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

Not Applicable.

14. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** No

15. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

16. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

Not Applicable.

III. Common Sense Initiative (CSI) Questions

17. **Was this rule filed with the Common Sense Initiative Office?** Yes

18. **Does this rule have an adverse impact on business?** Yes

A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** No

B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

Though the text of this rule does not itself impose a penalty or sanction, ODH does have authority to take action for failure to comply.

C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** No

D. **Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?** No

IV. Regulatory Restriction Requirements under S.B. 9. Note: This section only applies to agencies described in R.C. 121.95(A).

19. **Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95?** No

A. **How many new regulatory restrictions do you propose adding to this rule?**

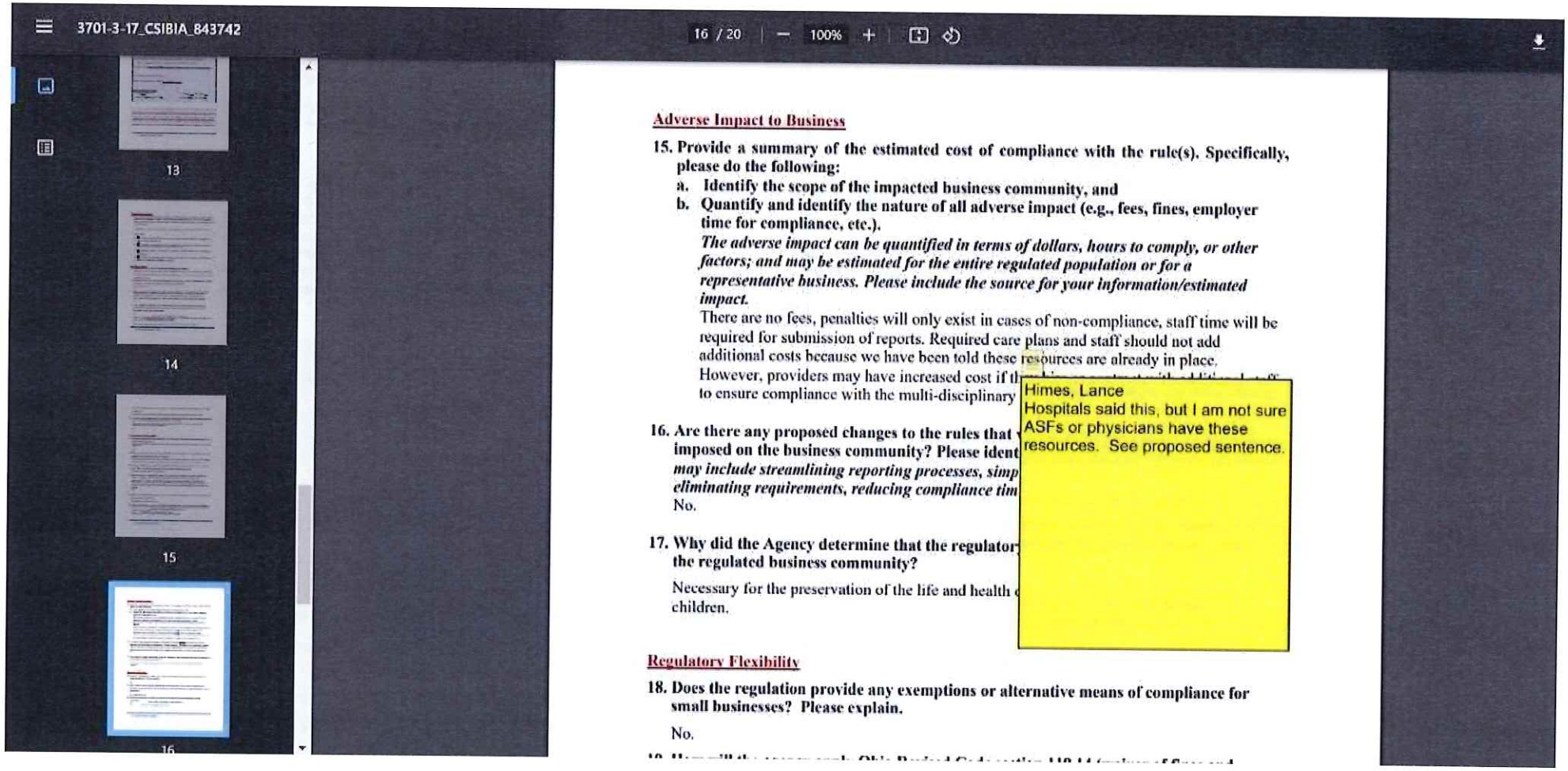
Not Applicable

B. **How many existing regulatory restrictions do you propose removing from this rule?**

Not Applicable

C. **If you are not removing existing regulatory restrictions from this rule, please list the rule number(s) from which you are removing restrictions.**

Not Applicable



Director of Ohio Department of Health, Lance Himes, is even unsure if the above language that was submitted to the Common Sense Initiative is true. He suggested alternative wording to the document that was not submitted to CSI for review. If Lance is correct and only hospitals have this available, there will be a large cost to private physicians and ambulatory surgical facilities.

ODH 3701-83-61

Common Sense Initiative

Mike DeWine, *Governor* Joseph Baker, *Director*
Jon Husted, *Lt. Governor*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Health

Rule Contact Name and Contact Information: Tyler Herrmann, tyler.herrmann@odh.ohio.gov

Regulation/Package Title (a general description of the rules' substantive content):

Quality Standards for Gender Transition Treatment at Health Care Facilities

Rule Number(s): 3701-83-61

Date of Submission for CSI Review: 1/24/24

Public Comment Period End Date: 2/5/24

Rule Type/Number of Rules:

New/ X rules — No Change/____ rules (FYR? ___)
Amended/____ rules (FYR? ___) — Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

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Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**
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   The draft regulation imposes quality standards for the provision of care for gender-related conditions.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

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   No.

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   Preservation of the life and health of the people of Ohio, including children.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIPublicComments@governor.ohio.gov

The draft regulation imposes quality standards for the provision of care for gender-related conditions for minors.

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0.00

Not Applicable.

13. **What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?**

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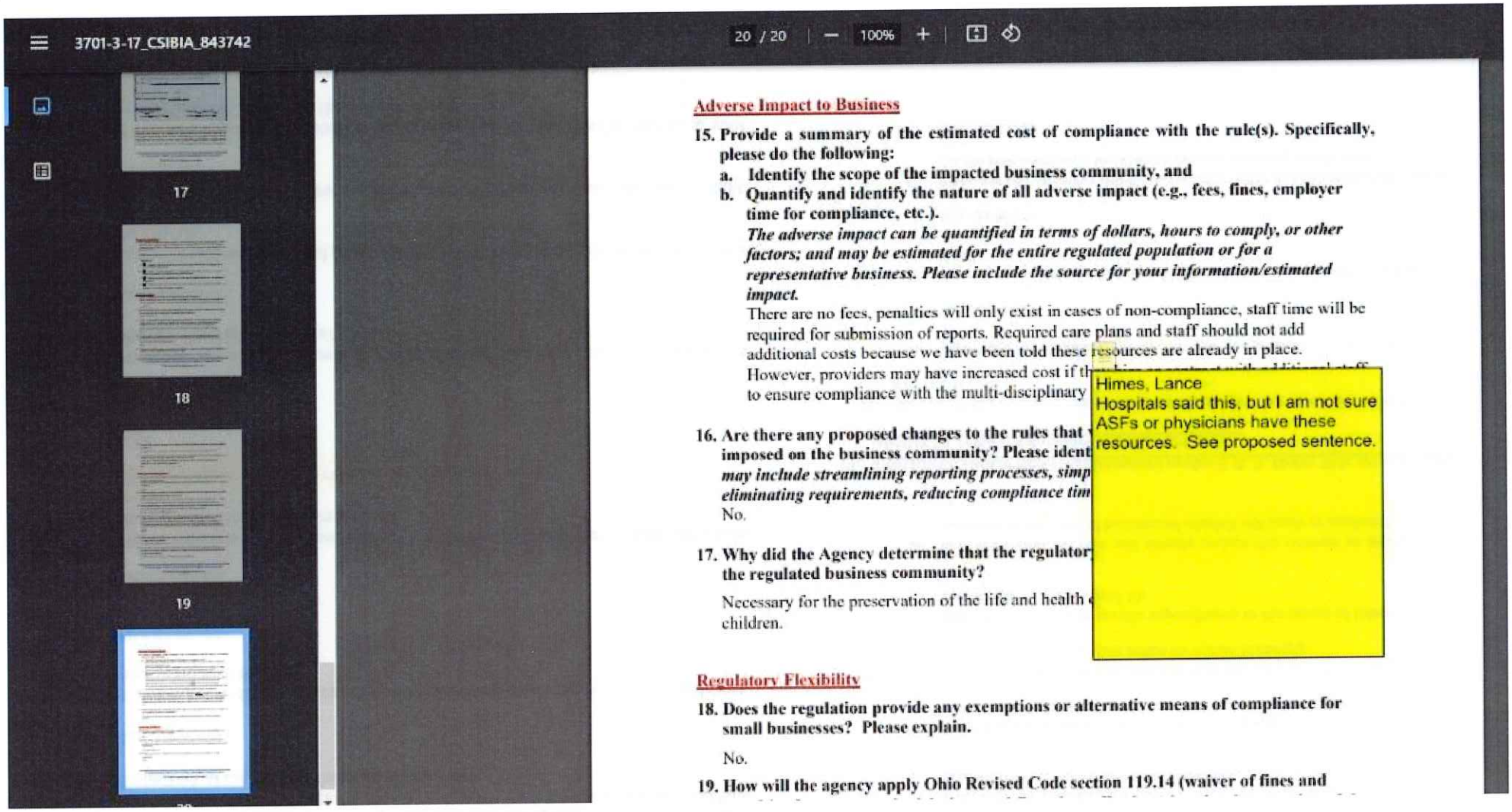
Not Applicable



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WITNESS FORM
REGULAR AGENDA

JOINT COMMITTEE ON AGENCY RULE REVIEW

Agenda Item # 19
(Only 1 item # per Witness Slip)

Please check if you are an Agency Representative? ■

Name: Liam Strausbaugh
(PLEASE PRINT LEGIBLY)

Name, address, and phone of Organization/Department that you represent:

National Association of Social Workers - Ohio Chapter
400 W Wilson Bridge Rd, Ste 103, Worthington, OH 43085
614-461-4484

Rule number(s): 5122-14-12.1 & 5122-26-19

PROPONENT: ☐ **OPPONENT:** ■

Please check basis for opposition testimony:

Legislative intent _____	Legislative authority _____
Conflict with other rule X	Incomplete/inaccurate RSFA X
Incorporation by reference _____	Adverse Business Impact Justification X
Regulatory Restriction Justification X	Implements federal law or rule that is more stringent or burdensome than federal law or rule requires _____

Are you submitting written testimony? Yes ■ No ☐

JCARR OMHAS Testimony

(A) The proposed rule or revised proposed rule exceeds the scope of its statutory authority.
No argument

(B) The proposed rule or revised rule conflicts with the legislative intent of the statute under which it was proposed.
No argument

(C) The proposed rule or revised proposed rule conflicts with another proposed or existing rule.
Both proposed ODH and OMHAS rules conflict with each other in multiple areas, but also with existing language within the OAC.

Subject	OMHAS Language	ODH Language	Current Rule
Privacy		3701-3-17(C)(1)(c) requires healthcare providers to disclose **"specific information about the nature of any diagnosis"** 3701-3-17(C)(1)(d) will "lead to disclosure of individual identities" as the population being targeted by these rules is so miniscule that it may be **possible to combine demographic information with the "specific information about the nature of any diagnosis" to reveal an individual's identity**	4757-5-01(D) "social workers should **protect the confidentiality of all information obtained** in the course of professional service"
Referral	5122-26-19(B)(1) – (B)(2) "The provider employers or has available for referral **for the in-person, direct provision of services"** 5122-14-12.1(C)(1) "The provider employs or has available for referral"	3701-59-07(B)(1) – (B)(2) "Employs or has available for referral"	

Care Plan	5122-26-19(B)(3) Care plans must include specific services to be provided by the professionals specified in (B)(1) and (B)(2) and other professionals from appropriate disciplines, a process for acquiring **consent from each minor individual's parent/guardian/custodian**, and a detailed plan of action for individuals **seeking to detransition**	3701-59-07(B)(3) Care plans must include a demonstrably active role in the minor individual's care, sufficient informed consent for **both minor individuals receiving care AND parent/guardian/custodian**, and a detailed plan of action for individuals **seeking to detransition OR cease treatment** 3701-83-61(B)(3) Care plans must include a demonstrably active role in the minor individual's care, sufficient informed consent for **both minor individuals receiving care AND parent/guardian/custodian**, and a detailed plan of action for individuals **seeking to detransition OR cease treatment**	4757-5-01(D) "social workers should **protect the confidentiality of all information obtained** in the course of professional service" 5122-27-03 Care plans should include description of specific health services and support needs, anticipated goals, name of all services being provided, frequency of services, documentation of care plan review
Consent	Consent can be provided by each minor individual's parent, guardian, or custodian (5122-26-19(B)(3))	Consent must be obtained from the minor's parent, guardian, or custodian **AND from the minor** (3701-59-07(B)(3) and 3701-83-61(B)(3))	ORC 3129.03(A) states that consent is needed from **one** parent, guardian, or custodian ORC 4731.97 **If an individual is a minor, they lack the capacity to consent**
Hormones	5122-14-12.1 and 5122-26-19 State that providers cannot provide hormonal interventions for the purposes of gender transition unless certain requirements are met	3701-59-07 States that providers cannot provide hormonal interventions for the purposes of gender transition unless certain requirements are met	ORC 3129.02(A)(2) States that hormonal interventions may not be provided unless certain requirements are met, but **these requirements differ** from both ODH and OMHAS proposed rules

Surgery		3701-59-06 and 3701-83-60 It is impermissible for gender reassignment or genital gender reassignment surgeries or referrals for surgeries cannot be completed	ORC 3129.02(A)(1) Physicians cannot perform gender reassignment surgeries on minor individuals, so ODH rules are redundant and unnecessary

(D) The proposed rule or revised proposed rule incorporates a text or other material by reference and:
No argument

(E) The agency has failed to prepare a complete and accurate rule summary and fiscal analysis of the proposed rule or revised proposed rule as required by section 106.024 of the Revised Code.
CSI Business Impact Analysis (BIA) page 1 inaccurately identifies OMHAS rules as 5122-14-12.1 and 5122-**16**-19, rather than 5122-14-12.1 and 5122-**26**-19. While this is likely a simple typing error, it does not reflect an accurate rule summary and analysis. Assuming that it was an error and that the analysis is referring to correct rule number 5122-26-19 and 5122-14-12.1, it also failed to provide an accurate summary of estimated costs of compliance with the rule. CSI BIA states on page 6, "there may be administrative costs related to annually demonstrating compliance with the standards specified in the rules", but does not state on page 2 that there is likely to be a reduction in revenue or increase of expenses as a result of the rules. Page 5 also states there is no possible way OMHAS proposed rules are duplicative in any way, though 5122-14-12.1 and 5122-26-19 are both duplicative in some areas with ORC 3129.02(A)(2).

(F) The agency has failed to demonstrate through the business impact analysis, recommendations from the common sense initiative office, and the memorandum of response that the regulatory intent of the proposed rule or revised proposed rule justifies its adverse impact on business in this state.
Neither the ODH nor the OMHAS rules contemplate or take into consideration the significant expenses, additional workload, and potential for new or further designed systems for care plan implementation in order to comply with all of these rules. Because the business impact analysis does not even adequately analyze the implications on business expenses, they cannot realistically justify these expenses.

(G) If the state agency is subject to sections 121.95, 121.951, 121.952, and 121.953 of the Revised Code, the agency has failed to justify the proposed adoption, amendment, or recission of a rule containing a regulatory restriction.
OMHAS is a state agency subject to the ORC sections listed above.
Proposed OMHAS rules are unnecessary given ORC 3129.02(A)(2) and no justification for this is provided.

(H) The proposed rule or revised proposed rule implements a federal law or rule in a manner that is more stringent or burdensome than the federal law or rule requires.
No argument

April 15, 2024

Submitted via email to JCARR1@jcarr.state.oh.us

Joint Committee on Agency Rule Review (JCARR)
Ohio General Assembly
ATTN: Comments on Gender Transition Care Rules
77 S High Street, Concourse Level
Columbus, OH 43215

Re: Rule 5122-14-12.1 [Gender Transition Care] & Rule 5122-26-19 [Gender Transition Care]

I am writing on behalf of Equitas Health, which is headquartered in Columbus, Ohio, to provide information related to you all's review of revisions to administrative rules – Rule 5122-14-12.1: Gender Transition Care and Rule 5122-26-19: Gender Transition Care – as proposed by Governor Mike DeWine and the Ohio Dept. of Mental Health and Addiction Services (MHAS). As noted in this cover letter and in the attached document, Equitas Health is in strong opposition to all portions of this proposed revision to existing administrative rules, and we encourage the Joint Committee on Agency Rule Review (JCARR) to recommend that all of these proposed administrative rules be invalidated.

As you may be aware, Equitas Health is a non-profit community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance "care for all." Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case management, overall care navigation, and a number of community health initiatives.

In the past three months, Equitas Health has filed three separate public comments related to Rule 5122-14-12.1: Gender Transition Care and Rule 5122-26-19: Gender Transition Care. To assist the committee in the review of these proposed administrative rules, we have attached our most recent public comment from the Ohio Dept. of Mental Health and Addiction Services' (MHAS') March 18 public hearing. Our agency remains deeply concerned about the impact that these proposed administrative rules will have on access to care for patients across Ohio. Additionally, our agency is also concerned that these proposed administrative rules may conflict with several of the JCARR prongs, as described in Ohio Revised Code Section 106.021. Specifically, we are concerned that these proposed administrative rules 1) exceed the statutory authority of Governor Mike DeWine and MHAS; 2) conflict

with the legislative intent under which these rules are being proposed; and 3) pose an adverse threat both to healthcare access and healthcare-related businesses throughout the state.

Given this and the concerns noted in the attached public comment, Equitas Health remains in strong opposition to all portions of this proposed revision to existing administrative rule. As such, we encourage the Joint Committee on Agency Rule Review (JCARR) to recommend that all of these proposed administrative rules be invalidated. If you have any comments or further questions, please feel free to reach out to us directly.

Sincerely,

Dr. Rhea Debussy (she/her)
Director of External Affairs
Equitas Health

March 18, 2024

Submitted via email to MH-SOT-GTC2-rules@mha.ohio.gov[1]

Ohio Dept. of Mental Health and Addiction Services (MHAS)
ATTN: Comments on Gender Transition Care Rules
30 East Broad Street, 36th floor
Columbus, OH 43215

Re: Rule 5122-14-12.1 [Gender Transition Care] & Rule 5122-26-19 [Gender Transition Care]

We are writing on behalf of Equitas Health, which is headquartered in Columbus, Ohio, to express comments and concerns related to additional revisions to administrative rules – Rule 5122-14-12.1: Gender Transition Care and Rule 5122-26-19 [Gender Transition Care] – as proposed by Governor Mike DeWine and the Ohio Dept. of Mental Health and Addiction Services (MHAS). As noted throughout this cover letter and public comment, Equitas Health is in strong opposition to all portions of this proposed revision to existing administrative rule.

As you may be aware, Equitas Health is a non-profit community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance "care for all." Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case management, overall care navigation, and a number of community health initiatives.[2]

As we have noted in the previous two rounds of revisions to these proposed administrative rules, our agency, our patients, and our broader community are deeply concerned about this and the impacts that it will have on access to care. Following the public comment period that ended on February 14, the Ohio Dept. of Mental Health and Addiction Services (MHAS) released a revised version of these proposed administrative rules, and in that revision, the agency only slightly changed the verbiage in

[1] Document prepared by Rhea Debussy, Ph.D. (she/her), Director of External and Oliver Licking (he/him), Gender Equity Policy Manager. Document reviewed by Adrianna Udinwe (she/her), Associate General Counsel and Sarah Green (they/she), Administrative Assistant – Advancement. Attachment prepared by Rhea Debussy, Ph.D. (she/her), Director of External. Document reviewed by Adrianna Udinwe (she/her), Associate General Counsel and Sarah Green (they/she), Administrative Assistant – Advancement.
[2] https://equitashealth.com/about-us/

Section (C)(3)(b) for Rule 5122-14-12.1 and Section (B)(3)(b) for Rule 5122-26-19. These inconsequential and negligible changes do not even begin to address the concerns that we have continued to highlight in our previous sets of public comments. For that reason, we are submitting this cover letter with our previous public comment attached.

We strongly recommend that the Ohio Dept. of Mental Health and Addiction Services (MHAS) carefully reviews this attached document, as it notes several issues of concern for patients, medical providers, the state government, and Ohio more broadly. As one of the largest providers of gender affirming care in the Midwest, we continue to strongly urge the Ohio Dept. of Mental Health and Addiction Services (MHAS) to fully and completely rescind all portions of these proposed administrative rules.

Sincerely,

Dr. Rhea Debussy (she/her)
Director of External Affairs
Equitas Health

Oliver Licking(he/him)
Gender Equity Policy Manager
Equitas Health

Equitas Health

February 14, 2024

Submitted via email to CSIPublicComments@governor.ohio.gov & MH-SOT-rules@mha.ohio.gov

Ohio Dept. of Mental Health and Addiction Services (MHAS)
CC: Office of Governor Mike DeWine
ATTN: Comments on Gender Transition Care Rules
30 East Broad Street, 36th floor
Columbus, OH 43215

Re: Rule 5122-14-12.1 [Gender Transition Care] & Rule 5122-26-19 [Gender Transition Care]

I am writing on behalf of Equitas Health, which is headquartered in Columbus, Ohio, to express comments and concerns related to revisions to administrative rules – Rule 5122-14-12.1: Gender Transition Care and Rule 5122-26-19 [Gender Transition Care] – as proposed by Governor Mike DeWine and the Ohio Dept. of Mental Health and Addiction Services (MHAS). As noted throughout this public comment, Equitas Health is in strong opposition to all portions of this proposed revision to existing administrative rule.

As you may be aware, Equitas Health is a non-profit community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance "care for all." Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case management, overall care navigation, and a number of community health initiatives. Regarding this public comment, our agency, our patients, and our broader community are concerned about this proposed rule. As one of the largest providers of gender affirming care in the Midwest, we strongly urge the Ohio Dept. of Mental Health and Addiction Services (MHAS) to fully and completely rescind all portions of these proposed administrative rules.

Overall Recommendation: We strongly urge the Ohio Dept. of Mental Health and Addiction Services (MHAS) to fully and completely rescind the proposed administrative rules, given their numerous contradictions to evidence-based and medically recommended standards of transition-related medical care.

In their current form, the proposed administrative rules would create a situation in which in-patient psychiatric providers will fail the standard outlined in sub-section (H) of other areas of administrative

code – i.e. "to promote recovery and meet the comprehensive needs of each patient" – for many of their transgender, non-binary, gender expansive, and intersex patients.[3] The proposed revisions outlined below fail to meet the standards of care, as outlined by leading medical associations like the World Professional Association of Transgender Health (WPATH).[4]

As noted above, we strongly recommend that all portions of these proposed administrative rules be fully and completely rescinded. Below, we have provided additional details about our concerns related to each sub-section of these proposed administrative rules.

1. Rule 5122-14-12.1 [Gender Transition Care]:

A. **Regarding sub-section (A) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, sub-section (A) relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex').[5] Further, the language in (A) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. As such, we remain deeply concerned with how this language specifically targets patients receiving gender affirming care services, while also placing an undue burden upon those associated with said services. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[6] Section 1557 of the Affordable Care Act (ACA),[7] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[8]

B. **Regarding sub-section (B) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded.** More specifically, sub-section (B) would prohibit in-patient psychiatric providers from administering or furnishing medications that are necessary for transition-related care (i.e. hormone replacement therapy or HRT) in many circumstances. If implemented as currently written, this proposed revision will prohibit numerous in-patient psychiatric patients from accessing life-saving and medically recommended medications, such as testosterone, estrogen, progesterone, etc. Expecting in-patient psychiatric patients to simply stop said

[3] See page 4: https://mha.ohio.gov/static/AboutUs/RulesandRegulations/DraftRules/5122-14-12-Final_01052024.pdf
[4] See WPATH's *Standards of Care for the Health of Transgender and Gender Diverse People*, version 8. 2022. Taylor and Francis Group. Available at: https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644
[5] See GLAAD's *GLAAD Media Reference Guide,* 11th edition. Available at: https://glaad.org/reference/trans-terms
[6] See 14th Amendment to the U.S. Constitution. National Archives and Records Administration (NARA). Available at: https://www.archives.gov/milestone-documents/14th-amendment
[7] See Section 1557 of the Patient Protection and Affordable Care Act. U.S. Dept. of Health and Human Services (HHS). Available at: https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
[8] See Article I, Section 22 (The Right to Reproductive Freedom with Protections for Health and Safety) of the Ohio Constitution. Ohio Legislative Service Commission. Available at: https://codes.ohio.gov/ohio-constitution/section-1.22#:~:text=Article%20I%2C%20Section%2022%20%7C%20The,Protections%20for%20Health%20and%20Safety

medications 'cold turkey' places medical providers in an unethical situation, and alarmingly, it also facilitates active harm against patients, given that this practice would go against the medical recommendations that are referenced above. As such, this entire section should be rescinded from consideration. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[9] Section 1557 of the Affordable Care Act (ACA),[10] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[11]

C. **Regarding sub-section (C) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and completely rescinded.** As noted above in our discussion of sub-section (B), sub-section (C) also directly targets gender affirming care services by placing an undue burden on medical providers and patients, while also directly conflicting with existing standards of care. As such, it should be completely rescinded. Similar to sub-section (B), this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[12] Section 1557 of the Affordable Care Act (ACA),[13] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[14]

D. **Regarding sub-section (D) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (D) of the proposed administrative rule be fully and completely rescinded.** The entirety of sub-section (D) – in addition to much of the language used within the sub-section – would facilitate the creation of medical policies and practices that rely upon outdated information about medical care for intersex patients.[15] If implemented as written, the language used in (D) would allow intersex minors to access some forms of medical care; however, the language in (H) may disallow intersex adults to access such forms of medical care, pending additional revisions to administrative rules. Additionally, (D)(1) has an unusually narrow understanding of intersex identities and variations, and the language in (D)(1) would unfairly restrict access to many intersex patients, so (D)(1) should be completely struck.[16] Similarly, (D)(2) should also be completely struck for the same reasons. Finally, the language used in (D), as currently written, would also protect medical providers

[9] See *supra* note 6.
[10] See *supra* note 7.
[11] See *supra* note 8.
[12] See *supra* note 6.
[13] See *supra* note 7.
[14] See *supra* note 8.
[15] See interAct and Lamda Legal's *Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies.* 2018. Available at: https://legacy.lambdalegal.org/sites/default/files/publications/downloads/resource_20180731_hospital-policies-intersex.pdf
[16] See the Intersex Society of North America's (ISNA's) "What is Intersex?" Available at: https://isna.org/faq/what_is_intersex/; see also interAct's "Intersex Variations Glossary." 2022. Available at: https://interactadvocates.org/wp-content/uploads/2022/10/Intersex-Variations-Glossary.pdf

and surgeons, who perform medically unnecessary and often non-consensual surgeries on intersex newborns and children.[17] Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[18] Section 1557 of the Affordable Care Act (ACA),[19] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[20] and state malpractice law.[21]

E. Regarding sub-section (E) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (E) of the proposed administrative rule be fully and completely rescinded. The provisions for the grandparent clause in sub-section (E) are unnecessarily narrow, and we would recommend rescinding this portion of the administrative rule, along with the rest of the proposed administrative rule. If other portions of the proposed administrative rule are kept intact, then we would strongly recommend extending the grandparent clause to a timeframe of 15 years after the effective date of the rule, which would ensure that existing patients can age into adult medical care services without interruption.

F. Regarding sub-section (F) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (F) of the proposed administrative rule be fully and completely rescinded. In addition to the concerns noted throughout this comment, the practices described in this portion of the proposed administrative rule raise a number of ethical questions and patient privacy concerns, while also creating an undue reporting burden with an overly cumbersome amount of patient and treatment information. We strongly hold the position that such data should not be collected by the government and/or shared with the General Assembly, given numerous ethical and patient privacy concerns. As such, this portion of the proposed administrative rule may directly conflict with areas of federal law, such as 1st Amendment of the U.S. Constitution (i.e. implicit protections related to the right to privacy)[22] and the Health Insurance Portability and Accountability Act (HIPPA).[23]

G. Regarding sub-section (G) of Rule 5122-14-12.1: We strongly recommend that all portions of sub-section (G) of the proposed administrative rule be fully and completely rescinded.

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[17] See Human Rights Watch's "Intersex Children." Available at: https://www.hrw.org/topic/childrens-rights/intersex-children

[18] See *supra* note 6.

[19] See *supra* note 7.

[20] See *supra* note 8.

[21] See Ohio Revised Code Section 2305.113: Medical Malpractice Actions. Available at: https://codes.ohio.gov/ohio-revised-code/section-2305.113

[22] See 1st Amendment to the Bill of Rights of the U.S. Constitution. National Archives and Records Administration (NARA). Available at: https://www.archives.gov/founding-docs/bill-of-rights-transcript

[23] See Health Information Privacy. U.S. Dept. of Health and Human Services (HHS). Available at: https://www.hhs.gov/hipaa/index.html

We recommend rescinding sub-section (G) along with all other portions of the proposed administrative rule, as it would be rendered moot.

2. Rule 5122-26-19 [Gender Transition Care]:

A. Regarding sub-section (A) of Rule 5122-26-19: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded. In addition to the concerns noted above, sub-section (A) relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex').[24] Further, the language in (A) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. As such, we remain deeply concerned with how this language specifically targets patients receiving gender affirming care services, while also placing an undue burden upon those associated with said services. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[25] Section 1557 of the Affordable Care Act (ACA),[26] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[27]

B. Regarding sub-section (B) of Rule 5122-26-19: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded. More specifically, the requirements outlined in sub-section (B) would severely limit access to medications that are necessary for transition-related care (i.e. hormone replacement therapy or HRT). If implemented as currently written, this proposed revision will restrict access to life-saving and medically recommended medications, such as testosterone, estrogen, progesterone, etc. Further, the requirements in this section directly conflict with existing standards of care. As such, this entire section should be rescinded from consideration. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[28] Section 1557 of the Affordable Care Act (ACA),[29] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[30]

C. Regarding sub-section (C) of Rule 5122-26-19: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and completely rescinded. The entirety of sub-section (C) – in addition to much of the language used within the sub-section

[24] See *supra* note 5.
[25] See *supra* note 6.
[26] See *supra* note 7.
[27] See *supra* note 8.
[28] See *supra* note 6.
[29] See *supra* note 7.
[30] See *supra* note 8.

– would facilitate the creation of medical policies and practices that rely upon outdated information about medical care for intersex patients.[31] If implemented as written, the language used in (C) would allow intersex minors to access some forms of medical care; however, the language in (C) may disallow intersex adults to access such forms of medical care, pending additional revisions to administrative rules. Additionally, (C)(1) has an unusually narrow understanding of intersex identities and variations, and the language in (C)(1) would unfairly restrict access to many intersex patients, so (C)(1) should be completely struck.[32] Similarly, (C)(2) should also be completely struck for the same reasons. Finally, the language used in (C), as currently written, would also protect medical providers and surgeons, who perform medically unnecessary and often non-consensual surgeries on intersex newborns and children.[33] Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[34] Section 1557 of the Affordable Care Act (ACA),[35] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[36] and state malpractice law.[37]

D. **Regarding sub-section (D) of Rule 5122-26-19: We strongly recommend that all portions of sub-section (D) of the proposed administrative rule be fully and completely rescinded.** The provisions for the grandparent clause in sub-section (D) are unnecessarily narrow, and we would recommend rescinding this portion of the administrative rule, along with the rest of the proposed administrative rule. If other portions of the proposed administrative rule are kept intact, then we would strongly recommend extending the grandparent clause to a timeframe of 15 years after the effective date of the rule, which would ensure that existing patients can age into adult medical care services without interruption.

E. **Regarding sub-section (E) of Rule 5122-26-19 We strongly recommend that all portions of sub-section (E) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted throughout this comment, the practices described in this portion of the proposed administrative rule raise a number of ethical questions and patient privacy concerns, while also creating an undue reporting burden with an overly cumbersome amount of patient and treatment information. We strongly hold the position that such data should not be collected by the government and/or shared with the General Assembly, given numerous ethical and patient privacy concerns. As such, this portion of the proposed administrative rule may directly conflict with areas of federal law, such as 1st

[31] See *supra* note 15.
[32] See *supra* note 16.
[33] See *supra* note 17.
[34] See *supra* note 6.
[35] See *supra* note 7.
[36] See *supra* note 8.
[37] See *supra* note 21.

Amendment of the U.S. Constitution (i.e. implicit protections related to the right to privacy)[38] and the Health Insurance Portability and Accountability Act (HIPPA).[39]

F. Regarding sub-section (F) of Rule 5122-26-19: We strongly recommend that all portions of sub-section (F) of the proposed administrative rule be fully and completely rescinded. We recommend rescinding sub-section (F) along with all other portions of the proposed administrative rule, as it would be rendered moot.

Concluding Remarks: To conclude, we strongly urge the Ohio Dept. of Mental Health and Addiction Services (MHAS) to do the following:

1) **Fully and completely rescind all portions of theses proposed administrative rules, given their numerous contradictions to evidence-based and medically recommended standards of transition-related medical care.**

Equitas Health would like to thank you for this opportunity to present comments and concerns on the proposed administrative rules. Should you have any questions about our comments, please feel free to contact Dr. Rhea Debussy (she/her), Director of External Affairs at Equitas Health.

[38] See *supra* note 22.
[39] See *supra* note 23.

April 15, 2024

Submitted via email to JCARR1@jcarr.state.oh.us

Joint Committee on Agency Rule Review (JCARR)
Ohio General Assembly
ATTN: Comments on Gender Transition Care Rules
77 S High Street, Concourse Level
Columbus, OH 43215

Re: Rule 3701-3-17 [Reporting Gender-Related Condition Diagnoses and Gender Transition Care]; 3701-59-06 [Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]; 3701-59-07 [Quality Standards for Gender Transition Treatment at Hospitals]; Rule 3701-83-60 [Health Care Facility Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]; and Rule 3701-83-61 [Quality Standards for Gender Transition Treatment at Health Care Facilities]

I am writing on behalf of Equitas Health, which is headquartered in Columbus, Ohio, to provide information related to you all's review of administrative rules – Rule 3701-3-17: Reporting Gender-Related Condition Diagnoses and Gender Transition Care; 3701-59-06: Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors; 3701-59-07: Quality Standards for Gender Transition Treatment at Hospitals; Rule 3701-83-60: Health Care Facility Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors; and Rule 3701-83-61: Quality Standards for Gender Transition Treatment at Health Care Facilities – as proposed by Governor Mike DeWine and the Ohio Dept. of Health (ODH). As noted in this cover letter and in the attached document, Equitas Health is in strong opposition to all portions of these proposed administrative rules, and we encourage the Joint Committee on Agency Rule Review (JCARR) to recommend that all of these proposed administrative rules be invalidated.

As you may be aware, Equitas Health is a non-profit community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance "care for all." Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case management, overall care navigation, and a number of community health initiatives.

In the past three months, Equitas Health has filed two separate public comments related to the aforementioned administrative rules. To assist the committee in the review of these proposed administrative rules, we have attached our most recent public comment from the Ohio Dept. of Health's (ODH's) March 21 public hearing. Our agency remains deeply concerned about the impact that these proposed administrative rules will have on access to care for patients across Ohio. Additionally, our agency is also concerned that these proposed administrative rules may conflict with several of the JCARR prongs, as described in Ohio Revised Code Section 106.021. Specifically, we are concerned that these proposed administrative rules 1) exceed the statutory authority of Governor Mike DeWine and ODH; 2) conflict with the legislative intent under which these rules are being proposed; and 3) pose an adverse threat both to healthcare access and healthcare-related businesses throughout the state.

Given this and the concerns noted in the attached public comment, Equitas Health remains in strong opposition to all portions of these proposed administrative rules. As such, we encourage the Joint Committee on Agency Rule Review (JCARR) to recommend that all of these proposed administrative rules be invalidated. If you have any comments or further questions, please feel free to reach out to us directly.

Sincerely,

Dr. Rhea Debussy (she/her)
Director of External Affairs
Equitas Health

March 21, 2024

Submitted via email to Alicyn.Carrel@odh.ohio.gov[1]

Ohio Dept. of Health (ODH)
ATTN: Comments on Gender Transition Care Rules
246 N High Street
Columbus, OH 43215

Re: Rule 3701-3-17 [Reporting Gender-Related Condition Diagnoses and Gender Transition Care]; 3701-59-06 [Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]; 3701-59-07 [Quality Standards for Gender Transition Treatment at Hospitals]; Rule 3701-83-60 [Health Care Facility Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]; and Rule 3701-83-61 [Quality Standards for Gender Transition Treatment at Health Care Facilities]

I am writing on behalf of Equitas Health, which is headquartered in Columbus, Ohio, to express comments and concerns with administrative rules – Rule 3701-3-17: Reporting Gender-Related Condition Diagnoses and Gender Transition Care; 3701-59-06: Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors; 3701-59-07: Quality Standards for Gender Transition Treatment at Hospitals; Rule 3701-83-60: Health Care Facility Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors; and Rule 3701-83-61: Quality Standards for Gender Transition Treatment at Health Care Facilities– as proposed by Governor Mike DeWine and the Ohio Dept. of Health (ODH). As noted throughout this public comment, Equitas Health is in strong opposition to all portions of these proposed administrative rules.

As you may be aware, Equitas Health is a non-profit community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance "care for all." Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case

[1] Document prepared by Rhea Debussy, Ph.D. (she/her), Director of External Affairs and Oliver Licking (he/him), Gender Equity Policy Manager. Document reviewed by Sam Brinker (he/him), General Counsel and Adrianna Udinwe (she/her), Associate General Counsel.

management, overall care navigation, and a number of community health initiatives.[2] Regarding this public comment, our agency, our patients, and our broader community are concerned about these proposed rules. As one of the largest providers of gender affirming care in the Midwest, we strongly urge the Ohio Dept. of Health (ODH) to fully and completely rescind all portions of these proposed administrative rules.

Overall Recommendation: We strongly urge the Ohio Dept. of Health (ODH) to fully and completely rescind all portions of these proposed administrative rules, given their numerous contradictions to evidence-based and medically recommended standards of transition-related medical care.

In their current form, the proposed administrative rules fail to meet the standards of care, as outlined by leading medical associations like the World Professional Association of Transgender Health (WPATH).[3] As such, the proposed administrative rules would run counter to such evidence-based and medically recommended standards of care, and they would result in harm to transgender, non-binary, gender expansive, and intersex patients across the state.

As mentioned in our previous public comments, the proposed administrative rules will limit access to gender affirming care services (including both physical and mental health services for youth) and related medications that are necessary for transition-related care (i.e. puberty blockers to temporarily pause the development of secondary sex characteristics). If implemented as currently written, this proposed administrative rule will enact a *de facto* or shadow ban that dramatically impacts existing access to life-saving care and medically recommended medications. Such draconian administrative rules, which runs counter to evidence-based and medically recommended standards of care, will place medical providers in an unethical situation, and alarmingly, they will also facilitate active harm against patients, given that these practices would go against the medical recommendations that are referenced above.

As noted both above and in our previous public comments on this matter, we strongly recommend that all portions of these proposed administrative rules be fully and completely rescinded. Below, we have provided additional details about our concerns related to each sub-section of these proposed administrative rules.

1. Rule 3701-3-17 [Reporting Gender-Related Condition Diagnosis and Gender Transition Care]

A. Regarding sub-section (A) of Rule 3701-3-17: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded. In addition to the concerns noted above, sub-section (A)

[2] https://equitashealth.com/about-us/

[3] See WPATH's *Standards of Care for the Health of Transgender and Gender Diverse People*, version 8. 2022. Taylor and Francis Group. Available at: https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644

relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex') in (A)(1).[4] Further, the language in (A)(3)-(A)(4) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. There are similar concerns with the language used in (A)(7), and such issues – which largely stem from a hastily and poorly crafted set of proposed administrative rules – would also create unintended impacts on other people (i.e. cisgender people receiving reproductive surgical like vasectomies and hysterectomies). In addition to limiting access to care for transgender, non-binary, gender expansive, and intersex people, the language set forth in (A)(7)(a) and (A)(7)(b) would place an undue burden on medical providers. And finally, we remain deeply concerned with how this language specifically targets patients receiving gender affirming care services, while also placing an undue burden upon those associated with said services. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[5] Section 1557 of the Affordable Care Act (ACA),[6] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[7]

B. **Regarding sub-section (B) of Rule 3701-3-17: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted throughout this comment, the practices described in this portion of the proposed administrative rule raise a number of ethical questions and patient privacy concerns, while also creating an undue reporting burden with an overly restrictive thirty-day timeline for such reporting. As such, this portion of the proposed administrative rule may directly conflict with areas of federal law, such as 1st Amendment of the U.S. Constitution (i.e. implicit protections related to the right to privacy)[8] and the Health Insurance Portability and Accountability Act (HIPPA).[9]

C. **Regarding sub-section (C) of Rule 3701-3-17: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and**

[4] See GLAAD's *GLAAD Media Reference Guide,* 11th edition. Available at: https://glaad.org/reference/trans-terms
[5] See 14th Amendment to the U.S. Constitution. National Archives and Records Administration (NARA). Available at: https://www.archives.gov/milestone-documents/14th-amendment
[6] See Section 1557 of the Patient Protection and Affordable Care Act. U.S. Dept. of Health and Human Services (HHS). Available at: https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html
[7] See Article I, Section 22 (The Right to Reproductive Freedom with Protections for Health and Safety) of the Ohio Constitution. Ohio Legislative Service Commission. Available at: https://codes.ohio.gov/ohio-constitution/section-1.22#:~:text=Article%20I%2C%20Section%2022%20%7C%20The,Protections%20for%20Health%20and%20Safety
[8] See 1st Amendment to the Bill of Rights of the U.S. Constitution. National Archives and Records Administration (NARA). Available at: https://www.archives.gov/founding-docs/bill-of-rights-transcript
[9] See Health Information Privacy. U.S. Dept. of Health and Human Services (HHS). Available at: https://www.hhs.gov/hipaa/index.html

completely rescinded. In addition to the concerns noted throughout this comment, the practices described in this portion of the proposed administrative rule raise a number of ethical questions and patient privacy concerns, while also creating an undue reporting burden with an overly cumbersome amount of patient and treatment information. The newly added portion of sub-section(C)(1)(d) from the February 7 revision is also concerning, and in our understanding, there is no apparent compelling governmental interest in the state of Ohio collecting this additional basic demographic information. As such, this portion of the proposed administrative rule may directly conflict with areas of federal law, such as 1st Amendment of the U.S. Constitution (i.e. implicit protections related to the right to privacy)[10] and the Health Insurance Portability and Accountability Act (HIPPA).[11]

D. **Regarding sub-section (D) of Rule 3701-3-17: We strongly recommend that all portions of sub-section (D) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted throughout this comment, the practices described in this portion of the proposed administrative rule raise a number of ethical questions and patient privacy concerns, while also creating an undue reporting burden with an overly cumbersome amount of patient and treatment information. We strongly hold the position that such data should not be collected by the government and/or shared with the General Assembly, given numerous ethical and patient privacy concerns. As such, this portion of the proposed administrative rule may directly conflict with areas of federal law, such as 1st Amendment of the U.S. Constitution (i.e. implicit protections related to the right to privacy)[12] and the Health Insurance Portability and Accountability Act (HIPPA).[13]

E. **Regarding sub-section (E) of Rule 3701-3-17: We strongly recommend that all portions of sub-section (E) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted throughout this comment, this portion of the proposed administrative rule still raises a number of concerns. Given the reporting requirements noted in sub-sections (B), (C), and (D), even aggregate data can inadvertently release personally identifiable and protected health information in certain circumstances, such as those described throughout this proposed administrative rule. For instance, aggregate data can be split for the purposes of analysis, and when certain variables (i.e. location, age, sex assigned at birth, gender identity, etc.) are controlled for, this could presumably allow individuals to make inferences that jeopardize the privacy of individual patients within aggregate data samples. As such, this portion of the proposed administrative rule may directly conflict with areas of federal law, such as 1st Amendment of the

[10] See *supra* note 8.
[11] See supra note 9.
[12] See *supra* note 8.
[13] See supra note 9.

U.S. Constitution (i.e. implicit protections related to the right to privacy)[14] and the Health Insurance Portability and Accountability Act (HIPPA).[15]

2. Rule 3701-59-06 [Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]

A. Regarding sub-section (A) of Rule 3701-59-06: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded. In addition to the concerns noted above, sub-section (A) relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex') in (A)(1).[16] Further, the language in (A)(3)-(A)(4) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[17] Section 1557 of the Affordable Care Act (ACA),[18] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[19]

B. Regarding sub-section (B) of Rule 3701-59-06: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded. The entirety of sub-section (B) relies upon outdated information about evidence-based and medically recommended standards of care, since the surgeries in question are not occurring in the state of Ohio. As such, this portion of the proposed administrative rule is completely redundant and unnecessary, so it should be completely struck. Further, the language in (B)(1) may be interpreted as a 'gag order' for medical providers, and in addition to placing an undue burden upon them, this would both unfairly restrict speech and limit the information provided to patients. Given this, the language may directly conflict with several areas of existing federal and state law, such as Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety)[20] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of both direct speech and/or symbolic speech and expression).[21]

[14] See *supra* note 8.
[15] See supra note 9.
[16] See *supra* note 4.
[17] See *supra* note 5.
[18] See *supra* note 6.
[19] See *supra* note 7.
[20] See *supra* note 7.
[21] See *supra* note 8.

C. **Regarding sub-section (C) of Rule 3701-59-06: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and completely rescinded.** The entirety of sub-section (C) – in addition to much of the language used within the sub-section – would facilitate the creation of medical policies and practices that rely upon outdated information about medical care for intersex patients.[22] Additionally, (C)(1) has an unusually narrow understanding of intersex identities and variations, and the language in (C)(1) would unfairly restrict access to many intersex patients, so (C)(1) should be completely struck.[23] Similarly, (C)(2) should also be completely struck for the same reasons. Finally, the language used in (C), as currently written, would also protect medical providers and surgeons, who perform medically unnecessary and often non-consensual surgeries on intersex newborns and children.[24] Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[25] Section 1557 of the Affordable Care Act (ACA),[26] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[27] and state malpractice law.[28]

3. Rule 3701-59-07 [Quality Standards for Gender Transition Treatment at Hospitals]

A. **Regarding sub-section (A) of Rule 3701-59-07: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, sub-section (A) relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex') in (A)(1).[29] Further, the language in (A)(3)-(A)(4) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. Additionally, we remain deeply concerned with how this language specifically targets patients receiving gender affirming care services, while also placing an undue burden upon medical providers who are associated with said

[22] See interAct and Lamda Legal's *Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies.* 2018. Available at: https://legacy.lambdalegal.org/sites/default/files/publications/downloads/resource_20180731_hospital-policies-intersex.pdf

[23] See the Intersex Society of North America's (ISNA's) "What is Intersex?" Available at: https://isna.org/faq/what_is_intersex/; see also interAct's "Intersex Variations Glossary." 2022. Available at: https://interactadvocates.org/wp-content/uploads/2022/10/Intersex-Variations-Glossary.pdf

[24] See Human Rights Watch's "Intersex Children." Available at: https://www.hrw.org/topic/childrens-rights/intersex-children

[25] See *supra* note 5.

[26] See *supra* note 6.

[27] See *supra* note 7.

[28] See Ohio Revised Code Section 2305.113: Medical Malpractice Actions. Available at: https://codes.ohio.gov/ohio-revised-code/section-2305.113

[29] See *supra* note 4.

services. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[30] Section 1557 of the Affordable Care Act (ACA),[31] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[32]

B. **Regarding sub-section (B) of Rule 3701-59-07: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, the entirety of sub-section (B) relies upon outdated information about evidence-based and medically recommended standards of care, while also placing an undue burden on both medical providers and their patients.[33] Further, (B)(1) and (B)(2) should be completely struck, given that they are out-of-line with existing evidence-based and medically recommended standards of care already in practice across the country. Similarly, (B)(3) should also be completely struck for the same reasons. Regarding (B)(3), this portion of the proposed rule would place an exceptional undue burden on medical providers and patients, particularly given the lack of clarity within language like that used in (B)(3)(a) and other portions of the sub-section. This portion of the proposed rule would have a particularly harmful impact on individual people's health, medical providers' ability to practice, and Ohio's economy (i.e. because it would likely force smaller practices to close for business). More specifically, (B)(4) should follow the medically recommended standards of care set forth by WPATH, and mental health requirements should not extend beyond those already in place. In addition to this, it would also have a disparate impact on transgender, non-binary, gender expansive, and intersex youth of color, people in rural communities, and people with a lower socioeconomic status. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[34] Section 1557 of the Affordable Care Act (ACA),[35] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[36] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of symbolic speech and expression).[37]

[30] See *supra* note 5.
[31] See *supra* note 6.
[32] See *supra* note 7.
[33] See *supra* note 3.
[34] See *supra* note 5.
[35] See *supra* note 6.
[36] See *supra* note 7.
[37] See *supra* note 8.

C. **Regarding sub-section (C) of Rule 3701-59-07: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, the entirety of sub-section (C) relies upon outdated information about evidence-based and medically recommended standards of care, while also placing an undue burden on both medical providers and their patients.[38] As with other portions of this proposed rule, we also question what compelling governmental interest exists for the government to restrict access to evidence-based and medically recommended care simply because a patient is under eighteen years of age. Furthermore, sub-section (C) relies upon information from sub-section (B) to which we have already expressed strong opposition. Finally and as with other portions of this proposed administrative rule, this language may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[39] Section 1557 of the Affordable Care Act (ACA),[40] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[41] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of symbolic speech and expression).[42]

D. **Regarding sub-section (D) of Rule 3701-59-07: We strongly recommend that all portions of sub-section (D) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, the entirety of sub-section (D) relies upon outdated information about evidence-based and medically recommended standards of care, while also placing an undue burden on both medical providers and their patients.[43] As with other portions of this proposed rule, we also question what compelling governmental interest exists for the government to restrict access to evidence-based and medically recommended care simply because a patient is under twenty-one years of age. Finally and as with other portions of this proposed administrative rule, this language may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[44] Section 1557 of the Affordable Care Act (ACA),[45] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[46] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of symbolic speech and expression).[47]

[38] See *supra* note 3.
[39] See *supra* note 5.
[40] See *supra* note 6.
[41] See *supra* note 7.
[42] See *supra* note 8.
[43] See *supra* note 3.
[44] See *supra* note 5.
[45] See *supra* note 6.
[46] See *supra* note 7.
[47] See *supra* note 8.

E. **Regarding sub-section (E) of Rule 3701-59-07: We strongly recommend that all portions of sub-section (E) of the proposed administrative rule be fully and completely rescinded.** The entirety of sub-section (E) – in addition to much of the language used within the sub-section – would facilitate the creation of medical policies and practices that rely upon outdated information about medical care for intersex patients.[48] Additionally, (E)(1) has an unusually narrow understanding of intersex identities and variations, and the language in (E)(1) would unfairly restrict access to many intersex patients, so (E)(1) should be completely struck.[49] Similarly, (E)(2) should also be completely struck for the same reasons. Finally, the language used in (E), as currently written, would also protect medical providers and surgeons, who perform medically unnecessary and often non-consensual surgeries on intersex newborns and children.[50] Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[51] Section 1557 of the Affordable Care Act (ACA),[52] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[53] and state malpractice law.[54]

F. **Regarding sub-section (F) of Rule 3701-59-07: We strongly recommend that all portions of sub-section (F) of the proposed administrative rule be fully and completely rescinded.** Due to the serious concerns expressed about other portions of this rule and the fact that we have recommended them to be rescinded, sub-section (F) is redundant, and as such, should be struck.

4. Rule 3701-83-60 [Health Care Facility Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]

A. **Regarding sub-section (A) of Rule 3701-83-60: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, sub-section (A) relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex') in (A)(1).[55] Further, the language in (A)(2)-(A)(4) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. Further, the definitions set forth in (A)(5) are particularly

[48] See *supra* note 22.
[49] See *supra* note 23.
[50] See *supra* note 24.
[51] See *supra* note 5.
[52] See *supra* note 6.
[53] See *supra* note 7.
[54] See *supra* note 28.
[55] See *supra* note 4.

perplexing, particularly in reference to (A)(5)(b), (A)(5)(d), (A)(5)(e) and (A)(5)(f). Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[56] Section 1557 of the Affordable Care Act (ACA),[57] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[58]

B. **Regarding sub-section (B) of Rule 3701-83-60: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded.** The entirety of sub-section (B) relies upon outdated information about evidence-based and medically recommended standards of care, since the surgeries in question are not occurring in the state of Ohio. As such, this portion of the proposed administrative rule is completely redundant and unnecessary, so it should be completely struck. Further, the language in (B)(1) may be interpreted as a 'gag order' for medical providers, and in addition to placing an undue burden upon them, this would both unfairly restrict speech and limit the information provided to patients. Given this, the language may directly conflict with several areas of existing federal and state law, such as Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety)[59] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of both direct speech and/or symbolic speech and expression).[60]

C. **Regarding sub-section (C) of Rule 3701-83-60: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and completely rescinded.** The entirety of sub-section (C) – in addition to much of the language used within the sub-section – would facilitate the creation of medical policies and practices that rely upon outdated information about medical care for intersex patients.[61] Additionally, (C)(1) has an unusually narrow understanding of intersex identities and variations, and the language in (C)(1) would unfairly restrict access to many intersex patients, so (C)(1) should be completely struck.[62] Similarly, (C)(2) should also be completely struck for the same reasons. Finally, the language used in (C), as currently written, would also protect medical providers and surgeons, who perform medically unnecessary and often non-consensual surgeries on intersex newborns and children.[63] Given all of this, this portion of the proposed

[56] See *supra* note 5.
[57] See *supra* note 6.
[58] See *supra* note 7.
[59] See *supra* note 7.
[60] See *supra* note 8.
[61] See *supra* note 22.
[62] See *supra* note 23.
[63] See *supra* note 24.

administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[64] Section 1557 of the Affordable Care Act (ACA),[65] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[66] and state malpractice law.[67]

5. Rule 3701-83-61 [Quality Standards for Gender Transition Treatment at Health Care Facilities]

A. **Regarding sub-section (A) of Rule 3701-83-61: We strongly recommend that all portions of sub-section (A) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, sub-section (A) relies upon a number of outdated terms (i.e. 'biological sex,' and 'birth sex') in (A)(1).[68] Further, the language in (A)(2)-(A)(4) unfairly targets evidence-based healthcare services for transgender, non-binary, and gender expansive people, while also containing provisions that will indirectly impact access to care for intersex people among others. Further, the definitions set forth in (A)(5) are particularly perplexing, particularly in reference to (A)(5)(b), (A)(5)(d), (A)(5)(e) and (A)(5)(f). Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[69] Section 1557 of the Affordable Care Act (ACA),[70] and Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety).[71]

B. **Regarding sub-section (B) of Rule 3701-83-61: We strongly recommend that all portions of sub-section (B) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, the entirety of sub-section (B) relies upon outdated information about evidence-based and medically recommended standards of care, while also placing an undue burden on both medical providers and their patients.[72] Further, (B)(1) and (B)(2) should be completely struck, given that they are out-of-line with existing evidence-based and medically recommended standards of care already in practice across the country. Similarly, (B)(3) should also be completely struck for the same reasons. Regarding (B)(3), this portion of the proposed rule would place an exceptional undue burden on medical providers and patients, particularly given the lack of clarity within language like that used in (B)(3)(a) and other portions of the

[64] See *supra* note 5.
[65] See *supra* note 6.
[66] See *supra* note 7.
[67] See *supra* note 28.
[68] See *supra* note 4.
[69] See *supra* note 5.
[70] See *supra* note 6.
[71] See *supra* note 7.
[72] See *supra* note 3.

sub-section. This portion of the proposed rule would have a particularly harmful impact on individual people's health, medical providers' ability to practice, and Ohio's economy (i.e. because it would likely force smaller practices to close for business). More specifically, (B)(4) should follow the medically recommended standards of care set forth by WPATH, and mental health requirements should not extend beyond those already in place. In addition to this, it would also have a disparate impact on transgender, non-binary, gender expansive, and intersex youth of color, people in rural communities, and people with a lower socioeconomic status. Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[73] Section 1557 of the Affordable Care Act (ACA),[74] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[75] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of symbolic speech and expression).[76]

C. **Regarding sub-section (C) of Rule 3701-83-61: We strongly recommend that all portions of sub-section (C) of the proposed administrative rule be fully and completely rescinded.** In addition to the concerns noted above, the entirety of sub-section (C) relies upon outdated information about evidence-based and medically recommended standards of care, while also placing an undue burden on both medical providers and their patients.[77] As with other portions of this proposed rule, we also question what compelling governmental interest exists for the government to restrict access to evidence-based and medically recommended care simply because a patient is under eighteen years of age. Furthermore, sub-section (C) relies upon information from sub-section (B) to which we have already expressed strong opposition. Finally and as with other portions of this proposed administrative rule, this language may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[78] Section 1557 of the Affordable Care Act (ACA),[79] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[80] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of symbolic speech and expression).[81]

D. **Regarding sub-section (D) of Rule 3701-83-61: We strongly recommend that all portions of sub-section (D) of the proposed administrative rule be fully and completely**

[73] See *supra* note 5.
[74] See *supra* note 6.
[75] See *supra* note 7.
[76] See *supra* note 8.
[77] See *supra* note 3.
[78] See *supra* note 5.
[79] See *supra* note 6.
[80] See *supra* note 7.
[81] See *supra* note 8.

rescinded. In addition to the concerns noted above, the entirety of sub-section (D) relies upon outdated information about evidence-based and medically recommended standards of care, while also placing an undue burden on both medical providers and their patients.[82] As with other portions of this proposed rule, we also question what compelling governmental interest exists for the government to restrict access to evidence-based and medically recommended care simply because a patient is under twenty-one years of age. Finally and as with other portions of this proposed administrative rule, this language may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[83] Section 1557 of the Affordable Care Act (ACA),[84] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[85] and the 1st Amendment of the U.S. Constitution (i.e. freedom of speech in the form of symbolic speech and expression).[86]

E. Regarding sub-section (E) of Rule 3701-83-61: We strongly recommend that all portions of sub-section (E) of the proposed administrative rule be fully and completely rescinded. The entirety of sub-section (E) – in addition to much of the language used within the sub-section – would facilitate the creation of medical policies and practices that rely upon outdated information about medical care for intersex patients.[87] Additionally, (E)(1) has an unusually narrow understanding of intersex identities and variations, and the language in (E)(1) would unfairly restrict access to many intersex patients, so (E)(1) should be completely struck.[88] Similarly, (E)(2) should also be completely struck for the same reasons. Finally, the language used in (E), as currently written, would also protect medical providers and surgeons, who perform medically unnecessary and often non-consensual surgeries on intersex newborns and children.[89] Given all of this, this portion of the proposed administrative rule may directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution,[90] Section 1557 of the Affordable Care Act (ACA),[91] Section 22 of the Bill of Rights of the Ohio Constitution (i.e. "The Right to Reproductive Freedom with Protections for Health and Safety),[92] and state malpractice law.[93]

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[82] See *supra* note 3.
[83] See *supra* note 5.
[84] See *supra* note 6.
[85] See *supra* note 7.
[86] See *supra* note 8.
[87] See *supra* note 22.
[88] See *supra* note 23.
[89] See *supra* note 24.
[90] See *supra* note 5.
[91] See *supra* note 6.
[92] See *supra* note 7.
[93] See *supra* note 28.

F. **Regarding sub-section (F) of Rule 3701-83-61: We strongly recommend that all portions of sub-section (F) of the proposed administrative rule be fully and completely rescinded.** Due to the serious concerns expressed about other portions of this rule and the fact that we have recommended them to be rescinded, sub-section (F) is redundant, and as such, should be struck.

Concluding Remarks: To conclude, we strongly recommend that the Ohio Dept. of Health (ODH) does the following:

1) **Fully and completely rescind all portions of these proposed administrative rules, given their numerous contradictions to evidence-based and medically recommended standards of transition-related medical care.**

Equitas Health would like to thank you for this opportunity to present comments and concerns on the proposed administrative rule. Should you have any questions about our comments, please feel free to contact Dr. Rhea Debussy (she/her), Director of External Affairs at Equitas Health.

Hello,

My name is Connor Kirchens. I was born in Ohio, and have lived here all of my life. I have lived and worked in Columbus for 6 years now.

I am submitting this written testimony for the public hearing on April 15th at 1:30pm EDT.

I strongly and deeply oppose the proposed rules.

I demand that the rules be dropped.

These are two very interlinked sets of rules that overall create a web of surveillance over gender affirming care, among other regulations. They are unnecessary and incredibly harmful, and they should be rescinded in their entirety.

Any restrictions or banning of transgender healthcare for minors or adults will lead to death. This study found that compared with the general population, transgender individuals with a gender incongruence were more than six times as likely to have been hospitalized after a suicide attempt. (https://www.psychiatry.org/news-room/news-releases/study-finds-long-term-mental-health-benefits-of-ge#:~:text=The%20study%20found%20the%20odds,same%20association%20for%20hormone%20treatment.&text=more%20than%20six%20times%20as,hospitalized%20after%20a%20suicide%20attempt.)

I do not support the state of Ohio interfering in the medical care or the pursuit of happiness of transgender people.

The Department's proposal would add onerous requirements that will reduce available resources for this type of care even though it can be lifesaving.

I remain concerned that the proposal continues to unnecessarily strip transgender minors of their bodily autonomy and further stigmatizes an already vulnerable population of Ohioans.

It's an undue burden on healthcare providers to have to provide this data. Clerical and bureaucratic fatigue are the goal.

The administrative rules and the laws keep piling on that are detrimental and harmful towards our community.

Please, make a difference today, and do not let these rules go into effect.

They serve only to benefit the already powerful, and only to further marginalize those that deserve to be lifted up.

Connor Kirchens

Honorable Members of JCARR,

My name is Lis Regula, and I'm a resident of Columbus, Ohio. I am writing to express my strong opposition to the proposed rules regarding Gender Transition for minors and Health Data Reporting for minors and adults, as presented by the Ohio Department of Health (ODH) and the Ohio Department of Mental Health and Addiction Services (OMHAS). These proposed rules exceed the legal authority of these departments and pose significant concerns regarding their impact on businesses, the Ohio economy, and constitutional rights.

Firstly, it is evident that these rules conflict with the intent of Ohio Administrative Rules. The proposed regulations stretch beyond the bounds of the agencies' statutory authority and conflict with legislative intent. Such overreach undermines the rule of law and sets a dangerous precedent for future regulatory actions.

Secondly, these rules will undoubtedly have a detrimental effect on businesses and the Ohio economy. However, there has been a glaring absence of a good-faith effort to analyze these impacts. The agencies have failed to prepare a comprehensive and accurate fiscal analysis, as mandated by ORC 106.024. Without a thorough assessment of the potential economic consequences, moving forward with these regulations is irresponsible.

Thirdly, these rules raise serious constitutional concerns. By imposing restrictions on gender transition for minors and mandating health data reporting for minors and adults, the agencies are infringing upon fundamental rights and liberties. These regulations encroach upon individuals' autonomy and privacy, violating the principles enshrined in the Constitution.

Furthermore, the agencies have failed to meet several procedural requirements outlined in Ohio law. The rule summary and fiscal analysis are incomplete and inaccurate, as mandated by ORC 106.024. Additionally, the adverse impact on businesses has not been adequately justified or addressed, as required by ORC 107.52.

In conclusion, I urge the Joint Committee on Agency Rule Review to reject the proposed rules on Gender Transition and Health Data Reporting. These regulations exceed the agencies' statutory authority, conflict with legislative intent, and pose significant constitutional and economic concerns. It is very important that these proposed rules be thoroughly reconsidered and revised in accordance with legal and procedural requirements.

Thank you for considering my testimony on this critical matter.

Sincerely,

Lis Regula, Ph. D

Mari Alschuler, Ph.D., LISW-
888 Edenridge Drive
Boardman, OH 44512
(330) 550-0363
marialschuler@gmail.com

April 3, 2024

To the Joint Committee on Agency Rule Review and Ohio State Assembly:

My name is Mari Alschuler, Ph.D., LISW-S. I am a Professor of Social Work at Youngstown State University and a gender-affirming psychotherapist licensed in the state of Ohio. My testimony reflects my own opinions, not those of my employers, and is based on my 35 years of professional experience.

On March 21st, I was one of the people who testified in person at ODH's Directors Public Rules Meeting. Everyone who attended and testified was there to ask ODH to revise or invalidate the proposed rules. After the meeting, I was informed that ODH Directors refused to revise any of these rules and instead passed them as they exist onto you. This is appalling. We all had valid, rule-specific objections to most of the proposed rules.

You, the Joint Committee on Agency Rule Review and Ohio State Assembly, have the power to invalidate these rules. I am writing now to request that you invalidate all proposed rules. I strongly recommend that you not permit HB 68 to be enacted in Ohio.

I humbly request that you enter the following testimony into the record.

The proposed rules exceed the scope of the state agencies' statutory authority as to the confidential and protected work of social workers and other health professionals. These agencies have no authority to deny medically necessary medical care to minors who have parental approval and consent. They cannot ask minors to CONSENT to treatment. They cannot tell therapists that they are not permitted to make referrals for medical care. **Neither agency has conducted a business analysis or impact evaluation.**

I provide gender-affirming care that respects the dignity and worth of all people. That is one of the ethical standards of the social work profession I am proud to uphold. I see clients all over Ohio in person and via telehealth as one of a limited number of licensed mental health professionals who specialize in working with trans and nonbinary people. These agencies cannot tell licensed mental health professionals that they cannot conduct teletherapy within the state of Ohio.

The rules are too stringent as well as too burdensome for mental health professionals, the agencies that employ us, and the electronic health reporting programs or platforms that we use.

ODH Rules 3701-59-07(B)(1) and 3701-83-61(B)(1) create confusion regarding not only **who** can provide psychotherapy for people presenting with gender-related clinical issues but also **how** this care can be provided. The revised ODH Rules 3701-59-07(B)(1) and 3701-83-61(B)(1) propose professionals providing care have "availability for in-person care and consultation when necessary." *So can providers use telehealth or not?* This rule requires **referrals** for "in-person, direct provision of services," but this is not required in ODH revised Rules 3701-59-07(B)(1) and 3701-83-61(B)(1). This needs to be invalidated.

Further, it is unclear how providers are expected to "show" a "demonstrably active role in the minor individual's care," for those of us treating youth for gender-related issues. These rules need to be invalidated.

These rules violate Federal Confidentiality and Privacy Laws under HIPAA and the Hi-Tech Act:

Regarding ODH 3701-3-17(C)(1)(c) and (d): The requirement to provide "specific information about the nature of any diagnosis" is still required in the revised Rules and **violates federal law** (**HIPAA and its Privacy Rule**). They further violate the National Association of Social Workers *Code of Ethics* Standard 1.07(c) which explains "social workers should protect the confidentiality of all information obtained in the course of professional service" as well as Ohio's Counselor, Social Worker, and Marriage and Family Therapist Board's Rules and Laws set forth under Ch. 4757 (cswmft.ohio.gov). These revised rules must be invalidated.

ODH 3701-3-17(C)(2) offers a new provision clarifying that reported data "will not include patient names, addresses, or other personally identifiable information," but still fails to protect the small population of trans and gender diverse youth across Ohio from identification given the other reporting requirements. Given this, **ODH cannot breach protected health information under HIPAA and the Hi-Tech Act**. This demographic data cannot be truly anonymized and thus creates a safety and surveillance risk. This rule must be invalidated.

3701-3-17(D) of the revised Rule adds a clause to omit "information that would lead to the disclosure of individual identities" from shared aggregate data. Given the totality of the reporting requirements and small population of trans and gender diverse youth, data will not be truly anonymized and creates a safety and surveillance risk. **Releasing confidential information which can lead to identifying patients is against our *Code of Ethics* and will violate the Privacy Rule requirements of HIPAA and the Hi-Tech Act.**

The proposed rules will have an adverse impact on businesses like the small therapy group practice in which I practice and further violate Section 1557 of the medical necessity requirements for gender-affirming care (GAC) under the Affordable Care Act (ACA).

I serve Ohioans who are seeking congruence between their assigned gender at birth and the way they perceive and believe their current gender to be. I perform assessments using the *Diagnostic and Statistical Manual* published by the American Psychological Association (chapter on Gender Dysphoria). I use inventories like the Utrecht Gender Congruence Scale and intensively interview clients to ascertain--based on my professional opinion--if they meet the diagnostic criteria. I may then refer the client to be evaluated by an endocrinologist for medical necessity for cross-gender hormone treatment. Only adults may be referred to surgeons should the client be requesting gender-confirming surgical intervention. **NO MINORS IN OHIO RECEIVE GENDER-RELATED SURGERY. THIS IS BIASED MISINFORMATION MEANT TO SWAY PUBLIC OPINION AND CREATE HARMFUL POLITICAL POLICIES and ACTS LIKE HB68 and the proposed rules you are reviewing now.**

5122-14-12.1(C)(1) requires a "mental health professional" who the provider employs or has available for referral. 5122-26-19(A)(5) defines providers who may provide gender-affirming care, including social workers. Social workers will now have to meet specific obligations as set forth in the revised Rule which is likely to bring us into conflict with our profession's ethical obligations as well as the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board's rules and laws set forth in Ch. 4757 (cswmft.ohio.gov).

ODH 3701-3-17(B): Although the text of the revised Rules did not change from the initial Rules, the implications for social workers have changed since we are now specifically named in the Rules and thus become clearly subject to these reporting requirements for providing treatment for a "gender-related condition." There is no diagnosis with that name. Gender-related conditions include: puberty, menstruation, menopause, erectile dysfunction, uterine, cervical and prostate cancers, and so forth. Gender-related clinical issues can include pregnancy and infertility; puberty and adolescence; sexual orientation; menopause; grief, depression, anxiety; sexual dysfunction; gender role conflicts; parenting and marital issues, and so forth. Gender dysphoria is the only diagosis in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition Revised, or DSM-5-TR (APA, 2022). The implications for revealing personal information related to one's sex or gender or gender identity are vague and overstep the authority of these agencies. This rule must be wholly invalidated.

ODH 3701-59-06(B) and 3701-83-60(B) prohibit "direct or indirect referral" to other providers and prohibit giving a minor information on where or how to receive care regarding "gender reassignment surgery or genital gender reassignment surgery." These proposed rules restrict my professional obligation to provide linkage and referrals to other mental health providers as well as to medical providers, including endocrinologists for teens and adults, and surgeons for adults wishing to have gender-confirmation surgery so that they can live authentically in their bodies. **This violates the First Amendment of the United States Constitution,** which permits Americans to speak and write freely. Telling mental health professionals that we cannot provide linkage and referrals to medical professionals is a content and viewpoint-based regulation of speech subject to strict scrutiny which the State cannot meet.

3701-59-07(B)(3)(b) and 3701-83-61(B)(3)(b) changed the informed consent requirement from the initial rules. The revised Rules require "sufficient informed **consent** for both minor individuals receiving care and the minor individual's parents." **Children can neither assent nor consent to treatment. Teenagers may "assent" to care but cannot legally "consent" to care.**

O.R.C. §3129: This Rule contains major flaws regarding informed consent from minors.

- Teenagers may give "assent" but not "consent" per U.S. law. The rule refers to minors being required to give "informed consent."
- 5122-14-12.1(C)(3)(b): O.R.C. §3129.03(A) only requires informed consent from one parent, legal custodian, or guardian. HB68 stated that "one residential parent" may give informed consent for the treatment of their minor child. This O.R.C. requires "informed consent from each minor patient and the minor patient's parent or legal guardian." Providers will not be able to comply with this Rule as written or provide the resulting gender affirming care. This revised Rule also does not align with those permitted to give consent in HB 68 as it excludes a minor's legal custodian. Revised OMHAS rules only allow for consent from a parent or guardian and does not mention a custodian having the ability to provide informed consent at all.
- Social workers must comply with O.R.C. §3129.03(A) to treat "a minor individual who presents for the diagnosis or treatment of a gender-related condition**." What is set forth in paragraphs (B) and (C) is against the law.**

O.R.C. 3129 should be invalidated in its entirety because the rules contain incurable defects that are unconstitutional, unclear, unfeasible, and require social workers to act unethically regarding comply with reporting requirements which require disclosing confidential information against our social work *Code of Ethics* [National Association for Social Workers, NASW] as well as **against HIPAA's Privacy Rule—a violation of federal law.**

The proposed rules will have an adverse effect on businesses:

5122-26-19(B)(4) incorporates O.A.C. 5122-27-03 which sets forth requirements for treatment plans. This was not in the first set of proposed Rules. Revised ODH rules describe a new kind of care plan and introduce an inspection requirement. Social workers write 'treatment plans' and it is unclear if this is what is meant by the rules. It is also unclear what information will be required to provide the kind of care plan outlined in the revised Rules.

Inspection Requirement: Small private agencies such as the one at which I work do not have an infrastructure available to accommodate the described inspection. There remain many questions regarding frequency, timing, and depth of the inspection and no information about the qualifications of those who will be conducting these inspections, or who would have the oversight over these so-called inspectors. It is also unclear what information will be required to provide the kind of care plan outlined in the revised Rules. Social workers and other mental health professionals do not need government overseeing our documentation, including treatment plans. This section needs to be invalidated.

5122-14-12.1(D): This provision allows intersex individuals and those who need treatment for receiving gender transition services exclusion from the requirements of this Rule. One difference in this Rule from the initial proposed Rules is that it previously allowed surgery; this has been taken out of the revised Rules**. This provision violates the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution** as it discriminates

on the basis of sex and cannot meet intermediate scrutiny requirements as interpreted by the courts.

HB 68—no matter how it is revised—remains a discriminatory anti-transgender, anti-family, anti-self-determination bill. OHMHAS and ODH rules directly affect people who 00identify as transgender, intersex, or nonbinary. By voting to overturn Gov. DeWine's veto, the Ohio House and Senate have told Ohioans that some of us do not deserve bodily autonomy, the right to health care, mental health care, medical care, or the physical safety afforded to every other Ohioan in their schools, place of business, public space, and bathroom.

As you must be aware, 1 in 5 Ohioans live with a mental health or substance use disorder. Demand has risen for mental health/addiction care since 2019, exacerbated by COVID-19. Nearly 2.4 million Ohioans live in communities without enough behavioral health professionals. Gov. DeWine stated he couldn't pass a bill that presumed that legislators know better how to take care of their loved ones—youth or adult—than their parents, therapists, or doctors.

These rules directly affect people who identify as transgender, intersex, or nonbinary. By voting to overturn Gov. DeWine's veto, the Ohio House and Senate have told Ohioans that some of us do not deserve bodily autonomy, the right to health care, mental health care, medical care, or the physical safety afforded to every other Ohioan in their schools, places of business, public spaces, sports teams, and bathrooms. These proposed State rules are intended to help implement HB68, a discriminatory, anti-transgender, anti-family, and anti-self-determination bill. **They need to be invalidated.**

Ohio legislators do not understand the stress, anxiety, depression, and sheer terror trans and queer people are living in due to their onslaught of hateful, misinformed, biased, ignorant beliefs and laws enacted to further invalidate the lives of people wishing to live healthy, authentic lives. Our queer children and adults are bullied, assaulted, murdered. Yet queer, intersex, and trans people are not shrinking violets. Sadly, many may choose to die by suicide rather than live in this hate-mongering political atmosphere. Their blood is on your hands.

Ohio is not a welcoming state anymore due to this hateful political climate. Behavioral health providers who are gender specialists like me will be forced to choose where to live and work. We will leave Ohio for states where we can provide gender-affirming care without threat of prosecution or loss of our livelihoods. Ohio cannot afford a loss of behavioral health professionals like me.

Do not support the enactment of HB 68! Please invalidate all revised rules put before you today.

Respectfully submitted by
Mari Alschuler, Ph.D., LISW-S

THE TREVOR PROJECT

For Young LGBTQ Lives

April 11, 2024

Ohio General Assembly
Joint Committee on Agency Rule Review
Via email:jcarr1@jcarr.state.oh.us

RE: ODH & OMHAS Gender Transition & Data Collection Rules

Dear Members of the Joint Committee on Agency Rule Review,

I am writing on behalf of The Trevor Project to urge the Joint Committee on Agency Rule Review (JCARR) to invalidate the ODH & OMHAS gender transition & data collection rules.These rules blatantly violate JCARR's criteria for validation, and would impose unnecessary and detrimental barriers to essential medical care for patients which do not align with current standards of care for transgender young people.

As reflected in The Trevor Project's previous comments on the proposed rules, barriers to transgender medical care are contradicted by established medical standards of care. **Further, access to transgender medical care has been associated with significantly lower odds of suicide risk among transgender and nonbinary youth.**

The Trevor Project is the leading suicide prevention and crisis intervention organization for lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) young people. We work to save young lives by providing free and confidential 24/7 crisis services via phone, text, and chat. We also operate TrevorSpace, the largest safe space social networking site for LGBTQ+ youth, as well as innovative education, research, and advocacy programs.

The medical practices in question embody well established standards of care for transgender individuals. The latest standards are set forth by the World Professional Association for Transgender Health (WPATH) and are based on decades of clinical research and experience. Their efficacy is additionally demonstrated by the positive impact that transgender people who have access to the care report on their mental and physical health.[1] For this reason, every major

[1] World Professional Association for Transgender Health, Standards of Care Version 8 (2022), available at https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

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medical and mental health association has affirmed the validity and importance of the WPATH standards of care for transgender patients, including youth. [234567] The proposed rule maintains that minors must receive health and counseling services over a period of no less than six months. This blanket requirement imposes a restrictive timeline that goes against current standards of care, which emphasize individualized medical assessments. The proposed stringent requirements imposed on healthcare providers create unnecessary barriers to care for minors seeking transgender medical care, and undermine the expertise of medical professionals in favor of elected officials who are highly unlikely to have a background in healthcare, and are even less likely to possess competencies in the area of medicine they are attempting to restrict.

Further, the Agencies did not demonstrate that the regulatory intent of the rule justifies its adverse impact on business by failing to submit a fiscal analysis, in addition to failing to present evidence that Ohioans who receive transgender medical care are being harmed, which does not meet the intent of these rules to protect the "life and health" of Ohioans. Rather, the vast majority of evidence presented by medical experts in Ohio shows that the proposed rules will actively harm the physical and mental health of the patients in their care.

Suicide is the second leading cause of death among young people ages 10 to 14, and the third leading cause of death among 15-24 year olds in the United States, and we know that transgender and nonbinary young people are significantly more likely to attempt suicide than their peers.[8] However, we also know that trans youth are not prone to suicide simply because of their gender identity. Increased experiences of victimization and discriminatory policies – like this proposed rule– can contribute to higher risk for anxiety, depression, and attempting suicide among trans youth.[9]

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[2] American Psychological Association. APA Policy Statement on Affirming Evidence-Based Inclusive Care for Transgender, Gender Diverse, and Nonbinary Individuals, Addressing Misinformation, and the Role of Psychological Practice and Science. (2024), available at https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care.pdf

[3] American Medical Association. American Medical Association Fights to Protect Health Care for Transgender Patients (2021), available at https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update.

[4] American Psychiatric Association, et al., Frontline Physicians Oppose Legislation That Interferes in or Criminalizes Patient Care, American Psychiatric Association (2021), available at https://www.aafp.org/news/media-center/statements/frontline-physicians-oppose-legislation.html.

[5] American Academy of Pediatrics, American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth (2021), available at https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/.

[6] Endocrine Society & Pediatric Endocrine Society, Discriminatory Policies Threaten Care for Transgender, Gender Diverse Individuals (2020), available at https://www.endocrine.org/news-and-advocacy/news-room/2020/discriminatory-policies-threaten-care-for-transgender-gender-diverse-individuals.

[7] American Academy of Child & Adolescent Psychiatry, AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth (2019), available at https://www.aacap.org/AACAP/Latest_News/. AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx.

[8] The Trevor Project. (2023). 2023 U.S. national survey on the mental health of LGBTQ young people. https://www.thetrevorproject.org/survey-2023/assets/static/05_TREVOR05_2023survey.pdf

[9] Green, Amy & Price, Myeshia & Dorison, Sam. (2021). Cumulative minority stress and suicide risk among LGBTQ youth. American Journal of Community Psychology. 69. 10.1002/ajcp.12553.

Fortunately, access to well established best practices in medical care for transgender young people can protect and even save lives.Transgender medical care for youth, such as hormone therapy, is associated with positive mental health outcomes including showing promise for reducing suicide risk. In February 2022, the Journal of the American Medical Association published new research that found transgender medical care for transgender teens was associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality over a 12-month follow-up.[10]

Unfortunately, this life-saving care is not easily accessible for transgender young people. The average wait time for treatment in the United States is 10 months.[11] Additionally, The Trevor Project's research and direct experience serving youth in crisis reveals many trans youth actively want medical and mental health support but cannot get it for various reasons, including cost. **The Trevor Project's 2022 National Survey on LGBTQ+ Youth Mental Health found that 58% of LGBTQ youth in Ohio who wanted mental health care were not able to get it.**[12] These proposed rules, including the six month evaluation and counseling period, would further exacerbate the lack of access to essential health care that transgender youth in Ohio already suffer. All youth, including trans and nonbinary youth, deserve to feel safe and accepted in their community while getting the care they require and deserve.

For these reasons, The Trevor Project urges the Joint Committee to invalidate the ODH & OMHAS gender transition & data collection rules.

Should you have any questions or if we can be of any assistance regarding this matter, please do not hesitate to contact me at Gabby.doyle@thetrevorproject.org.

Sincerely,

Gabrielle Doyle
Senior Manager of State Advocacy
The Trevor Project

[10] Diana M. Tordoff, et al., Mental Health Outcomes in Transgender and non-binary Youths Receiving Gender-Affirming Care 5(2) JAMA (2022), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423.
[11] Diana M. Tordoff, et al., Factors Associated with Time to Receiving Gender-Affirming Hormones and Puberty Blockers at a Pediatric Clinic Serving Transgender and non-binary Youth, J. Transgender Health (2022), ahead of print, available at https://www.liebertpub.com/doi/abs/10.1089/trgh.2021.0116.
[12] The Trevor Project, 2022 National Survey on LGBTQ Youth Mental Health - Ohio, available at https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State-Ohio.pdf.

To whom it may concern:

Thank you for the opportunity to provide written testimony regarding Ohio Department of Health (ODH) rules 3701-3-17, 3701-59-07 and 3701-83-61 and Ohio Department of Mental Health and Addiction Services (OMHAS) rules 5122-14-12.1 and 5122-26-19 regarding the provision of gender affirming care. Because these rules violate several of the Joint Committee on Agency Rule Review (JCARR) prongs, the rules should be invalidated.

Requirement for reporting

JCARR should invalidate Rule 3701-3-17 because ODH has failed to prepare a fiscal analysis of the rule as required by ORC §106.024.

Rule 3701-3-17 provides for reporting beyond any kind of reporting the State has ever before collected (i.e., related to emergency situations and communicable disease and public health threats). Despite this radical shift in reporting and extensive burden placed on providers, ODH did no financial analysis of the rule. The rule creates a significant unfunded burden on providers, demanding they do detailed reports on every single patient visit and report the information within 30 days of the visit. For some providers, this could mean 15-20 reports a day or 300-400 reports per month. Unpaid. The burden and cost on providers has the likely outcome of transgender patients losing care. The unfunded demands for so much extra reporting will certainly cause some providers to drop transgender patients because of the uncompensated additional time required for every visit. The State already has a shortage of mental health providers and of providers who provide transition care. This requirement will exacerbate the problem – not just for transgender people but for many cisgender Ohioans as well.

JCARR should invalidate Rule 3701-3-17 because the rule has an adverse impact on business and ODH has failed to demonstrate through a business impact analysis that the regulatory intent of the rule justifies its adverse impact on business.

Pursuant to ORC §170.52, a rule has an adverse impact on business if, among other reasons, it imposes a criminal or civil penalty or creates a cause of action, or requires specifics expenditures or the report of information or it would be likely to directly increase expenses of the line of business to which it applies. All three of those criteria are met with respect to Rule 3701-3-17. ODH's business impact analysis completely failed to analyze the impact on physicians and transgender patients and their families. Accordingly, ODH has not justified the significant adverse impact the rule will entail. More specifically, to my knowledge, ODH has not released an updated business impact analysis since the modified rules were released. The original business impact analysis undertook no analysis in response to question 15 as to how much time and cost this burdensome reporting will cost providers. Moreover, the answers to questions 6 and 17 in the original business impact analysis are patently false -- the reporting of inception and discontinuation of care, each treatment received and the invasive details of such treatment will do nothing to preserve lives.

JCARR should invalidate Rule 3701-3-17 because the rule conflicts with an existing rule or law.

Ohio Revised Code section 3701.17, ODH rules 3701-83-07 and 3701-83-11 and The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[1] requires that health care providers keep protected health information confidential. "Protected health information" is "information … that describes an individual's past, present, or future physical or mental health status or condition, receipt of treatment or care, or purchase of health products, if… [t]he information could be used to reveal the identity of the individual who is the subject of the information, either by using the information alone or with ther information that is available to predictable recipients of the information."[2] Ohio Revised Code section 3701.17(B) prohibits ODH to release such information without the patient's written consent other than very limited exceptions, none of which is applicable here. Due to the specificity of the data being reported, such as age, individual care plan, medication dosage, number of therapy visits, sex and other characteristics, the risk of data triangulation is extremely high given the small population size, especially in rural regions of the State. This reporting will violate the privacy of transgender patients.

JCARR should invalidate Rule 3701-3-17 because the rule conflicts with the legislative intent of the statute under which it is proposed. Indeed, the rule conflicts with ODH's own purpose and mission.

This reporting – far beyond any kind of data collection ODH has ever undertaken – exceeds ODH's rulemaking authority under Ohio Revised Code Chapter 3701 and is beyond the legislative intent of Chapter 3701. Moreover, the rule conflicts with ODH's own purpose and mission to address health inequities and disparities and assure quality in health care services to protect the health and safety of Ohioans. Rule 3701-3-17 will make greater the inequities and disparities in healthcare for transgender Ohioans and lower the quality and availability of such care. Rule 3701-3-17 will put already difficult to access healthcare even farther out of reach for many. We already face a shortage of providers, long wait times, complicated screening processes, and barriers to accessing gender affirming care. The transgender community needs more accessible gender-affirming care, not less. Burdensome paperwork and expensive, unnecessary requirements will conspire to make Ohio an inhospitable place for doctors who treat transgender patients to practice. We will lose our best providers and every Ohioan will suffer.

JCARR should invalidate Rule 3701-3-17 because it fails all four of Common Sense Initiative's goals.

The mission of Common Sense Initiative (CSI) is to reform Ohio's regulatory policies to make Ohio a jobs and business-friendly state. The program has four focused goals: 1)

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[1] Public Law 104-191. See rules promulgated at 45 C.F.R Part 160.
[2] O.R.C. §3701.17(A)(2).

regulations should facilitate economic growth, 2) regulations should be transparent and responsive, 3) compliance should be easy and inexpensive, and 4) regulations should be fair and consistent. Rule 3701-3-17 fails all four CSI goals.

Rule 3701-3-17 does not facilitate economic growth. As stated above, the rule creates a significant unfunded burden on providers and will certainly cause some providers to drop transgender patients. Moreover, the state purpose for the rule – research – also fails. The rule requires reporting relating to anyone experiencing some form of incongruence – rather than limiting reporting to those meeting the diagnostic criteria. Further, the rule requires reporting of a diagnosis of a gender-related condition even if no medical treatment is provided and covers reporting of therapy as a treatment. Multiple providers will report the same patient for different services. And the rule requires reporting of cessation of treatment without reasons for ceasing with a specific provider. Accordingly, the data will have the effect of overreporting and give the appearance of a higher population of transgender persons than actually exist. It will also artificially inflate the perceived number of patients who desist. This is especially so given that mandated reporting is required even if no medical treatment is provided. Section (D) requires all data collected by ODH will be forwarded to the General Assembly and the public semi-annually. The data isn't being reported to a research institution. ODH is not funding the work or adding expertise. ODH is not evaluating or interpreting the data to expand knowledge and improve care. ODH has not put forth any research purpose for the collection of the data.

Rule 3701-3-17 is not responsive to the community. According to news reports, 6,000 comments were submitted to ODH's first set of rules regarding transgender care and 4,000 comments were submitted to ODH's second set of rules regarding transgender care, in each case comments were exclusively or overwhelmingly opposing the rules.[3] In the ODH hearing on March 21 only opponents of ODH's rules testified.

Compliance with rule 3701-3-17 is neither easy nor inexpensive. As stated above, the rule creates a significant unfunded burden on providers and will certainly cause some providers to drop transgender patients. Further, the rule itself raises questions about how to comply. For example, for reporting under subsection (C) regarding cessation of care, if a patient doesn't return to a clinic, is the clinic supposed to track that a patient did not make a follow up appointment in another unfunded and complicated mandate? When is the clinic supposed to determine that the patient has ceased treatment? How will ODH avoid double counting people who cease treatment at one facility and initiate treatment at another facility?

Rule 3701-3-17 is not fair and consistent. There is no other kind of care that has reporting of any similar nature. The rules appear to be politically motivated to target transgender people.

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[3] Henry, Megan, *Thousands submit comments on revised proposed Ohio administrative rules for transgender health care,* Ohio Capital Journal, 3/5/2024 https://ohiocapitaljournal.com/2024/03/05/thousands-submit-comments-on-revised-proposed-ohio-administrative-rule-for-transgender-health-care/

Restrictions on gender affirming care for minors

Gender affirming care is been successful, effective, and lifesaving.[4] For children, Ohio is unique because our pediatric hospitals and medical providers take a cautious, "whole child" approach to treating transgender children. As background, gender-affirming care (referred to in the rules as "gender transition services") is not novel or unproven. The evidence for gender-affirming care is comparable to the evidence for many other widely accepted treatments in pediatrics. Gender-affirming care also is not experimental. There are decades of studies supporting the benefits of gender-affirming care where medically indicated,[5] which is why it is the standard of care for gender dysphoria.

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[4] Matouk, KM et al, *Gender Affirming Care Saves Lives,* Columbia University (2022), https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives.

[5] Studies include (but are not limited to) the following: Nolan, BJ, et al, *Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization,* Diabetes & Endocrinology (2023) (randomized control study finding statistically significant decrease in gender dysphoria & depression & decrease in suicidality in individuals taking testosterone as compared to those who had testosterone delayed by 3 months), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2809058; Tordoff, DM, et al, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care,* JAMA Netw Open (2022) (control study finding 60% lower odds of depression & 73% lower odds of suicidality for group receiving treatment), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423; McPherson, S, et al, *Psychological Outcomes of 12-15 Year-Olds with Gender Dysphoria Receiving Pubertal Suppression in the UK: Assessing Reliable and Clinically Significant Change,* J Sex Marital Ther (2023) [(secondary analysis clinically significant change in mental health), https://www.tandfonline.com/doi/full/10.1080/0092623X.2023.2281986; Green, AE, et al, *Association of Gender-Affirming Hormone With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth,* J. Adolescent Health (2022)(finding that receipt of gender-affirming hormone therapy was associated with significantly lower odds of experiencing symptoms of depression in the previous 2 weeks), https://doi.org/10.1016/j.jadohealth.2021.10.036; Chen, D, et al, *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, N Engl J Med (2023) (longitudinal study finding statistically significant declines in depression & anxiety & statistically significant increases in appearance congruence, positive affect & life satisfaction due to gender-affirming hormone therapy), https://www.nejm.org/doi/full/10.1056/NEJMoa2206297; Achille, C, et al, *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youth: preliminary results,* Intl J. Pediatr. Endocrinol. (2020) (endocrine intervention lead to decrease in depression & suicidal ideation & increase in quality of life), https://doi.org/10.1186/s13633-020-00078-2; de Vries, ALC, et al, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, Pediatrics (2014), (longitudinal study finding positive correlation between gender reassignment surgery & improvements in psychological functioning had steadily improved, with well-being being similar to or better than same-age young adults without gender dysphoria), https://doi.org/10.1542/peds.2013-2958 (link to summary only); Carmichael, P, et al, *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, PLOS ONE (2021) (prospective observational study in children on puberty blockes finding normal liver function, basic haematology and biochemistry & no or minimal changes in bone mineral content & bone mineral density), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0243894; van der Miesen, AIR, et al, *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*, J. Adolescent Health, (2020) (survey assessment finding transgender adolescents receiving puberty suppression had fewer emotional & behavioral problems than transgender adolescents who did not receive gender-affirming care & fewer or similar problems than their same-age cisgender peers), https://www.jahonline.org/article/S1054-139X(20)30027-6/fulltext (link to summary only); Giovanardi, G, et al, *Transition memories: experiences of trans adult women with hormone therapy and their beliefs on the usage of hormone blockers to suppress puberty*, J Endocrinol Invest (2019) (structured interview study finding participants valued puberty blockers as a treatment protocol), https://doi.org/10.1007/s40618-019-01045-2 (link to summary only); Godiwala, P, et al, *Puberty Suppression Followed by Testosterone Therapy Does Not Impair Reproductive Potential in Female Mice*, Endocrinology (2023) (studying the effects of puberty suppression & then testosterone in female mice),

Notably, the treatments that fall under the umbrella of gender-affirming care, such as the provision of puberty blockers, hormone therapy and surgery (such as breast reduction), are still available without restriction to youth for treating conditions other than gender dysphoria. For example, puberty-delaying medication is commonly used to treat precocious puberty, testosterone is used to treat cisgender boys with delayed puberty or hypogonadism, cisgender boys who experience gynecomastia (enlarged breast tissue) may have surgery to reduce breast tissue, cisgender girls with polycystic ovarian syndrome may be treated with hormones to minimize undesired facial and body hair, and cisgender girls may have breast reduction surgery for medical or purely cosmetic reasons. The side effects of puberty-delaying treatment, hormone therapy and surgery are comparable when used to treat gender dysphoria and when used to treat other conditions. In each case, doctors advise patients and their parents about the risks and benefits of treatment and tailor recommendations to the individual patient's needs. Parents consent to treatment and, for adolescents, the patient gives their assent.

JCARR should invalidate Rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 because they conflict with an existing rule or law.

ODH rule 3701-83-09 requires that health care facilities provide care in accordance with accepted standards of care. Rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 (collectively referred to as the "Youth Care Rules") provide restrictions on the provision of gender affirming care to minors against the care standards of the World Professional Association

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https://pubmed.ncbi.nlm.nih.gov/37768169/ (link to summary only); Boogers, LS, et al, , *Transgender Girls Grow Tall: Adult Height Is Unaffected by GnRH Analogue and Estradiol Treatment*, J. Clinical Endocrinol. & Metabolism (2022) (study finding that puberty blockers & hormone therapy did not impact adult height), https://doi.org/10.1210/clinem/dgac349; Peitzmeier, SM, et al, *Time to First Onset of Chest Binding–Related Symptoms in Transgender Youth*, Pediatrics (2021) (survey finding majority of people who experience symptoms from chest binding do so within the first binding-year, but several skin-related & rare but serious outcomes (eg, rib fracture) took longer to occur & that pain presents rapidly but continues to rise in intensity over time, peaking at >5 years of binding), https://doi.org/10.1542/peds.2020-0728; Tessaris, D, et al, *Combined treatment with bicalutamide and anastrozole in a young boy with peripheral precocious puberty due to McCune-Albright Syndrome*, Endocr J. (2012) (observational study of 4 year-old boy with precocious puberty treated with puberty blockers finding therapy was well tolerated for all its duration & no side effects were noted) https://www.jstage.jst.go.jp/article/endocrj/59/2/59_EJ11-0214/_article; Jensen, RK, et al, *Effect of Concurrent Gonadotropin-Releasing Hormone Agonist Treatment on Dose and Side Effects of Gender-Affirming Hormone Therapy in Adolescent Transgender Patients*, Transgend Health (2019) (retrospective review of medical records of transgender minors receiving hormone therapy finding puberty blocker use was associated with a significantly lower average dose of hormones), https://www.liebertpub.com/doi/10.1089/trgh.2018.0061.

for Transgender Health[6] and the Endocrine Society[7][8]. Accordingly, the rules violate rule 3701-83-09.

Article I, section 21 of the Ohio Constitution provides for free access to healthcare. Specifically, it states, "[n]o federal, state, or local law or rule shall prohibit the purchase or sale of Health Care…" Further, Article I, Section 21(C) provides that "[n]o federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care…" Gender-affirming care, including gender-affirming surgery where appropriate in the judgment of a physician, is "health care" within the meaning of Article I, Section 21. By prohibiting gender-affirming surgery for minors in contravention of physician recommendations, the Youth Care Rules prohibit the purchase and sale of health care in violation of the Ohio Constitution. By imposing a penalty on performing gender-affirming surgeries and even discussing treatment options with minor patients and their families, the Youth Care Rules violate the Ohio Constitution.

Article 1, section 2 of the Ohio Constitution and the 14th amendment to the U.S. Constitution provide for equal protection under the law. The Youth Care Rules provide restrictions on healthcare solely for transgender youth in violation of these constitutional provisions. As detailed above, treatments that fall under the umbrella of gender-affirming care, such as the provision of puberty blockers, hormone therapy and surgery (such as breast reduction), are still available without restriction for youth for treating conditions other than gender dysphoria. In restriction treatments solely for transgender youth, the Youth Care Rules expressly discriminate against transgender adolescents based on their sex. Specifically, it discriminates against them based on their sex assigned at birth, based on the incongruence between their sex and their gender identity, based on their transgender status, and based on their failure to conform to stereotypes and expected behavior associated with their sex assigned at birth. Moreover, the Youth Care Rules violate the same constitutional provisions because they discriminate against the parents of transgender youth by denying them the same ability to secure

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[6] The World Professional Association for Transgender Health (WPATH) has issued Standards of Care for the Health of Transgender and Gender Diverse People since 1979. The current version is Standards of Care Version 8 (SOC-8), published in 2022. SOC-8 provides guidelines for multidisciplinary care of transgender individuals, including youth and adolescents, and describes the criteria for medical treatment of gender dysphoria in adolescents and adults. Such treatment may include puberty-delaying medication, hormone treatment and, where medically indicated, surgery. Every major medical organization in the United States recognizes that these treatments can be medically necessary to treat gender dysphoria. SOC-8 is based on a rigorous and methodological evidence-based approach. Its recommendations, which reflect expert consensus, are informed by a systematic review of the evidence and an assessment of the benefits and harms of alternative care options.

[7] The Endocrine Society, an international medical organization of over 18,000 endocrinology researchers and clinicians, has also published a clinical practice guideline for the treatment of gender-dysphoric individuals and provides protocols for the medically necessary treatment of gender dysphoria similar to those outlined in SOC-8.

[8] SOC-8 and the Endocrine Society guidelines and protocols are supported by the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American College of Physicians, the American Academy of Family Physicians, the American Academy of Child & Adolescent Psychiatry, the Endocrine Society, the Pediatric Endocrine Society, the American College of Obstetricians and Gynecologists, the American Psychological Association and the United States Professional Association for Transgender Health.

necessary medical care for their children that other parents can obtain, purely on the basis of their child's sex and transgender status.

Article I, section 16 of the Ohio Constitution provides that each person shall have a remedy "by due course of law" and the 5th and 14th amendments of the U.S. Constitution provide that no person shall be deprived of "life, liberty, or property, without due process of law." The clauses have been interpreted to provide fundamental rights for parents to seek and follow medical advice to protect the health and well-being of their minor children. The Youth Care Rules provide restrictions on those parental rights in contravention of those constitutional provisions.

JCARR should invalidate Rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 because ODH has failed to prepare a fiscal analysis of the rule as required by ORC §106.024.

ODH failed to conduct any financial analysis. MHAS presented a cursory discussion, without analysis, noting the cost to psychiatric hospitals if they "choose to provide gender transition care." Note that the MHAS rule prohibits a psychiatric hospital from administering or refilling already prescribed medication to a transgender youth. This will mean that psychiatric hospitals will either have to screen out transgender youth receiving gender-affirming medical treatment or they will have to comply with the expensive rules solely to provide medications prescribed by compliant providers. This was not addressed in the financial analysis. And the impact to transgender youth in need of in-patient psychiatric care was not addressed at all.

JCARR should invalidate Rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 because they have an adverse impact on business and ODH and MHAS have failed to demonstrate through a business impact analysis that the regulatory intent of the rule justifies its adverse impact on business.

Pursuant to ORC 170.52 a rule has an adverse impact on business if, among other reasons, it imposes a criminal or civil penalty or creates a cause of action, or requires specifics expenditures or the report of information or it would be likely to directly increase expenses of the line of business to which it applies. All three of those criteria are met with respect to the Youth Care Rules. Gender-affirming care saves lives. There is no evidence that restricting gender-affirming care – and certainly not taking away vital access to in-patient psychiatric facilities – will improve care for transgender youth. The increased cost and risk to business (and the extreme detriment to patients) is not justified.

JCARR should invalidate Rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 because they fail Common Sense Initiative's goals.

As stated above, CSI's goals are that: 1) regulations should facilitate economic growth, 2) regulations should be transparent and responsive, 3) compliance should be easy and

inexpensive, and 4) regulations should be fair and consistent. Rule 3701-3-17 fails all four CSI goals.

As stated above, the Youth Care Rules do not facilitate economic growth. In fact, they impede it by causing providers to leave the State and putting strain on our already burdened health care system (particularly mental health resources) and contributing to Ohio's brain drain.

The Youth Care Rules are not responsive to the community. According to news reports, as stated above, a combined 10,000 comments were submitted to ODH's initial and revised proposed rules and 6,800 pages of comments were submitted to MHAS regarding its first set of proposed rules; in each case comments were exclusively or overwhelmingly opposing the rules.[9] In both the ODH and MHAS hearings on March 21 and March 18, respectively, only opponents of the rules testified.

Compliance with rules 3701-59-07 and 3701-83061 is not easy or inexpensive. Aligning with a mental health professional and an endocrinologist and creating a plan in accordance with the rules – along with the reporting requirements – will be difficult and costly.

The Youth Care Rules are neither fair nor consistent. As discussed above, the Youth Care Rules provide restrictions on healthcare solely for transgender youth but the same treatments are still available without restriction for youth for treating conditions other than gender dysphoria. Moreover, rules 3701-59-07 and 3701-83-61 deny parents of transgender youth the same ability to secure necessary medical care for their children that other parents can obtain, purely on the basis of their child's sex and transgender status.

JCARR should invalidate Rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 because the rule conflicts with the legislative intent of the statute under which it is proposed. Indeed, the rule conflicts with ODH's own purpose and mission.

The specificity of the requirements for the care of transgender youth in the Youth Care Rules is far beyond any kind of rulemaking undertaken by ODH or MHAS, exceeds their rulemaking authority under Ohio Revised Code Chapters 3701 and 5122, and is beyond the legislative intent of those chapters. According to the ODH website, two of ODH's mandates are to address health inequities and disparities and to assure quality in health care services, to protect the health and safety of Ohioans. Rules 3701-59-07 and 3701-83-61 will make greater the inequities and disparities in healthcare for transgender Ohioans and lower the quality and availability of such care. Withholding or delaying gender-affirming medical treatment from adolescents with gender dysphoria when it is medically indicated puts them at risk of severe and irreversible harm to their health and well-being. Without treatment, transgender adolescents and young adults report several-fold higher rates of depression, anxiety, suicidal ideation and suicide

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[9] Henry, *supra,* 3/31/24. Henry, Megan. *Thousands submit comments on proposed Ohio administrative rule on transgender health care,* Ohio Capital Journal, 1/31/2024 https://ohiocapitaljournal.com/2024/01/31/thousands-submit-comments-on-proposed-ohio-administrative-rule-on-transgender-health-care/.

attempts, as compared to their cisgender counterparts. When transgender adolescents are able to access puberty-delaying medication and hormone therapy, their distress recedes, and their mental health improves. Both clinical experience and medical studies confirm that, for many young people, this treatment is transformative, and they go from experiencing pain and suffering to thriving.[10]

These rules will put already difficult to access healthcare even farther out of reach for many. We already face a shortage of providers, long wait times, complicated screening processes, and barriers to accessing gender affirming care. The transgender community needs more accessible gender-affirming care, not less. Parents of transgender children have already been warned by some of their children's providers that if prohibitions on even discussing treatment options with families and patients are implemented they will leave the State or may forgo treating transgender patients altogether to avoid any potential risk of liability. We will lose our best providers and every Ohioan will suffer.

The above reasons overwhelmingly support JCARR's invalidation of Rules 3701-3-17, 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19 and I respectively request that the Committee take such action.

Sincerely,

Halle Martin

[10] Matouk et al, *supra;* Nolan, *supra;* Tordoff, *supra,* McPherson, *supra*; Green, *supra*; Chen, *supra*; Achille, *supra*; de Vries, *supra*; van der Miesen, *supra*.

Pro-Choice Ohio

Representative Jamie Callender & Senator Theresa Gavarone
Chairpersons
Joint Committee on Agency Rule Review

Chairperson Gavarone, and members of JCARR, my name is Jaime Miracle and I am the Deputy Director for Pro-Choice Ohio. I am here today testifying on the proposed rules from the Ohio Department of Health (ODH) and Ohio Department of Mental Health and Addiction Services (ODMHAS) related to the provision of gender-affirming medical care for transgender Ohioans and data collection on individuals receiving this care. I thank the committee for their time and hearing these comments today.

Pro-Choice Ohio is dedicated to bodily autonomy and the freedom of Ohioans to make their own personal healthcare decisions without government interference or control. These proposed rules are in direct conflict with those values. Transgender individuals in Ohio should be able to access life-saving, gender-affirming medical care in their communities from trusted healthcare providers. These proposed rules will significantly restrict this access to care. More specifically for this hearing's purpose these rules violate JCARR prongs, will cause harm to Ohioans across the state, and should be rescinded.

It is my understanding that four of the rules included in this rule package have been pulled from the agenda, which I am very thankful for. Those rules violated multiple JCARR prongs, especially the prong about conflicting with other existing or proposed rules and exceeding the agency's statutory authority. These rules are also completely unnecessary, putting the state between individuals and their healthcare providers. In addition to them being pulled from the agenda today, they should not be re-filed. Because of the status change for these four rules the remainder of my testimony today will be about the rule that is still before JCARR today, ODH rule 3701-03-17, data collection.

This proposed rule around data collection by ODH (3701-03-17) violates the first JCARR prong and exceeds the scope of an agency's statutory authority. ODH cites Ohio Revised Code (ORC) 3701.13 and 3701.23 as their authority to promulgate this rule around data collection. These sections are around the powers of ODH more generally and their powers around data collection. Those sections of code do not grant ODH unlimited access to healthcare information and are not absolute. We saw this in multiple instances during the pandemic when the legislature passed laws restricting ODH's powers under a formally declared public health emergency. So now, with no such public health emergency in existence, absolutely no evidence that there is any danger to the health of Ohioans, ODH is trying to use code sections for "reporting contagious or infectious diseases" to pry into the private healthcare decisions of Ohioans and their families. Throughout the pandemic the Ohio Legislature repeated that decisions around one's healthcare options must be left to the individual and not mandated or overseen by the state. Forcing healthcare providers across the state to send personal, private medical information on their patients to ODH when there is absolutely no public health reason for doing so is a gross misrepresentation of ODH's powers and should not be allowed to stand.

The ODH rules around data collection also (3701-3-17) violate the JCARR prong on business impact. This rule most certainly has an adverse impact on business, and the agency failed to demonstrate through the business impact analysis that the regulatory intent of the rule justifies its adverse impact on business. In fact, ODH didn't even recognize one of the biggest impacts these rules could have on the healthcare providers that they are trying to regulate, the risk of harassment and threats of violence that could occur due to these data reporting requirements.

In his press conference announcing these rule packages, Governor DeWine stated that lack of data was a significant barrier to creating policy around the subject of gender-affirming care. In his remarks he wrongly compared collecting data around gender-affirming care to the reporting of infectious disease cases. Collecting data around infectious disease cases is critical to the mission of the Ohio Department of Health. Being able to detect outbreaks of disease and work to mitigate its spread has a direct public health impact and improves the lives of Ohioans. That is not at all the same as collecting data around the private, personal medical decisions made by Ohioans and their families.

While data collection for infectious diseases is simple and clear (numbers of cases and where they are located) and directly related to the purpose of ODH, it is much more complicated and charged, and has a greater impact on business, when data collection processes are applied to highly politicized medical services like abortion or gender-affirming care. Unlike infectious disease reporting, what is ODH going to do with this data, other than create a report to sit on a shelf in some government office?

In their rule summary and fiscal analysis ODH listed "preservation of the life and health of the people of Ohio, including children," as the reasons for proposing this rule, and the justification for creating an adverse impact on business. How is collecting data on what kinds of medical treatments Ohioans are choosing for themselves and their families "preserving the life and health of people of Ohio"? ODH provides no documentation for how this data "preserves life and health", there was no testimony at the ODH public hearing from proponents talking about why these rules were justified. JCARR cannot just take ODH at its word that these rules are necessary to preserve life and health when ODH has provided zero evidence that this is the case. ODH must provide real evidence that the collection of the data and the impact it will have on healthcare professionals is justified. They have failed to do that.

What are the potential adverse impacts as a result of this rule? In addition to the unnecessary invasion into patient privacy, requiring doctors to choose between following the law and following their medical ethics, and the unnecessary time that will have to be spent filling out paperwork for the state rather than helping patients lead healthy lives, this rule package as written would leave healthcare professionals open to harassment and threats of violence. Although rule 3701-3-17 has minimal, and I would argue woefully insufficient, protections for patient privacy, there is nothing in the rule about protecting the identities of the healthcare providers who provide gender-affirming care in our state. We have seen time and again where physicians' information collected by ODH around the provision of abortion services is not considered protected information and has

led to harassment of physicians and healthcare facilities. Doctors who have signed variance agreements between abortion clinics and hospitals have been targeted for harassment by anti-abortion groups.[1] This harassment hasn't just been limited to the physicians themselves. In one case, the teenage daughter of a doctor in Dayton was a target of harassment by anti-abortion groups when going out for a run in her neighborhood.

Attacks against facilities and individual medical professionals who provide gender-affirming care have increased significantly as legislative attacks on these healthcare services have become more prevalent. Facilities that provide gender-affirming care have received online harassment, bomb threats, and callers have threatened providers at the facilities. One bomb threat was even here in Ohio at Akron Children's Hospital. A study also found that the rates of harassment increased in states where they had passed bills like House Bill 68 and rules like the ones proposed by ODH and ODMHAS.[2]

Bomb threats and threats against the personal safety of medical professionals and their families are an adverse impact on business. Nowhere in ODH's filing does the agency outline that following these new regulations imposed upon them by the state would open medical professionals to harassment and threats of violence. Nowhere in their filings does ODH detail how these attacks on business are justified by the need for this unnecessary and potentially harmful data collection about the private, personal medical decisions made by Ohioans and their families.

For all of the reasons outlined above, ODH proposed rule 3701-03-17 should be immediately rescinded and not reconsidered, along with the other rules surrounding gender affirming care from ODH and ODMHAS. Thank you.

[1] https://projectweaklink.com/wp-content/uploads/2016/01/WrightState.pdf

[2] Bomb threats and violence: Pediatric gender-affirming care providers fear for their lives. *Salon*, September 19, 2023. https://www.salon.com/2023/09/19/bomb-and-violence-pediatric-gender-affirming-care-providers-fear-for-their-lives/

Members of the JCARR Committee:

I am a lifelong Ohio resident, and I am asking you today to please invalidate the Gender Transition Rules: O.A.C. 3701-83-60, 3701-59-06. and 3701-3-17 , Item 14 on the agenda, because:

1. The rules exceed the scope of the agency's **statutory authority**;
2.
3.
4. The rules conflict with the legislative **intent** of the statute under which they are proposed;
5.
6.
7. The agency has failed to prepare a **complete and accurate** rule summary and fiscal analysis of the rule (see ORC 106.024);
8.
9.
10. If the rule has an adverse impact on business (see ORC 107.52), the agency has failed to demonstrate through the business impact analysis, recommendations from the Common Sense Initiative office, and the agency's memorandum of response, that the regulatory intent of the rule justifies its **adverse impact on business**; and

11. The rules are **unconstitutional**.

Thank you.

--
James C. Knapp, Esq.

Trans Allies of Ohio
ogden.j@transalliesohio.org
https://transalliesohio.org/

April 14, 2024

Joint Committee on Rule Review (JCARR)
ATTN: ODH & OMHAS Rules, Regular Agenda Item @ April 15, 2024 JCARR Hearing
77 South High Street, Concourse Level
Columbus, Ohio 43215

Submitted via email to JCARR1@jcarr.state.oh.us

RE: Comments on ODH Rules 3701-3-17, 3701-59-06, 3701-83-60

Dear Committee Chairs Gavarone, Callender, and other members of the JCARR Committee,

Thank you for the opportunity to voice our opposition to ODH Rule 3701-3-17 and OMHAS Rules 3701-59-06, 3701-83-60 with respect to their adherence to JCARR "prongs" or criteria for state agency rule development. I am Jeanne Ogden, co-founder of Trans Allies of Ohio and have met most of you already. We are a grassroots organization supporting trans advocacy across the State of Ohio. I am here today on behalf of our families with transgender children, both youth and adult, transgender community members, and advocates. We are here today to ask the committee to recommend invalidation of these rules for the following reasons.

The rules exceed the scope of the Agency's statutory authority granted by ORC 3701.23 which addresses infectious agents and communicable diseases. Transgender people and their healthcare are not contagious or infectious. The fact that ODH and OMHAS listed ORC 3701.23 as the source of their statutory authority is both offensive and deeply damaging to our children and community members who are already the subject of stalking, threats of physical harm, and harassment as a result of incendiary comparisons like this one.

The rules conflict with the legislative intent of the laws under which they are proposed. The legislative intent of ORC 3701.13, which is also a stretch to include here because it deals primarily with contagions, is to preserve "the life and health of the people," but little if any evidence was presented to show that Ohioans who receive gender-affirming care in Ohio are

being harmed or that their lives and health are at risk. Conversely, and in conflict with the statutory authority granted by 3701.13, ODH Rule 3701-3-17 will cause harm as adult patients avoid doctors knowing their “de-identified” data will be handed over to hostile Ohio legislators and made publicly available. Ohio’s brand of gender-affirming care improves lives. The Agencies received thousands of pages of testimony attesting to that fact.

The Agencies did not demonstrate “that the regulatory intent of the rule justifies its adverse impact on business,” because the fiscal analysis submitted for Rule 3701-3-17 barely touched upon the exorbitant costs forced on businesses to comply with this rule. We stated in the previous paragraph that this rule will not preserve the life and health of the people. Here, we must point out that providers are being given a huge, unfunded, government mandate to report data, without the consent of their patients, when other methods, less harmful to businesses, might be employed to achieve the regulatory intent of these rules.

Further, businesses across Ohio, who are already struggling to meet their staffing needs, will be handicapped in their efforts to meet those needs as parents of transgender youth, transgender adults, and those who value the rights of others move out of Ohio to avoid this unsettling, unconstitutional assault on privacy, safety, and bodily autonomy. Look no further than the 917 opponent testimonies to 23 in favor of Senate Bill 83 (Senate). Young people do not want this heavy handed harassment of LGBTQ people in Ohio. Mandating intrusive, unnecessary reporting requirements regarding the health of LGBTQ people in Ohio will have an adverse impact on Ohio businesses whose continued success relies upon a growing pool of talented, skilled workers.

We ask that you do what is right for Ohio and hold ODH and OMHAS to the highest standards during your consideration of these rules and recommend they be invalidated by the General Assembly.

Best,
Jeanne Ogden on behalf of Trans Allies of Ohio

Senate Bill 83 committee activity. Senate Bill 83 Committee Activity | 135th General Assembly | Ohio Legislature. (n.d.). https://www.legislature.ohio.gov/legislation/135/sb83/committee

Jennifer Williams Testimony for JCARR on April 15, 2024

I am speaking to you in opposition to Rule numbers 3701-83-60, 3701-59-06, 3701-3-17 as I believe that they are unconstitutional as they violate the rights of Ohioans, unnecessary as they produce no public good and will not help transgender Ohioans and they are unwanted by those who will be most affected by the Rules - transgender Ohioans, their families and their healthcare providers.

Having your government collect large amounts of health data on you and others like you (whether adult or child), without your voluntary consent will violate already established privacy laws and open up potentials for litigation under CFR-42 and HIPPA. Authoritarian, Socialist and Totalitarian governments due that type of thing and such actions are not legal or American in my opinion. I have even heard that undercover investigators will be used to pose as parents to investigate medical providers treating transgender patients. I hope that isn't true as I don't want that to be the Ohio my relatives in Columbus and Cincinnati live in.

Implementation of these rules will place a real cost to Ohio in business creativity, talent drain and potentially, loss of businesses. Right now, talented employees of Ohio companies are contacting companies in New Jersey and other states regarding moving from Ohio due to the ramifications of these Rules and the recently passed bill HB68. I can assure you that my Garden State is quite interested in residents of the Buckeye state moving there to help our companies and build new industries. By your own definition, the two Ohio agencies drafting these Rules did not demonstrate that the regulatory intent of the rule justifies its adverse impact on business as no fiscal analysis was submitted.

While I understand that the regulatory intent of these Rules is to supposedly protect the life and health of Ohioans, there was no evidence presented to show that Ohioans receiving gender-affirming care in Ohio are consistently being harmed. Actually, the opposite is true. These Rules will cause undue harm and injury as adult patients will begin avoiding doctors as they will know that their "de-identified" data will be provided to Ohio legislators opposed to them and their healthcare. This information will be made public and will unnecessarily delay or hold back care from the few transgender children who will need this care. As a fellow elected official who is transgender, I want to assure that these Rules will have unintended consequences in the age of the internet and artificial intelligence. It will not be hard for evil-doers to cause harm to transgender Ohioans given even scant public information available on their healthcare treatment.

Having traveled our country and met or spoken with many of my fellow transgender Americans, I implore you to not destroy the great system of healthcare you already have. Especially, the transgender clinics you have at your various Children's hospitals. Regarding transgender medical care, Ohio is a model state in our country and frankly, my home state of New Jersey could learn a thing or two from how Ohio has handled things up until a few months ago. As I sit here before you, I want you to know that Ohio's transgender healthcare system immeasurably

improves lives. Please keep that going. You have been given incredible amounts of testimony, including my own, which attests to the successes you already own, and little testimony refuting what I am many others have said or written. Thank you for listening to me today.

Public Comments on proposed changes to 3701-3-17

FOR THE HEARING ON MARCH 21ST, 2024 ON TEAMS

Meeting Call-In Information: Microsoft Teams meeting Join on your computer, mobile app or room device Click here to join the meeting Meeting ID: 249 987 672 891 Passcode: CodQw9

Jody Davis, RN, LISW-S

I work full time at The Ohio State University Wexner Medical Center. Besides my work in General Internal Medicine, I do some RN Care Coordination work with Urology and Plastics for patients seeking gender affirming care.

I have extensive experience caring for the transgender population of Central Ohio, and the families of transgender teens.

My comments below are my own and do not reflect any employed position.

3701-3-17 Reporting Gender-Related Condition Diagnoses and Gender Transition Care.

(A) As used in this rule:

(1) "Biological sex," "birth sex," and "sex" mean the biological indication of male and female, including sex chromosomes, naturally occurring sex hormones, gonads, and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender.

(2) "Cross-sex hormone" means testosterone, estrogen, or progesterone given to a minor individual in an amount greater than would normally be produced endogenously in a healthy individual of the minor individual's age and sex.

(3) "Gender reassignment surgery" means any surgery performed for the purpose of assisting an individual with gender transition that seeks to surgically alter or remove healthy physical or anatomical characteristics or features that are

typical for the individual's biological sex, in order to instill or create physiological or anatomical characteristics that resemble a sex different from the individual's birth sex, including genital or non-genital gender reassignment surgery.

(4) "Gender-related condition" means any condition where an individual feels an incongruence between the individual's gender identity and biological sex. "Gender-related condition" includes gender dysphoria.

(5) "Gender transition" means the process in which an individual goes from identifying with and living as a gender that corresponds to his or her biological sex to identifying with and living as a gender different from his or her biological sex, including social, legal, or physical changes.

(6) "Gender transition services" means any medical or surgical service (including physician services, inpatient and out patient hospital services, or prescription drugs or hormones) provided for the purpose of assisting an individual with gender transition that seeks to alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex, or to instill or create physiological or anatomical characteristics that resemble a sex different from the individual's birth sex, including medical services that provide puberty blocking drugs, cross-sex hormones, or other mechanisms to promote the development of feminizing or masculinizing features in the opposite sex, or genital or non-genital gender reassignment surgery.

(7) "Genital gender reassignment surgery" means surgery performed for the purpose of assisting an individual with gender transition and includes both of the following:

(a) Surgeries that sterilize, such as castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy;

(b) Surgeries that artificially construct tissue with the appearance of genitalia

that differs from the individual's biological sex, such as metoidiplasty,

phalloplasty, and vaginoplasty.

(B) A health care provider is obligated to report to the Department of Health within thirty

business days any:

- Reporting to health departments is generally reserved for the surveillance and control of communicable diseases, outbreaks, public health emergencies, and conditions that pose a threat to public health. Gender-affirming care, on the other hand, is a healthcare service aimed at improving the well-being of transgender and gender-diverse individuals and is not a public health concern. Saying the diagnosis of gender-related condition should be reportable in the State of Ohio falsely characterizes this potentially lifesaving care as a disease with public health threat.

- What exactly is in the definition of "gender transition services"? When it comes to the assessing and treating of patients, in the Diagnostic and Statistical Manual of Mental Illnesses, the only diagnosis is gender dysphoria (ICD10 Code F64.x). It is unclear how entities like the licensing board will interpret, investigate, or respond in instances where a minor is either questioning their gender or identifies as transgender/non-binary, but does not meet the diagnostic criteria for gender dysphoria.

- It is unclear who qualifies as a "health care provider." ORC 3701-3 defines it as "any person or government entity that provides health care services to individuals…and includes, but is not limited to, hospitals, medical clinics and offices, special care facilities, medical laboratories, physicians, dentists, physician assistants, registered and licensed practical nurses, emergency medical service organization personnel, and ambulance service personnel." Because this list is somewhat broad and includes the phrase "is not limited to," it is unclear if mental health professionals would be subject to this reporting requirement. Does a mental health professional fall into this list simply if they work in a medical office, but don't necessarily provide medical health care?

- Does this reporting requirement only apply to hospital systems, or would this requirement apply to all agencies and clinics that may provide treatment for gender conditions? Are you trying to create a "registry" of providers and clinics for further scrutiny?

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(1) diagnosis of a gender-related condition within thirty business days of such

diagnosis or treatment;

(2) prescription, initiation, or provision of treatment for said diagnosis including:

(a) gender reassignment surgery

(b) gender-transition services

(c) genital gender reassignment surgery

(3) cessation of treatment for a gender-related condition and the reason for such cessation; or

(4) any change of treatment plan for the purpose of detransitioning.

(C) A health care provider is obligated to submit reports identified in paragraph (B) of this rule using forms and formats approved by the director of health.

(1) At minimum, the forms and formats approved by the director of health will include:

(a) The age of the individual receiving a diagnosis, treatment, or cessation of treatment;

(b) The biological sex of the individual receiving a diagnosis, treatment, or cessation of treatment;

(c) Specific information about the nature of any diagnosis or the type of treatment being provided including, but not limited to, the names of any drugs or hormones.

- Mandating providers to report every treatment associated with gender transitioning would greatly increase administrative time on providers' end, which would have an adverse impact on the efficiency, productivity, and quality of clinical services being provided to patients.

- Reporting can inadvertently contribute to the stigmatization of transgender individuals, both by the patients themselves and by healthcare professionals, potentially exacerbating an already prevalent issue and can be a significant deterrent to the transgender communities from accessing essential medical care.

- When reporting mandates become excessively cumbersome, inefficient, or encompass conditions of minor public health significance, they can redirect healthcare resources away from direct patient care which deters individuals from seeking the healthcare services they need.

- While section (E) claims that information reported pursuant to this rule is considered protected health information, the requirement of including "specific information about the nature of any diagnosis" is in direct contradiction of this and may subject providers to liability. In March 2022, the U.S. Department of Health and Human Services – Office

for Civil Rights also issued guidance regarding gender-affirming care, civil rights, and patient privacy and directly stated their support of transgender youth and their families and condemned any attempts to restrict, challenge, or falsely characterize gender-affirming care or any attempts of impermissible disclosure of PHI[2].

[2] https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf

(D) Beginning January 31, 2025, the Department of Health will share aggregate data collected pursuant to this rule with the General Assembly and the public on or before January 31 and July 31 of each calendar year.

(E) Information reported pursuant to this rule is protected health information subject to section 3701.17 of the Revised Code. Information that does not identify an individual is not protected health information and may be released in summary, statistical, or aggregate form.

Public Comments on proposed changes to 3701-59-07

FOR THE HEARING ON MARCH 21ST, 2024 ON TEAMS

Meeting Call-In Information: Microsoft Teams meeting Join on your computer, mobile app or room device Click here to join the meeting Meeting ID: 249 987 672 891 Passcode: CodQw9

Jody Davis, RN, LISW-S

I work full time at The Ohio State University Wexner Medical Center. Besides my work in General Internal Medicine, I do some RN Care Coordination work with Urology and Plastics for patients seeking gender affirming care.

I have extensive experience caring for the transgender population of Central Ohio, and the families of transgender teens.

My comments below are my own and do not reflect any employed position.

3701-59-07 Quality Standards for Gender Transition Treatment at Hospitals.

(B) It is impermissible for a hospital, including children's hospitals, to provide to a minor individual any pharmacologic treatment such as the prescription of drugs or hormones for the purpose of treating a gender-related condition or assisting with gender transition unless the following standards are met:

(1) The hospital either employs or has available for referral a mental health professional with experience treating minor individuals;

(2) The hospital either employs or has available for referral a board-certified endocrinologist with experience treating minor individuals;

(3) The hospital has available for inspection upon request of the Department of Health an institutional, programmatic level, written, comprehensive, multi-disciplinary care plan which includes, at a minimum, the following:

(a) A demonstrably active role in the minor individual's care by the professionals listed in paragraphs B(1) and B(2) of this rule and other appropriate disciplines including availability for in-person care and consultation when necessary;

(b) Sufficient informed consent for both minor individuals receiving care and the minor individual's parents;

(i) The informed consent notice will include specific information about which treatments can and cannot be fully or partially undone or reversed;

(ii) The informed consent notice will include information about which treatments are or are not being offered off-label based on FDA approval.

(c) A detailed plan of action for individuals seeking to detransition or cease treatment.

(4) The minor individual has received not less than six months of comprehensive mental health counseling and evaluation provided by a mental health professional, documentation of which is obligated to be included in said minor individual's medical record.

- Quality control and standards of care, including gender-affirming care, are typically set by a combination of experts in field, academic medical institutions, government health agencies, clinical researchers. Some other key players in this process are medical boards, licensing bodies, accreditation organizations, and healthcare quality improvement benchmarks. However, in the proposed bill no contribution from the key stakeholders was obtained and I criticize the process as "top-down" or "uninformed" policymaking.

- What constitutes informed consent is vague in the document. Verbal informed consent should unequivocally be deemed sufficient. The perils of mandating written informed consent, particularly for these medications, are multifaceted, including the stigmatization of individuals, reluctance on the part of prescribers due to the administrative burden it imposes, and the imposition of language barriers, leaving those who do not read English at a disadvantage.

- In addition, there is a shortage of psychiatrists in Ohio. This creates unnecessary barriers to patients with medical needs to address their gender dysphoria symptoms.

- In relation to an institutional, programmatic level, written, comprehensive, multi-disciplinary care plan, do you have any guidelines on the details of this care

plan, and who is to be identified on the care plan? This care plan is not empirically supported by the WPATH guidelines, which are the de facto guidelines for the care of transgender patients.

- How often will the Department request this care plan? This care plan requirement will create an Administrative Burden, and create confusion on who / what departments within a hospital will create this care plan.

- Hospitals have primary care providers, specialists like Endocrinologists, Psychologists, etc. Does each specialty that works with a transgender minor send their specific notes in for a care plan, to one department "owner" that collects the information to be sent to ODH?

- In relation to these care plans, are these to be de identified of protected health information (PHI)? Will ODH keep these in a secure folder, only to be accessed as needed by ODH staff? Or will these care plans be made available to the public in any way?

- Will there be a record keeping policy for these care plans? Keep them for 7-10 years until destroyed?

- Will these care plans, as minor patients age, be sent along to hospitals the patients see as adults?

- Please clarify the OMHAS and ODH rules in relation to the six months of counseling for the minor before receiving gender related services at the hospital. If a 20-year-old receives a mental health evaluation and six months of counseling with their therapist prior to receiving a diagnosis of gender dysphoria, then goes to a hospital or health care center to begin hormone treatment, does that individual now need to restart the mental health evaluation because the previous one was not completed onsite?

Public Comments on proposed changes to 5122-26-19
2/20/24

For the public OhioMHAS hearing on **10 am on Monday, March 18, 2024**

Jody Davis, RN, LISW-S

I work full time at The Ohio State University Wexner Medical Center. Besides my work in General Internal Medicine, I do some RN Care Coordination work with Urology and Plastics for patients seeking gender affirming care.

I have extensive experience caring for the transgender population of Central Ohio, and the families of transgender teens. I have extensive experience working with the transgender population of Central Ohio, and the families of transgender teens.

My comments below are my own and do not reflect any employed position.

5122-26-19 | Gender Transition Care

(B) Except as provided in paragraphs (C) and (D) of this rule, is impermissible for a provider to provide pharmacologic treatment such as the prescription of drugs or hormones for the purpose of assisting a minor individual with gender transition unless the provider meets all of the following standards:

(1) The provider employs or has available for referral for the in-person, direct provision of services a mental health professional with experience treating minor patients in the applicable age group.

(2) The provider employs or has available for referral for the in-person, direct provision of services a board-certified endocrinologist with experience treating minor patients in the applicable age group.

(3) The provider has its own written, comprehensive, multi-disciplinary care plan that includes all of the following components: (a) The specific services to be provided by the professionals specified in paragraphs (B)(1) and (B)(2) of this rule and other professionals from appropriate disciplines.

(b) Acquisition of informed consent from each minor individual and the minor individual's parent or legal guardian. Such informed consent is to include specific information about the treatments that can and cannot be fully or partially undone or reversed.

(c) A detailed plan of action for individuals seeking to detransition.

- What constitutes informed consent is vague in the document. Verbal informed consent should unequivocally be deemed sufficient. The perils of mandating written informed consent, particularly for these medications, are multifaceted, including the stigmatization of individuals, reluctance on the part of prescribers due to the administrative burden it imposes, and the imposition of language barriers, leaving those who do not read English at a disadvantage.

- In addition, there is a shortage of psychiatrists in Ohio. This creates unnecessary barriers to patients with medical needs to address their gender dysphoria symptoms.

- People seeking to detransition are few and far between and I've never seen a detransition plan.

(4) The minor individual has received a comprehensive mental health evaluation and counseling services over a period of not less than six months based upon the assessed needs of the minor individual outlined in the individual's treatment plan required under rule 5122-27-03 of the Administrative Code, documentation of which is obligated to be included in the individual's medical record.

- Please clarify the OMHAS and ODH rules in relation to the six months of counseling for the minor before receiving gender related services at the hospital. If a 20-year-old receives a mental health evaluation and six months of counseling with their therapist prior to receiving a diagnosis of gender dysphoria, then goes to a hospital or health care center to begin hormone treatment, does that individual now need to restart the mental health evaluation because the previous one was not completed onsite?

(E) A provider that provides diagnosis and treatment for gender-related conditions is obligated to annually demonstrate compliance with the standards specified in paragraph (B) of this rule using forms and formats approved by the director of health. This annual compliance demonstration will include, at a minimum, submission of the written, comprehensive, multi-disciplinary care plan described in paragraph (B)(3) of this rule. In addition to this obligation, a provider is also to submit the reports described in rule 3701-3-17 of the Administrative Code to the department of health in accordance with that rule.

- When I go to look up 3701-3-17, I cannot find it. Will this be a new section of this AOC?

  Chapter 3701-3 - Ohio Administrative Code | Ohio Laws

- In relation to an institutional, programmatic level, written, comprehensive, multi-

disciplinary care plan, do you have any guidelines on the details of this care plan, and who is to be identified on the care plan? This care plan is not empirically supported by the WPATH guidelines, which are the de facto guidelines for the care of transgender patients.

- How often will the Department request this care plan? This care plan requirement will create an Administrative Burden, and create confusion on who / what departments within a hospital will create this care plan.

- Hospitals have primary care providers, specialists like Endocrinologists, Psychologists, etc. Does each specialty that works with a transgender minor send their specific notes in for a care plan, to one department "owner" that collects the information to be sent to the department?

- In relation to these care plans, are these to be de identified of protected health information (PHI)? Will OHMAS keep these in a secure folder, only to be accessed as needed by OHMAS staff? Or will these care plans be made available to the public in any way?

- Will there be a record keeping policy for these care plans? Keep them for 7-10 years until destroyed?

- Will these care plans, as minor patients age, be sent along to hospitals the patients see as adults?

-

(F) In the event that any provision of this rule conflicts with a statute or judicial decision, such statute or decision supersedes.

- Unless there is legal action / a legal judgment from a judge, HB68 is going into effect in April 2024. Will your proposed rules be reviewed to be in accordance with HB68, to reduce confusion amongst providers? Will then there be an additional review period that could be reviewed by the public for comment?

-

ODH & OHMAS Rules
Monday, April 15, 1:30pm
The Ohio Statehouse, Senate Finance Room

Chair Callender and members of the Ohio JCARR committee, I would like to voice my opposition to the ODH and OHMAS Rules.

While I appreciate the removal of restrictions for transgender adults, the current rules still set a very dangerous precedent for transgender kids. They support the concerning agenda that supports the eradication of the transgender population.

The requirement for having a bioethicist has been removed. That is a great step because that was an almost impossible requirement to adhere to. However, I will reiterate previous comments I've sent. The current structure for transgender care includes a team of professionals who follow a set of standards similar to those listed. The rules as written bar those teams of professionals from making the best treatment plan per a patient's needs as well as block parents from making the best decisions for their children. It is a violation of the Hippocratic Oath and parents rights. We are still telling families that the experts and parents can't be trusted to know what's right for their children.

I have a lot of questions about language. Terms like "providers", "counseling"and "diagnosis" are left vague. They are so vague that it is hard to understand what compliance fully means and what scenarios it is or isn't appropriate. The criteria is confusing. Without more clarity it leaves me to believe that many of these scenarios will result in a damaging interference between therapists and their patients. It could cause many scenarios where ethics come into question and keep providers from focusing on the best and most appropriate care because they are worried about interpretations of these regulations.

My next concert is mandated reporting, which appears to be an enormous government overreach in addition to being an unreasonable requirement. The workload alone for medical professionals having to file detailed reports every 30 days is completely unrealistic and overtaxing our hardworking providers. The amount of details required in these reports, while "de-identified" is so specific and part of such a small population it would be compromising for trans individuals and their families. The proposed reporting requirements do not take into account the importance and complexities of individualized care plans-nor do they take into account the myriad of reasons why a patient may "discontinue" care somewhere. There could be an insurance issue, a need to relocate or a search for a different provider for whatever reason. However, the current setup would have scenarios like that show up as a patient desisting and discontinuing care altogether. That would majorly skew any data collection-and ultimately paint a false narrative of trans healthcare and the needs of the trans population in Ohio.

Additionally, gender-nonconformity is described in the rules as a mental illness which further stigmatizes an already marginalized population.

I ask you to please not adopt rules 3701-59-07, 3701-83-61, 5122-14-12.1 and 5122-26-19.

Thank You For Your Time,
Katie

KALEIDOSCOPE YOUTH CENTER

Belonging Begins Here.

603 E. Town St.
Columbus, OH 43215

info@kycohio.org
614-294-5437

April 15, 2024

My name is Mallory Golski, I use she/her pronouns, and I'm the civic engagement and advocacy manager for Kaleidoscope Youth Center, Ohio's largest and longest-standing organization dedicated to serving and supporting LGBTQIA+ youth and young adults.

I spoke with young people from KYC, who expressed their concerns about these draft rules, which I'd like to share with you today. As you'll learn from their comments, the rules are a drastic overreach that exceed the scope of this body's authority and will detrimentally impact Ohio's ability to retain young people who will want to go to school and, eventually, work here in Ohio.

"To think that the government is going to have an in-detail log of how many trans people are in a particular area with their ages… that sounds like some kind of history that we learned about in school and we all know what happened with that. People are not understanding that if we do not pay attention to what's happening, it's going to turn into something bad. The fact that people my age are starting to worry about whether or not they should flee the country is f–ed up." **– KYC Youth**

"It reads like a dystopian novel. Why do you care? What does this do? What are you going to do with this information? You're not telling us what they're going to do with this information. If you think the government can't do it, oh yes they would. I thought we were better than this." **– KYC Youth**

"I like how we are talking about erasing history and trying to stop people from teaching about our own messed up history, when, at the same time, we are going through and repeating a lot of the same steps that we demonize in history. People say we would never do that again, but now we are forcing people to be outed and requiring these numbers to be counted. What's the data used for? Why do you need to know? Even if they're separating identity from procedure, that's someone's personal medical history. You can't take away my medical personal decision and tell me that it's wrong because of the way I identify. I am a human being and I should be

able to do what I want with my body. It's oppression of everybody who thinks differently from our government." **– KYC Youth**

"The data on pausing or switching or stopping providers is purposefully creating inaccurate data. Even if you ignore the blatant transphobia, that's medical malpractice. That's going to hurt people. Are you making other people jump through these hoops? This is government overreach. If you overreach into gender-affirming care, who's to say what comes next? What's to stop people from banning other procedures next? For the crowd who thinks it's going to be detrimental to my health, I tried to give myself cancer when I was 9 years old and started growing body parts that I didn't want on my body." **– KYC Youth**

"When people talk about trans kids a lot of the time they focus on the trans part and forget that trans kids are also kids. For me specifically, as a trans guy who has been able to be on testosterone, it has helped a lot with not only my confidence but also not quite feeling so hopeless and like I'll never be able to be seen as who I am. It felt freeing… I have felt so much more hope that I might be able to live as myself, in a body that feels like mine. Hope that there might be a time when I don't dread leaving the house because people still see me as a girl. Hope that I might one day be free to be myself, without fear that my access to this healthcare will be stripped away. Hope that I might one day wake up and finally be happy." **– KYC Youth**

"We as a public voted to protect bodily autonomy. How is this any different? It's health care." **– KYC Youth**

"As trans people, the acknowledgement of our dignity as people ends at birth." **– KYC Youth**

The proposed administrative rule changes are based on biased definitions, ignore well-established best practices, and restrict countless patients' access to gender-affirming care. Furthermore, many of the policies contained in the rules are now redundant under House Bill 68. Tacking on onerous reporting requirements and extraneous barriers to accessing care that's *already* effectively banned in Ohio only creates further confusion for health care providers and reinforces the faulty assumption that gender-affirming care is dangerous, complicated and unregulated.

I am deeply concerned by the excessive reporting requirements that remain under these proposed rules. While the data collected will be "de-identified," individuals receiving care may still run the risk of having their privacy or other data compromised. It also remains unclear how the collected information will distinguish between individuals who temporarily pause gender-affirming treatments or change providers when receiving this care will be accurately

distinguished from that of individuals who seek to cease care altogether. Unless there is a guaranteed way to ensure that individuals who intend to resume care will not be categorized as those who detransition *without* compromising their privacy, I remain concerned that the data collected will only further fuel inaccurate claims of high detransition and regret rates among transgender minors. Furthermore, likening the need to report gender-affirming treatments in the same way that cases of communicable diseases like covid-19 or food poisoning are reported dangerously perpetuates stigmas that exist regarding transgender individuals. Gender dysphoria is not a contagion, and treating it as such will lead to further discrimination against transgender individuals.

Transgender people already face enough barriers to accessing gender-affirming care – whether because of societal pressures that hinder their willingness or safety to come out and seek care in the first place, or because of existing standards and procedures in the treatment process. One trans teenager who attends Kaleidoscope Youth Center articulated the anxieties that many transgender people face when anticipating the implementation of additional barriers: *"Without a doubt my intrusive thoughts about self harm significantly increased when I had to wait a few more months for testosterone because the doctor wasn't there. I can practically guarantee you that if I had to wait for two more years to get on testosterone, I wouldn't make it."*

Put simply, any efforts to further restrict trans people's access to life-saving gender-affirming care will lead to more suicides and other detrimental mental health challenges.

Presently, Ohio has one of the most comprehensive and robust networks of gender-affirming care clinics in the country, particularly for transgender youth and young adults. Unfortunately, this network is already going to deteriorate with the passage of House Bill 68, and the proposed administrative rule changes, while better than their initial draft, only create further complications for hospitals and clinics, as well as the individuals seeking care. This will cause people to leave Ohio to seek safety and treatment elsewhere and harm countless other Ohioans who will not have the privilege of leaving the state and would be forced to get by without this life-saving care.

Transgender people are the experts in their own identities and experiences. Nobody should be denied the opportunity to live as their truest, most authentic self. Please respect the autonomy and dignity of all transgender individuals, heed the advice and guidance of Ohio's social workers, hospitals and gender-affirming care clinics, who are the experts at providing this best-practice care and reject the proposed administrative rules that would impact access to gender-affirming care.

EQUALITY OHIO

April 15, 2024

RE: Written Testimony on Proposed Rule 3701-3-17, Reporting Gender-Related Condition Diagnoses and Gender Transition Care

Written Testimony on Proposed Rule 3701-59-06, Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassigment [*sic*] **Surgery for Minors**

Written Testimony on Proposed Rule 3701-59-07, Quality Standards for Gender Transition Treatment at Hospitals

Dear Chair Gavarone, Vice Chair Callender, and Members of JCARR:

Thank you for the opportunity to testify regarding the latest proposed rules by ODH regarding regulating and surveilling the practice of gender-affirming care.

Equality Ohio is a statewide organization that seeks to transform systems and institutions so that LGBTQ+ Ohioans can fully access legal and lived equality. Our core values include dignity and self-determination for all people, including transgender and gender-diverse youth and adults in Ohio. We also believe that people, systems, and institutions can and should transform the ways in which they intentionally or unintentionally oppress others.

Equality Ohio reiterates our objection to the agency rules for the reasons stated in earlier comments. Additionally, because JCARR is charged with reviewing the rules with a particularly specific scope, several justifications for invalidating the rules are outlined in this testimony.

Executive Summary of Invalidity of Proposed Rules:

1. The rules exceed the regulatory authority of ODH: ODH has failed to meet its burden in showing that gender dysphoria is within the scope of authorized data collection pursuant to 3701.17.

2. The rules conflict with statutory intent: By repurposing an authority granted to prevent and mitigate disease; pursuing standards out of line with endorsed standards of care; and mandating discrimination, the rules are out of step with the statutory intent to regulate individualized medical treatment plans.

3. The Rule is In Conflict with Federal Law: Equal treatment for transgender people in healthcare services is mandated by federal law, and this rule would mandate unequal treatment and discrimination.

4. Further limiting access to gender affirming care will only exacerbate existing discrimination, furthering risk of violating other laws. Transgender people already face significant barriers in accessing this care, including discrimination in healthcare, and further limiting care will worsen discrimination, even when discrimination opens the door to liability or legal peril.

5. The rule would have an adverse impact on business that is not outweighed by any benefit. The business and public health impact of these rules are both clearly a net negative, and this harm is not justified legally nor will it do anything but harm patients, and ODH has failed to meet its burden in showing that the legislative intent justifies that adverse impact to business.

In addition to our previously filed comments and this written testimony, we also direct your attention to the comments submitted by TransOhio, Equitas, and the many experts and community members that submitted thoughtful written comments.

1. The rule exceeds ODH's regulatory authority: ODH has failed to meet its burden in showing that gender dysphoria is within the scope of authorized data collection pursuant to 3701.17.

The authority of ODH to collect and release data is limited in scope and bound by specific criteria. The ODH may only release data without the written consent of an individual if:

(1) The release of the information is **necessary to provide treatment *to the individual and* the information is released pursuant to a written agreement** that requires the recipient of the information to comply with the confidentiality requirements established under this section.

(2) The release of the information is **necessary to ensure the accuracy of the information *and* the information is released pursuant to a written agreement** that requires the recipient of the information to comply with the confidentiality requirements established under this section.

(3) The information is released **pursuant to a search warrant or subpoena** issued by or at the request of a grand jury or prosecutor in connection with a criminal investigation or prosecution.

(4) The director determines the release of the information is necessary, based on an evaluation of relevant information**, to avert or mitigate a clear threat to an individual or to the public health**. Information may be released pursuant to this division only to those persons or entities **necessary to control, prevent, or mitigate disease.**

(C) Information that does not identify an individual is not protected health information and may be released in summary, statistical, or aggregate form. Information that is in a **summary, statistical, or aggregate form *and* that does not identify an individual** is a public record under section 149.43 of the Revised Code and, upon request, shall be released by the director.

In failing to meet one of the three prongs authorizing the collection and release of data, and failing to ensure aggregate information would indeed be de-identified, this proposed rule exceeds ODH's regulatory authority.[1]

The lack of any description of safeguards for the reported data raises serious concerns about privacy and confidentiality.[2] Without an understanding of how ODH will safeguard this sensitive medical information, one cannot take comfort that it will be protected, and patients are likely to feel reluctant to share these data.[3] Simply acknowledging that the data constitute protected health information under state law is insufficient information about how they will be protected.[4]

ODH's addition of an undefined category of "basic demographic information," without any indication of what specifically ODH intends to be reported, only substantially increases these concerns. Asking the public to trust that ODH will not include any patient-identifiable data "as determined by the director of health" is cold comfort in the same regulations promulgated by the same director targeting a vulnerable community for restrictions on the care it needs.

2. The rules conflict with statutory intent: By repurposing an authority granted to prevent and mitigate disease; pursuing standards out of line with endorsed standards of care; and mandating discrimination, the rules are out of step with the statutory intent to regulate individualized medical treatment plans.

Applying data collection standards authorized with regards to communicable diseases to apply to any medical treatment subject to controversy, the ODH would render the standards and safeguards meaningless. Surveillance authorization for gender affirming care opens the door to any course of medical treatment becoming subject to surveillance, likely through an unjustified broad reading of "threat of public health." It is inherently out of step with the legislative intent of regulating care.

There is no compelling reason for mandatory data collection as outlined in this rule. Transgender and gender-diverse people do not present a public health threat to others.[5] The data collection portion of the rule prescribes sweeping, harmful, easily-weaponized surveillance requirements to transgender patients and the professionals that serve them.

These rules run afoul of the State Medical Board of Ohio's position on and posture towards corporatizing medical care. The State Medical Board has made clear that a

[1] ORC 3701.17
[2] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(C).
[3] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(C)(1).
[4] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(C)(2).
[5] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(A)(1).

physician must exercise professional judgment based on the best interest of the patient, rather than apply onerous one-size-fits all care. We reference here the State Medical Board of Ohio's Position Statement on Corporate Practice of Medicine:[6]

> The Ohio legislature has made it clear that the corporate practice of medicine doctrine no longer exists in Ohio. No matter the business entity, a physician must exercise professional judgment to render medical services based on the best interest of the patient and within the minimal standards of care of similar practitioners under the same or similar circumstance.

Neither a hospital or healthcare facility nor the State should be directing a universal care plan for transgender and gender-diverse patients.

ODH's mandatory reporting schema is, at best, unsound and flawed from the root up because it does not conform to best practices and places transgender and gender-diverse youth and their healthcare providers at risk without benefit. As such, these mandatory data reporting requirements are simply state surveillance of youth receiving gender-affirming care. Transgender and gender-diverse youth do need appropriately-informed data collection, and we refer you to TransOhio's previously submitted model rule.

Not only is the data collection not providing a benefit to individual patients, but the validity of the data will be altogether useless. Accuracy of information will be compromised by a lack of sufficient clarity for clinicians or patients to understand its scope.[7] Fulfilling the data request regarding cessation is not straightforward, because there may be many reasons that care is ceased, and providers may not even know why a patient drops out of care.[8] Likewise, we renew our concern that fulfilling the data request regarding detransitioning is complicated and open to interpretation.[9] "Detransition" is not a defined term, and changing doses or ceasing hormone therapy is not always or even generally an indication that a patient does not identify as transgender anymore.

Disclosure of these data place both healthcare providers and their patients at risk without corresponding benefit.[10] We renew our concern that data contained in the reports from hospitals and healthcare facilities is vulnerable to predatory investigative demands and subpoenas, without clarifying language to the contrary.[11] ODH indicates that only aggregate data will be disclosed to the Ohio Legislature and to the public, but we remain unclear about how

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[6] State Medical Board of Ohio, Position Statement on Corporate Practice of Medicine (Mar. 15, 2012), available at: https://med.ohio.gov/laws-and-regulations/position-statements/corporate-practice-of-medicine.

[7] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(B).

[8] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(B)(1).

[9] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(B)(2).

[10] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(D).

[11] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(D)(1).

ODH intends to de-identify the data.[12] Frankly it is unclear whether the data even can be meaningfully deidentified, or how much protection deidentification actually provides.[13]

3. The Rule is In Conflict with Federal Law: Equal treatment for transgender people in healthcare services is mandated by federal law, and this rule would mandate unequal treatment and discrimination.

Despite constant targeted misinformation and false claims regarding its efficacy, the provision of gender-affirming care is well recognized by major medical associations, scientifically sound, and protected by federal law. A failure to treat transgender Ohioans equally to cisgender patients in healthcare conflicts with requirements outlined in federal law.

Differential treatment for transgender people in the provision of healthcare services contravenes federal law, which prohibits discrimination on the basis of gender identity. Section 1557 of the Affordable Care Act applies existing federal civil rights protections to the provision of healthcare and prohibits people from being subject to discrimination, excluded from participation, or denied the benefits of federally funded health programs or activities based on race, color, national origin, sex, age, or disability.[14] Numerous federal courts have concluded that Section 1557 prohibits discrimination on the basis of transgender status.[15] The Proposed

[12] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section III(D)(2).

[13] See generally, Elodie Currier Stoffel, *The Myth of Anonymity: De-Identified Data as Legal Fiction*, 54 N.M. L. Rev. 129 (2024), available at: https://digitalrepository.unm.edu/nmlr/vol54/iss1/5.

[14] 42 U.S.C. § 18116.

[15] See, e.g., Fain v. Crouch, No. 3:20-cv-00740, 2022 WL 3051015 (S.D.W.V. August 2, 2022) (finding that West Virginia's Medicaid program violated Section 1557 because of its blanket exclusion of gender-affirming care); C.P. by & through Pritchard v. Blue Cross Blue Shield of Illinois, 536 F. Supp. 3d 791 (W.D.Wash. 2021) (finding that Plaintiffs stated a claim of sex discrimination under § 1557 where they alleged that Defendant discriminated against Plaintiffs by applying an exclusion for transgender care because of sex); Tovar v. Essentia Health, No. 16-cv-00100- DWF-LIB (D. Minn. September 20, 2018) (holding that Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender identity); Boyden v. Conlin, No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause); Flack v. Wis. Dep't of Health Servs., No. 3:18-cv-00309-wmc (W.D. Wis. July 25, 2018) (holding that a Medicaid program's refusal to cover treatments related to gender transition is "text-book discrimination based on sex" in violation of the Affordable Care Act and the Equal Protection Clause of the Constitution); Cruz v. Zucker, 195 F.Supp.3d 554 (S.D.N.Y. 2016) (holding exclusion invalid under the Medicaid Act and the Affordable Care Act); Rumble v. Fairview Health Servs., No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act); Prescott v. Rady Children's Hosp.-San Diego, 265 F.Supp.3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act).
Other federal courts have found that similar federal sex discrimination laws also prohibit anti-transgender discrimination. See, e.g., Whitaker v. Kenosha Unified School District, No. 16-3522 (7th Cir. 2017) (Title IX and Equal Protection Clause); Dodds v. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX and Equal Protection Clause); Grimm v. Gloucester County School Board, No. 4:15-cv-54 (E.D. Va. May 22, 2018) (holding that denying a transgender boy access to school restrooms matching his gender violated Title IX and the Equal Protection Clause of the U.S. Constitution); M.A.B. v. Board of Education of Talbot

Rules violate Section 1557, would require providers to violate Section 1557, and should be invalidated.

There is growing momentum at the federal level to remove provisions that single out transgender people to be treated differently in the provision of healthcare services. Although there were attempts to roll back explicit protections for transgender consumers in HHS regulations to implement Section 1557, these efforts were enjoined.[16] New rules reinstating those protections in federal regulations are expected to be finalized in the coming weeks. However, the current lack of interpretive agency regulations does nothing to affect the obligations of covered entities under the Section 1557 underlying federal statute. For example, in *Prescott v. Rady's Children Hospital San Diego*, the district court considered a lawsuit filed by the mother of a deceased transgender child alleging that a children's hospital had violated Section 1557 by discriminating against her son, Kyler Prescott, because of his transgender status. The district court reaffirmed that Section 1557 of the ACA's sex discrimination protection includes discrimination on the basis of transgender identity. The court based its conclusion on longstanding circuit court case law on Title VII and Title IX. Because the court held that the underlying statute of Section 1557 prohibits discrimination on the basis of transgender status independently of its implementing regulation, the court denied the hospital's request for the case to be stayed based on injunction of the regulations. According to the court, "the ACA claim and the Court's decision under the ACA do not depend on the enforcement or constitutionality of the HHS's regulation."[17]

Additionally, rules are subject to existing federal regulations[18] that explicitly prohibit discrimination on the basis of sex.[19]. In states that have enacted bans on gender-affirming care for minors, numerous federal courts have determined that outlawing care for transgender people that is allowable for non-transgender people creates sex-based classifications that would fail heightened constitutional scrutiny.[20]

County, 286 F. Supp. 3d 704 (D. Md. March 12, 2018) (holding that prohibiting a transgender boy from boys' locker room based on transgender status is a Title IX sex-discrimination claim as well as a gender-stereotyping claim); A.C. by M.C. v. Metro. Sch. Dist. of Martinsville, 75 F.4th 760 (7th Cir 2023), *cert. denied sub nom*, Metro. Sch. Dist. v. A.C., No. 23-392, 2024 WL 156480 (U.S. Jan. 16, 2024) (holding that disallowing a transgender student from using the restroom in accordance with gender identity violated Title IX and likely equal protection rights).

[16] See, e.g., Walker v. Azar, No. 20CV2834FBSMG, 2020 WL 6363970, at *4 (E.D.N.Y. Oct. 29, 2020) (staying repeal of 2016 rule's definition of "on the basis of sex," "gender identity," and "sex stereotyping" set forth in 45 C.F.R. § 92.4 and of 45 C.F.R. § 92.206); Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs., 485 F. Supp. 3d 1, 64 (D.D.C. 2020).

[17] See Prescott, supra note 31; see also Boyden, supra note 31.

[18] See 45 C.F.R. § 92.3(b) ("As used in this part, 'health program or activity' encompasses all of the operations of entities principally engaged in the business of providing healthcare that receive Federal financial assistance as described in paragraph (a)(1) of this section.").

[19] 45 C.F.R. § 92.2 (prohibiting discrimination on the basis of sex).

[20] See Brandt v. Rutledge, No. 4:21CV00450 JM, 2023 WL 4073727 (E.D. Ark. June 20, 2023), appeal filed, No. 23-2681 (8th Cir. July 20, 2023); Eknes-Tucker v. Marshall, 603 F. Supp.3d 1131 (M.D. Ala. 2022), *rev'd*, 80 F.4th 1205 (11th Cir. 2023); *see also* Koe v. Noggle, No. 1:23-CV-2904-SEG, 2023 WL 5339281 (N.D. Ga. Aug. 20, 2023), *preliminary injunction stayed*, No. 1:23-CV-2904-SEG (N.D. Ga. Sept. 5, 2023); K.C. v. Individual Members of Med. Licensing Bd. of Indiana, No. 1:23-cv-00595-JPH-KMB, 2023 WL 4054086 (S.D. Ind. June 16, 2023), preliminary injunction stayed, K.C. v. Individual Members of Med. Licensing Bd. of Indiana, No. 23-2366, 2024 WL 811523 (7th Cir. Feb. 27, 2024); Dekker v. Weida,

4. Further limiting access to gender affirming care will only exacerbate existing discrimination, furthering risk of violating other laws. Transgender people already face significant barriers in accessing this care, including discrimination in healthcare, and further limiting care will worsen discrimination, even when discrimination opens the door to liability or legal peril.

Transgender people face substantial barriers to quality health care, including refusals of care and substandard care.[21] Despite the medical necessity of gender-affirming care, transgender people are targeted for denial of services even when the same services are covered for non-transgender people. This discriminatory mistreatment combined with widespread stigma correlates with significant health disparities and disproportionately poor health outcomes among transgender people.[22] Transgender people experience significant disparities in health indicators such as experiences of abuse and violence, mental and behavioral health concerns, and HIV infection. These disparities in turn link to higher levels of poverty, uninsurance, stigma, and

No. 4:22CV325-RH-MAF, 2023 WL 4102243 (N.D. Fla. June 21, 2023), *appeal filed*, No. 23-12155 (11th Cir. June 26, 2023); Doe v. Ladapo*,* No. 4:23cv114-RH-MAF, 2023 WL 3833848 (N.D. Fla. June 6, 2023), *appeal filed,* No. 23-12159 (11th Cir. June 27, 2023); Poe by & through Poe v. Labrador, No. 1:23-CV-00269-BLW, 2023 WL 8935065 (D. Idaho Dec. 26, 2023), *cert petition filed*, No. 23-763 (Feb. 21, 2024); L.W. by & through Williams v. Skrmetti, No. 3:23-CV-00376, 2023 WL 4232308 (M.D. Tenn. June 28, 2023), *rev'd and remanded*, 83 F.4th 460 (6th Cir. 2023), *cert petition filed*, No. 23-477 (Nov. 9, 2023).

[21] See, e.g.,National Academies of Sciences, Engineering, and Medicine (NASEM). 2020, p.7-8. Understanding the Well-Being of LGBTQI+ Populations. Washington, DC: The National Academies Press, available at: https://doi.org/10.17226/25877 ("The physical and mental health of [sexual and gender diverse] SGD populations is substantially affected by external influences that include discrimination, stigma, prejudice, and other social, political, and economic determinants of health…The disparities affecting SGD populations are driven by experiences of minority stress, which include both structural and interpersonal stigma, prejudice, discrimination, violence, and trauma."); Institute of Medicine, The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding (2011), available at: https://nap.nationalacademies.org/resource/13128/LGBT-Health-2011-Report-Brief.pdf.

[22] Wesp LM, Malcoe LH, Elliott A, Poteat T. Intersectionality Research for Transgender Health Justice: A Theory-Driven Conceptual Framework for Structural Analysis of Transgender Health Inequities. Transgend Health. 2019 Oct 29;4(1):287-296. doi: 10.1089/trgh.2019.0039. PMID: 31663035; PMCID: PMC6818474.

discrimination,[23] particularly when seeking health care.[24] In fact, Ohio is one of the top ten states from which U.S. Transgender Survey respondents moved because of state laws targeting transgender people for unequal treatment.[25] By arbitrarily singling out the transgender population and creating barriers to healthcare otherwise provided to non-transgender people, the Rules are clearly discriminatory and will undoubtedly contribute to increased discrimination towards the transgender community.

It is the overwhelming consensus among medical experts that gender-affirming treatments are medically necessary, effective, and safe when clinically indicated to alleviate gender dysphoria. Major medical associations—including the American Medical Association, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the Endocrine Society, and the American Congress of Obstetricians and Gynecologists, among others—agree that gender-affirming services are medically necessary for many transgender people.[26] The standards for adolescents also state that "an individualized approach to clinical care is considered both ethical and necessary."[27]

Failure to render appropriate treatment for gender dysphoria can have significant, measurable negative health impacts for the patient. In a 2008 resolution, the AMA affirmed that mental health care, hormone therapy, and gender affirmation surgeries are effective, safe, and medically necessary treatments for people diagnosed with gender dysphoria.[28] The resolution further emphasizes that, without appropriate medical treatment, gender dysphoria can have consequences that include "clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death."[29]

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[23] Joint Commission, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide (2011), https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/lgbtfieldguide_web_linked_verpdf.pdf.

[24] See, James, S.E., Herman, J.L., Durso, L.E., & Heng-Lehtinen, R. (2024). Early Insights: A Report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality, Washington, DC., available at: https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf (finding that 48% of transgender respondents who saw a health care provider in the year prior to the survey were denied treatment, turned away or suffered mistreatment or discrimination for being transgender); see also, C. Medina & L. Mahowald, Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities (2022), available at: https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities/ (finding that 15% of transgender or nonbinary people reported that a healthcare provider refused to provide gender-affirming care).

[25] Id., Early Insights Report, at 23.

[26] See Transgender Legal Defense & Education Fund, Medical Organization Statements, available at: https://transhealthproject.org/resources/medical-organization-statements/.

[27] See WPATH, supra note 1 at 45.

[28] See AMA, supra note 5.

[29] Id.

Every major medical association in the United States supports WPATH and Endocrine Society treatment protocols for medically necessary gender-affirming care and opposes exclusions of treatment for gender dysphoria, including for children and adolescents.[30]

The presumption that ceasing care would not be harmful is not supported by science.[31] Presuming that absent other factors, terminating care would not cause harm to the minor is a scientifically faulty basis for making treatment decisions. The Constitution of the World Health Organization recognizes as a first principle that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[32] ODH's own website states its mission is "advancing the health and well-being of all Ohioans,"[33] and that responsibility includes transgender and gender-diverse Ohioans.

Rules 3701-59-06 and 3701-83-60 are not based on current medical standards and may result in harm to transgender and gender-diverse adolescents. Consistent with WPATH's paradigm of individualized assessment plans, the standards of care for adolescents do not support a total ban on "gender reassignment surgery" or "genital gender reassignment surgery" as those terms are defined in the Proposed Rules. Though surgical treatment may be less common for adolescents who are in puberty or have completed puberty, the standards of care emphasize that surgical procedures should not be ruled out across the board if the young person has the capacity to provide informed consent or assent.

Current standards of care contemplate the possibility that some surgical treatments may be medically necessary for adolescents under age 18 and that delaying them may risk harm. A complete ban on all gender-affirming surgeries for adolescents under age 18 ignores the individualized approach to care required by medical standards and should not be written into regulation. The WPATH standards do provide some guideposts for decision-making about surgery in adolescents, but an across-the-board ban in every circumstance short-circuits the case-by-case analysis that is the touchstone of the WPATH standards.

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[30] See, e.g., J. Rafferty, Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence and Section on Lesbian, Gay, Bisexual, & Transgender Health and Wellness, Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender Diverse Children and Adolescents, Pediatrics, 2018, 142(4):2018-2162; L.S. Beers, American Academy of Pediatrics Speaks Out Against Bills Harming Transgender Youth. American Academy of Pediatrics, 2021, available at: https://www.aap.org/en/news-room/news-releases/aap/2021/american-academy-of-pediatrics-speaks-out-against-bills-harming-transgender-youth/; AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth, American Academy of Child & Adolescent Psychiatry, 2019, available at: https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx; AMA Fights to Protect Health Care for Transgender Patients, American Medical Association, 2021, available at: https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update

[31] See Equality Ohio and TransOhio's comment on the Draft Rules submitted Feb. 5, 2024, at Section II(D)(4).

[32] World Health Organization, Constitution, available at https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf.

[33] https://odh.ohio.gov/.

Additionally, standards of care do shift and evolve over time as knowledge and research paradigms shift. It is unwise over the long term for ODH to write constantly-evolving medical standards into regulation. Interpreting the evidence base and applying it to the patient in front of them is a function best left to healthcare providers.

The additional requirement that the care plan must address cessation of treatment further confounds an already confusing section. The same concerns that we described in the Proposed Rule on reporting apply here.[34] Although this addition was probably intended to clarify the difference between detransition and simply ceasing treatment, without defining what "detransition" means, it just adds to the confusion of terms.

For example, it is unclear how changes in treatment such as reducing the doses of hormones would fit into this schema: how does ODH anticipate that healthcare providers will know what level of reduction of hormones would be considered by ODH to be detransition or cessation, given that individual context varies significantly? What about the elimination of one hormone while maintaining others (i.e. maintaining estrogen but eliminating androgen blockers)[35] or the addition of estrogen and/or progestin to testosterone therapy?[36] Even a not uncommon change in circumstance, such as a health insurance lapse or job loss, could result in long-term disruptions in care; without patient communication regarding context, will healthcare providers consider this detransition or cessation?

For clarity, we are not suggesting that ODH should attempt to define "detransition," because it means different things to different people and is not amenable to a standardized definition. If anything, these points show that at best it is a fool's errand to go down this road.

5. The rule would have an adverse impact on business that is not outweighed by any benefit: The business and public health impact of these rules are both clearly a net negative, and this harm is not justified legally nor will it do anything but harm patients, and ODH has failed to meet its burden in showing that the legislative intent justifies that adverse impact to business.

The conflict of laws, ambiguity in data standards, and potential harm to the patient make clear that the potential benefit of surveilling gender-affirming care is significantly outweighed by the harm to business interests in the state, let alone the unnecessary risk it could pose to gender-diverse patients and their healthcare providers.

Discrimination is bad for business. In Ohio, the total LGBTQ+ population (13+) is 462,000. Of that, 298,000 are in the workforce. 30% of the LGBTQ+ population is raising children. This is a sizable part of Ohio's population that can impact all industries. Ohio needs to make clear that

[34] See supra Section II(B).
[35] See, e.g., Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *The Cochrane database of systematic reviews*, *11*(11), CD013138, available at: https://doi.org/10.1002/14651858.CD013138.pub2.
[36] See WPATH, supra note 1, at 116.

we're "open for business" through inclusive policies that attract and retain the brightest and most talented employees and leaders. If we want our economy to compete and for employers to recruit the best talent, we need inclusive nondiscrimination laws.

Recently we've seen the economic harm that has hit other states' economies because they failed to adequately protect their LGBTQ+ workers:

- In Florida, overall teaching vacancies are at 5,300 at the beginning of the 2023-2024 academic year. Alpha Phi Alpha, the oldest historically Black collegiate fraternity, has decided to move theri 2025 convention due to harmful legislation being passed. The economic impact of the conference is a projected $4.6 million.
- In North Carolina, HB 2, an anti-LGBTQ+ bill, cost the state seven NCAA championship tournaments and the 2017 NBA All-Star game. The Greater Raleigh Convention and Visitors Bureau lost $3.1 million in tourism business. NBC estimated that North Carolina's state economy would lose between $39.7 million and $186 million due to boycotts (Kasperkevic). Economic blows like these hurt everyone, regardless of the industry you are in.
- The Center for American Progress has estimated the national cost of workplace discrimination is $64 billion annually. This is the cost for businesses to replace more than 2 million Americans who leave their jobs because of workplace discrimination.

To care about Ohio's economic success is to care about preventing discrimination against LGBTQ+ Ohioans, including and especially transgender Ohioans.

Conclusion

All Ohioans, including transgender and gender-diverse Ohioans, should have access to high quality and affordable healthcare that they need. Invalidating or rescinding the Proposed Rules is the only outcome that will ensure that transgender Ohioans continue to have access to the medically necessary services to which they are entitled under federal law should they want to utilize them, and avoid furthering the historic discrimination that transgender people have long faced in accessing healthcare services.

Thank you for the opportunity to submit testimony on the Proposed Rules. For the aforementioned reasons, we respectfully request that Proposed Rules 3701-3-17, 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61 be invalidated as written or rescinded and corrected.

If you have any questions about our comments, please feel free to contact us at policy@equalityohio.org.

Sincerely,

Maria Bruno, JD
Public Policy Director, Equality Ohio

Members of the JCARR Committee,

My name is Melissa Kelley and I am here today as a concerned Ohio citizen to urge you to invalidate ODH rules **3701-3-17** and **3701-59-06**.

These rules should be invalidated because the Department of Health is **acting beyond the scope of its authority**. Health departments typically regulate matters related to public health and safety. However, these rules extend into areas of medical treatment and individual autonomy, which traditionally fall under the purview of medical professionals and their patients. By prohibiting specific medical practices and interventions, especially only for a certain population, **both departments are overstepping bounds.**

In addition, JCARR should invalidate these rules because the rules will have an adverse impact on business and the Department of Health failed to demonstrate through a business impact analysis that the regulatory intent of the rule justifies its adverse impact on business. Pursuant to ORC §170.52, a rule has an **adverse impact on business** if, among other reasons, it imposes a criminal or civil penalty or creates a cause of action, or requires specifics expenditures or the report of information or it would be likely to directly increase expenses of the line of business to which it applies. **All three of those criteria are met.** The business impact analysis completely failed to analyze the impact on physicians and transgender patients and their families.

As I have shared, these rules conflict with existing and pending Ohio law and should therefore be invalidated.

JCARR Committee Members:

Thank you for the opportunity to provide written testimony regarding Ohio Department of Health (ODH) rule 3701-3-17. That's real should be invalidated because it violates several of the Joint Committee on Agency Rule Review (JCARR) prongs.

JCARR should invalidate the rule because it will have an adverse impact on business and ODH has not demonstrated that the regulatory intent justifies their adverse impact on business.

These reporting requirements in this rule place an extensive unfunded burden on, and poses a safety risk to, already overstretched providers. Medical professionals already face extensive amounts of paperwork and this will take away even more time that could be served helping patients. In addition, this puts them at risk. In late 2022 to early 2023, gender care providers in this state were targeted by hate groups with many receiving personal death threats and their practices receiving bomb threats. One of our daughter's providers left the state to avoid the harassment and another has stated they now carry a firearm to work every day. These rules will discourage new providers from moving here and give current providers added reasons to leave, exacerbating the medical desert in our state.

The stated regulatory intent is for research purposes. However, no such research is outlined or defined anywhere in these rules. In addition, vagueness and lack of standardization will cause inherent inaccuracies in the data, making it unusable for research purposes. Neither ODH nor research institutions will be analyzing the data and there is no discernible public health benefit to justify its collection.

JCARR should invalidate the rule because it conflicts with existing laws.

This rule violates Ohio and federal laws and rules governing privacy of personal medical information. Reporting the private medical data of transgender Ohioans to the General Assembly places those patients and their families at risk. While individual names are not included, transgender people represent such a tiny percentage of the population there are many instances where individuals could be identified. For example, while there are several transgender people in our county, our child is most likely the only one with her precise age, identified gender at birth, and treatment details. It would take virtually no effort for someone to identify her based on the "deidentified" required reporting data. Such reporting is unnecessary to ensure the health of the public and only serves the purpose of further stigmatizing transgender individuals. Were this rule to remain, as parents we would counsel our daughter to abandon the care team that has been treating her for multiple years and suggest she seek new doctors near where she attends college in another state rather than subject herself to the risks involved with such reporting. I also run a support group for transgender adults, many of whom live in smaller communities than we do. They report that they are already afraid to leave their homes and are terrified by the impact of these reporting requirements will have on them.

JCARR should invalidate the rule because it conflicts with the legislative intent, including ODH's own purpose and mission to address health inequities and disparities and assure quality in healthcare services to protect the health and safety of Ohioans.

This rule does the complete opposite of protecting the health and safety of Ohioans. Reporting private medical data without a patient's consent encourages patients to avoid medical care. Many transgender Ohioans already face extreme difficulties accessing care due to a severe lack of trained providers and this rule will only exacerbate this problem.

Dear Chair Callender,

As a concerned Ohioan, I urge JCARR to recommend the Ohio Department of Health to **not** adopt any rules restricting gender-affirming health care to transgender patients. I ask that you invalidate rules O.A.C. 3701-3-17, O.A.C. 3701-59-06, and O.A.C. 37-1-83-60 in their entirety.

Nathaniel Braun

513-289-4882

Zip code: 43220

4/15/2024

Testimony on Gender Transition Quality Standards and Reporting

To the Joint Committee on Agency Rule Review, thank you for the opportunity to submit testimony in opposition to the proposed Gender Transition Quality Standards and Reporting rules. The Ohio Counseling Association (OCA) and the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities of Ohio (SAIGEO) want to express our strong opposition to the following rules: 3701-3-17, 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61. We acknowledge that certain rules are being resubmitted, we nonetheless aim to formally register our concerns. As mental health providers committed to the well-being of all Ohioans we believe these rules will have detrimental effects on access to essential medical care, client confidentiality, and healthcare provider availability (Barbee, Deal, & Gonzales, 2022).

Foremost among our concerns is the severe restriction of access to critical medical care for minors experiencing gender dysphoria (Schaefer, Liehr, Stratford, & Patel, 2022). Mental health businesses providing gender-affirming care may experience a decrease in clients if individuals are unable to access their medical treatments such as hormone replacement therapy or puberty blockers. This restriction could result in a loss of clients for businesses, potentially leading to decreased revenue and decreased financial stability. Restrictions on gender-affirming care may discourage mental health professionals from specializing in this area or from practicing in states with stringent regulations. This could exacerbate existing shortages of qualified providers (Alexander, 2022) and as a result reduce the productivity of healthcare facilities.

The Early Insights of the 2022 US Transgender Survey (USTS) identified that 47% of respondents thought about relocating to another state because of their current state's legislators considering or passing laws that target transgender people. In addition, roughly 5% of participants had already moved out of their state because of such legislative actions (James et al., 2024). Ohio was one of the top ten states USTS respondents reported leaving. Transgender individuals and their families have even reported to news organizations that they are leaving Ohio due to discriminatory laws (James, Herman, Durso, et al., Henry 2023). SAIGEO board members have seen firsthand that clients are choosing to leave Ohio, taking with them their businesses and families, rather than continue to live in fear of laws impacting their ability to access care. We are concerned about the potential impacts these rules would have on our

economy as many minors and their parents consider receiving services outside of the state or relocating altogether (Huber, 2020).

Moreover, the requirement for healthcare providers to report information about the diagnosis and treatment of gender-related conditions to the Ohio Department of Health (ODH) raises significant concerns about client confidentiality and HIPAA protected information. HIPAA strictly regulates the disclosure of Protected Health Information (PHI), which includes any information that can be used to identify an individual's health status or healthcare provision. HIPAA mandates that healthcare providers maintain the confidentiality of their clients' medical information and requires healthcare providers to implement appropriate safeguards to protect the privacy and security of PHI. Transmitting treatment plans and client service information to the government introduces additional risks of unauthorized access, interception, or data breaches, especially if the process lacks adequate security measures to protect the information. HIPAA generally restricts the use or disclosure of PHI for purposes other than treatment, payment, or healthcare operations without the explicit consent of the individual. Requiring providers to submit detailed treatment plans and client service information may involve disclosing PHI without the explicit consent of the client, potentially exposing sensitive health-related details to unauthorized individuals within government agencies or beyond. This action could also involve the use of PHI beyond permissible purposes, all of which could violate HIPAA regulations. It remains unclear how this information will be collected, reviewed, or disposed of. Allowing this rule to proceed will undoubtedly raise concerns about HIPAA compliance and the management of PHI.

Additionally, the requirement for healthcare providers to report to the ODH within thirty days of a “diagnosis of a gender-related condition” will create administrative burden for providers, potentially exacerbating the shortage of competent healthcare providers in Ohio (The Ohio Council of Behavioral Health & Family Services Providers, 2021; Alexander, 2022). A shortage of healthcare providers limits the capacity of mental health businesses to meet the needs of clients seeking support. With fewer professionals available, mental health businesses may struggle to provide timely appointments and comprehensive care, potentially leading to longer wait times for clients and decreased client satisfaction. Mental health businesses that cannot offer gender-affirming care due to a lack of qualified providers may lose their competitive edge in the

market. Clients seeking gender-affirming services may choose businesses that specialize in these areas or travel to other regions where such services are more readily available, resulting in a loss of clientele for businesses that cannot meet these needs.

OCA and SAIGEO are committed to raising awareness and understanding of LGBTQIA+ issues within the counseling profession. We staunchly believe that these rules will create unnecessary barriers to care for Ohioans (Barbee, Deal, & Gonzales, 2022; Hughes et al., 2021). We remain steadfast in our commitment to advocate for the protection of confidentiality rights and ensuring equitable access to quality healthcare for all individuals, regardless of gender identity or expression. In conclusion, OCA and SAIGEO urge JCARR to reject the proposed Gender Transition Quality Standards and Reporting rules.

Statement written by Mariah Payne, MA, LPCC, SAIGEO 2023-2024 GRC Liaison

Reviewed by Kelsey Scanlan, PhD, LPCC-S, SAIGEO 2023-2024 Regional Representative (Central)/IT Representative and Emmett Drugan, M.Ed., LPCC, CDCA, SAIGEO 2023-2024 GRC Liaison

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TO: Joint Committee on Agency Rule Review (JCARR)
FROM: Sean McCann, Policy Strategist, ACLU of Ohio
DATE: April 15, 2024
RE: Opposition to proposed rule 3701-3-17

Chair Gavarone, Vice Chair Callender, and members of the Joint Committee on Agency Rule Review, thank you for the opportunity to provide testimony today. My name is Sean McCann, and I serve as a Policy Strategist for the American Civil Liberties Union (ACLU) of Ohio. I am testifying today in opposition to Ohio Department of Health (ODH) proposed rule 3701-3-17. Accordingly, we urge JCARR to recommend the invalidation of this rule.

I will begin by identifying the JCARR prongs we believe the rule violates. Then, I will provide our justification for these arguments.

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Firstly, ODH proposed rule 3701-3-17 both exceeds the scope of the agency's statutory authority and conflicts with the legislative intent of the statute under which it is proposed. Additionally, the business impact analysis falls short of demonstrating that the regulatory intent of the rule justifies its adverse impact on businesses.

Proposed rule 3701-3-17's cites Ohio Revised Code (ORC) section 3701.23 as providing statutory authority. Given that the plain language of the statute deals entirely with reporting contagious or infectious diseases, illnesses, health conditions, or unusual infectious agents or biological toxins, it is unclear how this statute can be used to justify regulations regarding gender dysphoria. 3701.23(B)(1-4) all name specific infectious diseases on which local health authorities must report information to ODH; (5) names "other contagious or infectious diseases, illnesses, health conditions, or unusual infectious agents or biological toxins posing a risk of human fatality or disability" as specified by the director of ODH. Clearly, gender dysphoria does not fall under any of those categories. For this reason, proposed rule 3701-3-17 violates the first JCARR prong by exceeding ODH's statutory authority as granted by ORC 3701.23.

Further, ORC 3701.23 was enacted under Amended Substitute House Bill (HB) 6 of the 125th General Assembly, which modified the powers and duties of the Department of Health "relative to bioterrorism and other public health matters," not relative to any general health condition. The law clearly was intended to address the preparedness of state and local public health authorities to respond to public health emergencies like epidemics, pandemics, mass casualties, and bioterrorism events. The incidence of gender dysphoria in individual patients does not fall under the purview of this statute. For this reason, 3701-3-17 also violates the second listed JCARR prong by conflicting with the legislative intent of the statute under which it was proposed.

Further, ODH's business impact analysis does not adequately address the adverse impact of the proposed rule. ODH provided only surface-level detail on the amount of stakeholder engagement they conducted prior to drafting and revising their rules. In response to question 10 of the Common Sense Initiative's (CSI's) Business Impact Analysis, which asks what input stakeholders provided and how that input affected the draft regulation, ODH staff responded with the following: "ODH staff participated in meetings with hospitals and physicians providing care for gender-related conditions and with children (and their parents) who have received such care." Staff responded to question 9, which asks the agency to list the stakeholders included in the development or review of the draft regulation, with "N/A."

From these answers, it is impossible to get a complete picture of how ODH conducted stakeholder outreach and to what extent staff accounted for stakeholder feedback from a variety of providers' perspectives, among other issues. For example, what works for a large hospital system might not work for a smaller health care facility that does not have the resources of the large hospital system. With that example in mind, we simply do not know whether all providers will be able to bear the burden and costs of these rules.

Additionally, while the rule at least attempts to protect patients' privacy (arguably inadequately), that protection is not extended to providers. This, too, represents a significant adverse impact. Given the increasing politicization of gender-affirming care, we have serious concerns that, once this data is made available in the manner the rule prescribes, individuals who would seek to target providers for harassment (or worse) will be able to identify them. Patients, their families, and their providers must be able to make the decisions that are best for the patient's health without fear that their personal information will be exposed and used in this way.

Thus, ODH failed to demonstrate clearly that the regulatory intent of the proposed regulations justifies the adverse impact on all impacted businesses.

Again, for these reasons, we urge this body to recommend that the Ohio General Assembly invalidate proposed rule 3701-3-17. At this time, I would be happy to address any questions committee members may have.

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Written-only Testimony for the JCARR Hearing on 4/15/2024
Submitted by: Stephanie L. Ash, MSW, LSW, Esq. (she/her), steph@stephanieash.net

RE: Ohio Department of Health (ODH) revised Rules 3701-3-17, 3701-59-06 and 3701-83-60, with additional commentary about ODH revised Rules 3701-59-07 and 3701-83-61 and Ohio Department of Mental Health & Addiction Services (OMHAS) revised Rules 5122-14-12.1 and 5122-26-19

Although JCARR is no longer scheduled to hear testimony about ODH revised Rules 3701-59-07 and 3701-83-61 and OMHAS revised Rules 5122-14-12.1 and 5122-26-19 on April 15, 2024, all the proposed Rules regarding gender transition services must be considered in relation to each other and in relation to Ohio Revised Code (ORC) Chapter 3129 since patients and Health Care Providers ("HCPs") may find themselves in each contemplated setting. Analysis for all revised gender transition Rules has been included for JCARR's consideration.

Ohio Revised Code §106.021 sets forth 8 prongs the Joint Committee on Agency Rule Review (JCARR) will consider when evaluating revised proposed Rules. The revised gender transition Rules from OMHAS and ODH do not sufficiently meet 5 out of the 8 prongs, thus JCARR should recommend to the Ohio Senate and House of Representatives the adoption of a concurrent resolution to invalidate the revised proposed rules in their entirety.

OMHAS and ODH fail to meet the following prongs:

§106.021(B) The proposed rule or revised proposed rule conflicts with the legislative intent of the statute under which it was proposed.

Revised ODH Rule **3701-3-17** is in the section of the Ohio Administrative Code (OAC) for reporting "Communicable Diseases" which are dangerous to public health, including but not limited to: plague, rabies, Ebola, leprosy, syphilis, and tuberculosis. Being trans or gender diverse is NOT a communicable disease and it is unacceptable Rulemakers chose to put this revised Rule in that section and further perpetuate stigma. The legislative intent of OAC Chapter 3701-3 is to track communicable disease and illness that could impact the public's health (see OAC 3701-3-02), not create a surveillance system to track and harass individual trans and gender diverse patients trying to access evidence-based gender-affirming care.

§106.021(C) The proposed rule or revised proposed rule conflicts with another proposed or existing rule.

The ODH and OMHAS gender transition Rules not only conflict with each other, but provisions within the same agency's revised Rules are incompatible and conflict with existing Rules in the OAC.

- **ODH revised Rule 3701-3-17(C)(1)(c)** requires HCPs to disclose "specific information about the nature of any diagnosis." Disclosure of this confidential Protected Health Information violates the National Association of Social Workers (NASW) Code of Ethics Standard 1.07(c) (incorporated

into the OAC via Rule 4757-5-01(D)) which explains "social workers should protect the confidentiality of all information obtained in the course of professional service."

- **ODH revised Rule 3701-3-17(C)(1)(d)** will "lead to the disclosure of individual identities" since the population being targeted by these Rules is so small it may be possible to combine demographic information with "specific information about the nature of any diagnosis" to reveal an individual's identity. The data will not be truly anonymized and creates a safety and surveillance risk for all trans and gender diverse Ohioans, which is against confidentiality requirements in the NASW Code of Ethics Standard 1.07(c) incorporated into OAC Rule 4757-5-01(D).
- **ODH revised Rule 3701-3-17(C)(2)** may exclude "patient names, addresses, or other personally identifiable information," but this provision still fails to protect the small population of trans and gender diverse Ohioans from identification given the other reporting requirements. This violates confidentiality requirements in the NASW Code of Ethics Standard 1.07(c) incorporated into OAC Rule 4757-5-01(D).
- **ODH revised Rule 3701-3-17(D)** excludes "any information that would lead to the disclosure of individual identities" from aggregate data, but this is not enough given the totality of the reporting requirements. Data will not be truly anonymized and creates a safety and surveillance risk for the small population of trans and gender diverse Ohioans. This violates confidentiality requirements in the NASW Code of Ethics Standard 1.07(c) incorporated into OAC Rule 4757-5-01(D).
- **ODH revised Rules 3701-59-07(B)(1)-(B)(2) and 3701-83-61(B)(1)-(B)(2)** conflict with OMHAS revised Rule 5122-26-19(B)(1)-(B)(2). The OMHAS Rule requires a referral for "in-person, direct provision of services" to a mental health professional and board-certified endocrinologist, but this is not required in these ODH revised Rules or in revised OMHAS Rule 5122-14-12.1(C)(1). This will create confusion for HCPs.
- **ODH revised Rules 3701-59-07(B)(3) and 3701-83-61(B)(3)** requires hospitals or health care facilities to have "available for inspection upon request of the Department of Health an institutional, programmatic level, written, comprehensive, multidisciplinary care plan" and sets forth what must be included. This is not the same care plan requirement in revised OMHAS Rule 5122-26-19(B)(3) and may require more information than is required for treatment planning under OAC 5122-27-03, incorporated into revised OMHAS Rule 5122-26-19(B)(4). This will cause confusion for HCPs. Also, like the other required reporting requirements in these revised Rules, they require social workers to act against the NASW Code of Ethics incorporated into OAC 4757-5-01(D) and disclose confidential information.
- **ODH revised Rules 3701-59-07(B)(3)(a) and 3701-83-61(B)(3)(a)** conflict with OMHAS requirements and will cause confusion for HCPs. The ODH Rules require documentation of a "demonstrably active role in the minor individual's care" and this conflicts with what is required in revised OMHAS Rules 5122-26-19(B)(3)(a) and 5122-14-12.1(C)(3)(a). Furthermore, revised OMHAS Rule 5122-26-19(B)(1)-(2) requires referrals for "in-person, direct provision of services," but revised OMHAS Rule 5122-14-12.1(C)(2) does not mention anything about in-person care. ODH revised Rules 3701-59-07(B)(3)(a) and 3701-83-61(B)(3)(a) just require that providers have "availability for in-person care and consultation when necessary." These conflicting requirements for the same patients and providers across healthcare settings will create confusion for HCPs.

- **ODH revised Rules 3701-59-07(B)(3)(b) and 3701-83-61(B)(3)(b)** requires "sufficient informed consent for both minor individuals receiving care and the minor individual's parents." Minors cannot give informed consent and providers will not be able to comply with this Rule as written or provide the resulting gender affirming care. Furthermore, these revised Rules conflict with ORC §3129.03(A), which only requires informed consent from one parent, legal custodian, or guardian for mental health professionals.

ODH revised Rules 3701-59-07 and 3701-83-61 and OMHAS revised Rules 5122-14-12.1 and 5122-26-19 conflict with the requirements of ORC §3129.02(A)(2) which prohibits a physician from prescribing "a cross-sex hormone or puberty-blocking drug for a minor individual for the purpose of assisting the minor individual with gender transition." Now that the revised ODH and OMHAS Rules no longer apply to adults ages 18-21, these revised Rules are against Ohio law and unnecessary.

ODH revised Rules 3701-59-06 and 3701-83-60 prohibits "gender reassignment surgery or genital gender reassignment surgery," but this is redundant and is already prohibited by ORC §3129.02(A)(1).

§106.021(E) The agency has failed to prepare a complete and accurate rule summary and fiscal analysis of the proposed rule or revised proposed rule as required by section 106.024 of the Revised Code.

Each revised Rule from ODH and OMHAS has an accompanying Rule Summary and Fiscal Analysis (RSFA) which incorporates a Business Impact Analysis from the Common Sense Initiative (Section III of each RSFA).

OMHAS has failed to prepare a complete and accurate RSFA for revised Rule 5122-26-19 and is in violation of the requirements of ORC §106.021(E). The Business Impact Analysis incorporated into Section III of the RSFA contemplates the impact for a nonexistent Rule 5122-16-19 as indicated on page 1 of the Analysis.

ODH and OMHAS have both failed to prepare a complete and accurate RSFA of the revised Rules as required by ORC §106.024 for two reasons. First, each RSFA answers "No" to the Question 18(D) which asks: "Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies?" This negative answer by ODH and OMHAS is demonstrably false as further outlined below. Second, the questions from CSI incorporated in Section III of each RSFA are incomplete and do not meet the requirements of ORC §106.021(E) as demonstrated by the following:

- The Business Impact Analysis for **ODH revised Rule 3701-3-17** does not meet the requirements of ORC §106.024(B)(6) as it does not provide an accurate "summary of the estimated cost of compliance with the rule to all directly affected persons." The Business Impact Analysis for ODH revised Rule 3701-3-17 provides: "There are no fees, penalties will only exist in cases of non-compliance, staff time will be required for submission of reports." This Analysis fails to take into consideration the considerable expense to build the contemplated reporting process which does not currently exist and is not feasible. Hospitals, health care facilities, psychiatric hospitals, and community behavioral health providers may be forced to divert scarce resources away from

all patients in order to comply with the burdensome reporting requirements in ODH revised Rule 3701-3-17 and this considerable impact was not considered for the Analysis. The Business Impact Analysis for ODH revised Rules 3701-59-06 and 3701-83-60 suffer from the same defect.

- Similarly, the Business Impact Analysis for **ODH revised Rules 3701-59-07 and 3701-83-61** do not meet the requirements of ORC §106.024(B)(6) as they also do not provide an accurate "summary of the estimated cost of compliance with the rule to all directly affected persons." The Business Impact Analysis for ODH revised Rules 3701-59-07 and 3701-83-61 are identical and provide: "There are no fees, penalties will only exist in cases of non-compliance, staff time will be required for submission of reports. Required care plans and staff should not add additional costs because we have been told these resources are already in place. However, providers may have increased cost if they hire or contract with additional staff to ensure compliance with the multi-disciplinary quality of care components." This Analysis fails to consider the impact to hospitals and health care facilities as there are not enough "board-certified endocrinologists" available to provide gender transition services and take over patients from current doctors and nurse practitioners who are competently providing gender-affirming care within the scope of their practice, but who are not board-certified endocrinologists. This unreasonable restriction on care will create barriers to care for all patients who will experience longer wait times to see providers and less choice as providers leave practice due to risk of liability, harassment by the State and hateful individuals and groups, and stress from unsustainable patient loads. Further, both revised Rules require hospitals or health care facilities to have "available for inspection upon request of the Department of Health an institutional, programmatic level, written, comprehensive, multidisciplinary care plan" and sets forth what must be included. This is not the same care plan requirement in revised OMHAS Rule 5122-26-19(B)(3) and may require more information than is required for treatment planning under OAC 5122-27-03, incorporated into revised OMHAS Rule 5122-26-19(B)(4). This will cause confusion for HCPs. Finally, the proposed inspection infrastructure and creation of the described care plan raises many new logistical, legal, and practical issues which were not contemplated in the Analysis. Who will prepare these care plans? Is there a limit on how often the Department of Health will request these "comprehensive" reports? How long will hospitals have to share this plan? These questions, and accompanying expenses, were not analyzed leaving the Analysis incomplete and noncompliant with ORC §106.024.
- ODH did not meet the requirements in ORC §106.024(B) for the Business Impact Analysis of **revised Rules 3701-3-17, 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61** as their answers to critical questions were insufficient and demonstrated a lack of adequate analysis. For example:
    - The answer to Question 11 (What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?) for all of the ODH revised Rules reads: "Medical expertise of ODH physicians." Anonymous advice from an undisclosed amount of physicians from unknown areas of expertise is not scientific data.
    - The answer to Question 13 (What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?) for ODH revised Rules 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61 reads: "No duplicate regulation exists." This is false as ORC §3129(A)(1) and (A)(2) prohibit surgeries or new hormone

therapies and not mentioning this duplication of regulations demonstrates a lack of due diligence when preparing the Analysis.

- The Business and Impact Analysis for **OMHAS revised Rule 5122-14-12.1** did not meet the requirements of ORC §106.024(B)(6) as it also did not provide an accurate "summary of the estimated cost of compliance with the rule to all directly affected persons." The Business Impact Analysis mentions that "there may be administrative costs related to annually demonstrating compliance with the standards specified in the rules," but fails to consider the impact to psychiatric hospitals to implement and follow the Rule. First, there are not enough "board-certified endocrinologists" available to provide gender transition services and take over patients from current doctors and nurse practitioners who are competently providing gender-affirming care within the scope of their practice, but who are not board-certified endocrinologists. This unreasonable restriction on care will create barriers to care for all patients who will experience longer wait times to see providers and less choice as providers leave practice due to risk of liability, harassment by the State and hateful individuals and groups, and stress from unsustainable patient loads. Also, the reporting requirements of ODH revised Rule 3701-3-17 is incorporated into 5122-14-12.1(F) and there is no analysis of costs for meeting the considerable expense to build the contemplated reporting process which does not currently exist and is not feasible.
- If OMHAS intended for the Business Impact Analysis for a nonexistent Rule 5122-16-19 to apply to **revised Rule 5122-26-19**, then this also did not meet the requirements of ORC §106.024(B)(6) because it did not provide an accurate "summary of the estimated cost of compliance with the rule to all directly affected persons." The Business Impact Analysis for nonexistent Rule 5122-16-19/revised Rule 5122-26-19 provides: "there may be administrative costs related to annually demonstrating compliance with the standards specified in the rules." As explained for the other revised Rules, the Analysis fails to consider the impact to community behavioral health providers to implement and follow the Rule given the lack of "board-certified endocrinologists" and the expected costs to create and maintain a reporting structure which does not currently exist as contemplated by ODH revised Rule 3701-3-17 and incorporated into 5122-26-19(E). Further, the requirements in OMHAS Rule 5122-26-19(B)(3) may require more information than is required for treatment planning under OAC 5122-27-03, incorporated into revised OMHAS Rule 5122-26-19(B)(4). This additional information required for treatment planning will add additional expenses which were not analyzed in the Business Impact Analysis.

As demonstrated, the RSFA for each revised Rule was not complete and accurate as required by this section because it did not contemplate or analyze the very likely reduction of revenue or increase in expenses each entity regulated by the revised Rules will experience.

§106.021(F) The agency has failed to demonstrate through the business impact analysis, recommendations from the common sense initiative office, and the memorandum of response that the regulatory intent of the proposed rule or revised proposed rule justifies its adverse impact on businesses in this state.

ODH and OMHAS have both failed to demonstrate the revised Rules justify their adverse impact on hospitals, health care facilities, and community behavioral health providers in Ohio as thoroughly

explained in the previous analysis of noncompliance with ORC §106.021(E). The Business Impact Analysis for all ODH and OMHAS revised Rules do not contemplate the significant expenses and expected impacts related to creating artificial barriers to accessing evidence-based gender-affirming care. Further, having to build a reporting and care plan infrastructure which does not currently exist and which has differing requirements amongst the revised Rules was not contemplated or adequately analyzed.

§106.021(G) If the state agency is subject to sections 121.95, 121.951, 121.952, and 121.953 of the Revised Code, the agency has failed to justify the proposed adoption, amendment, or rescission of a rule containing a regulatory restriction.

ODH and OMHAS are state agencies as defined in ORC §121.02(G) (lists ODH) and ORC §121.02(K) (lists OMHAS) and subject to the ORC sections listed in ORC §106.021(G).

The Rule Summary and Fiscal Analysis (RSFA), and incorporated Business Impact Analysis in Section III of each RSFA, provided for **ODH revised Rules 3701-3-17, 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61** has failed to justify the proposed adoption of these Rules. Reasonably foreseeable expenses and impacts were not analyzed and no scientific data was consulted. The "medical expertise of ODH physicians" mentioned is not scientific evidence as this source is unable to be verified, scrutinized, or evaluated because the physicians are anonymous, no information was provided as to how many ODH physicians were consulted, and their expertise is unknown. ODH has not adequately justified why this new regulation is needed or advisable given the regulatory limits imposed by ORC §121.95, §121.951, §121.952, and §121.953.

Further, **OMHAS revised Rules 5122-14.12.1 and 5122-26-19 and ODH revised Rules 3701-59-06, 3701-59-07, 3701-83-60, and 3701-83-61** conflict with ORC §3129.02(A)(1) and (A)(2) as they authorize action which is against Ohio law. Neither agency has mentioned or justified why these Rules are necessary given the enactment of ORC §3129.02 (A)(1) and (A)(2) and thus cannot meet the requirements of ORC §121.95, §121.951, §121.952, and §121.953.

As shown, the revised proposed gender transition Rules from OMHAS and ODH do not sufficiently meet 5 out of the 8 prongs as outlined in ORC §106.021. Therefore, it is respectfully requested that JCARR recommend to the Ohio Senate and House of Representatives the adoption of a concurrent resolution to invalidate the revised proposed rules in their entirety.

Ohio Department of Health
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TransOhio
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March 21, 2024

Testimony in Opposition to Gender Transition Rules

In response to the passage of HB68, the (un)SAFE Act, as well as the administrative rules proposed through the Ohio Departments of Health, TransOhio created an Emergency Fund to help those community members most directly affected relocate or access appropriate gender-affirming health care. In the first month, we distributed over $10,000.00 directly to families of transgender youth, assisted over 200 trans and nonbinary adults in establishing care outside of Ohio, and connected over 300 individuals to resources and community. Additionally, TransOhio also launched a peer support Warm Line to address the current and emerging mental health crisis. In less than 90 days, we received over 60 crisis calls. Our volunteers have addressed dozens of nonemergency calls, have provided comfort and community, and connected people to vital resources. Nearly 33% (⅓) of all of our calls have been from cisgender current providers of (or open to treating) transgender patients. These proposed rules are causing confusion, anxiety, and fear in cisgender people, too. We continue to hear in the media that these rules are “common sense” and “will only affect a tiny portion of the population.” Both assertions are categorically false.

Founded in 2005, TransOhio is a nonprofit organization dedicated to supporting the trans and allied communities in Ohio. TransOhio works to promote transgender rights, raise awareness about transgender issues, and provide resources and support to transgender individuals and their allies. TransOhio vehemently opposes the proposed “gender transition rules.” The trans community has suffered harm at the mere introduction of these rules. We’ve heard countless stories from individuals and families who have been told by health care professionals that they would have to stop, delay, or rush into establishing care to conform to these rules (which aren’t even in place).

TransOhio again urges the Ohio Department of Health to not adopt any rules restricting gender-affirming health care to transgender patients. We ask that you fully rescind and withdraw proposed rules O.A.C. 3701-3-17, O.A.C. 3701-59-06, O.A.C. 3701-59-07, O.A.C. 37-1-83-60, and O.A.C. 37-1-83-61 in their entirety.

3701-3-17 Gender Transition Quality Standards Reporting

Violation of Privacy Rights:
Requirements imposed by the rule could lead to the unnecessary disclosure of sensitive private medical information, undermining patient confidentiality and autonomy. The required reporting also may also put both patients and providers in jeopardy of harassment by anti-trans extremists, especially considering members of the transgender community have already been receiving death threats and certain hospital systems have already received bomb threats simply for treating transgender patients.

Unwarranted Safety Risks:
Disclosure of personal information about transgender individuals to the Ohio General Assembly could potentially put them (and their providers) at risk of targeted violence or harassment from individuals or groups politically opposed to gender-affirming care.

Loss of Trust in Healthcare System:
Patients may fear or delay seeking necessary healthcare services if they believe their personal information will be shared without their consent, leading to an exacerbation of health issues. This loss of trust will inevitably compromise patient safety and well-being.

3701-59-07 & 37-1-83-61 Quality Standards for Gender Transition Treatment

Violation of Anti-Discrimination Laws:
The rule may conflict with anti-discrimination laws, including federal laws, that protect individuals from discrimination based on sex or gender identity or expression. Denying individuals access to certain health care services based solely on their gender identity is clear discrimination.

Restriction of Medical Practice:
The rule restricts the ability of health care providers to practice medicine according to best practices and accepted standards of care. Healthcare professionals need to have the autonomy to determine the appropriate course of treatment for their patients based on medical evidence and professional experience and judgments.

Interference with Doctor-Patient Relationship:
By imposing strict standards on the provision of gender transition services, the rule interferes with the doctor-patient relationship. Medical decisions should be made based on individual patient needs and in consultation with qualified health care professionals, not dictated by government regulations.

Violation of Patient Rights:
The rule infringes upon the rights of transgender individuals to access necessary health care services. Denying certain gender transition services based on arbitrary standards is discriminatory and a violation of patients' rights to receive medically necessary care.

3701-59-06 & 37-1-83-61 Emergency Executive Orders

Violation of Equal Protection:
By imposing additional requirements for gender transition services compared to the same or similar medical treatments for cisgender patients, the rule violates the principle of equal protection under the law, treating transgender individuals differently solely based on their gender identity.

Inequitable Access to Care:
Implementing stringent standards for gender transition services could create unnecessary barriers to accessing essential healthcare for transgender individuals, potentially resulting in harm to their physical and mental well-being. This may contravene the principle of ensuring equal access to healthcare services for all individuals.

Interference with Parental Rights:
This rule restricts the rights of parents and guardians to make informed medical decisions regarding their children with their trusted health care providers and puts that power into the hands of administrators and politicians who have no right to interfere.

No Emergency:
Transgender children and adolescents have been receiving gender-affirming care in Ohio for decades without causing any widespread harm or crisis. To suddenly declare an emergency and restrict their access to necessary medical treatment is not only unnecessary but also deeply harmful. Furthermore, the inclusion of a legacy (or "grandfather") clause within the rule implicitly acknowledges that gender-affirming care is not inherently harmful.

Together, the Rules are Unnecessary, Unreasonable, Unlawful, and Unethical

These proposed "gender transition rules" are *unnecessary, unreasonable, unlawful*, and *unethical*. According to the U.S. Trans Survey, nearly one-third (33%) of trans patients has at least one negative interaction or experience while attempting to access gender-affirming care, including being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to explain/teach the provider about transgender people in order to get appropriate care. An estimated twenty-six percent (26%) of trans patients avoid or delay necessary medical treatment due to fear of being denied care or fear of mistreatment due solely to their transgender status. Additionally, thirty-three percent (33%) can not afford basic medical care. A staggering fifteen percent (15%) of respondents to that survey reported that a medical professional tried to stop them from transitioning. These rules in no way remedy this inequity, but instead perpetuates harmful stereotypes and excessive "gatekeeping."

Ohio has the right–and obligation–to enact laws, rules, and regulations to promote the health, safety, and welfare of its citizens. These rules do not accomplish the same. The rules promote discrimination and inequality. Simply put, we do not believe that the state has a compelling interest in restricting a provider's ability to practice gender-affirming health care or prohibiting a trans patient from receiving appropriate gender-affirming treatment.

Unnecessary

Current Landscape of Care:
Many transgender youth already face barriers to accessing appropriate, competent care such as lack of knowledgeable providers, insurance coverage limitations, and discrimination, particularly in rural and more conservative areas, and especially if the patient holds multiple minority identities.

History of Care:
Gender-affirming care has openly been provided for trans patients in the United States for decades, and Ohio has become world-renowned for our competent and compassionate care. Dr. Richard D. Murray performed gender-affirming surgeries in Youngstown, Ohio, as early as 1972. The area of transgender medicine is not novel or experimental. Gender-affirming care has a long history of successfully treating and/or managing gender dysphoria.

Inappropriate Government Intrusion and Overreach:
Limiting access to gender-affirming care is infringing upon an individual's right to make decisions about their own well-being. Additionally, the reporting requirement is a severe intrusion into private lives by the government for no clear purpose other than curiosity.

Unreasonable

Excessive Requirements:
Requiring mental health evaluations and counseling over a period of six (6) months places an undue burden on transgender minors seeking gender transition services, as well as their providers. This lengthy process may delay access to necessary care, exacerbating dysphoria and mental health concerns.

Limited Access to Qualified Providers:
Mandating specific qualifications for health care providers, such as board-certified endocrinologists and mental health professionals with experience treating minors of a particular age, may restrict access to care in areas with fewer qualified professionals, particularly in rural and under-served communities.

Intrusive Documentation Requirements:
Requiring detailed documentation of mental health evaluations and treatment plans compromises patient privacy and confidentiality. Trans minors may feel uncomfortable disclosing personal information, potentially hindering appropriate care or deterring them from seeking care altogether.

Undermining Patient Autonomy:
Requiring minors and their guardians to undergo a detailed informed consent process, including information about detransitioning, may undermine patient autonomy and decision-making. It could imply doubt or skepticism about the validity of a minor's gender identity, leading to psychological harm. Such a requirement also sets the tone that detransition is an ultimate goal, not overall patient health and wellness.
Potential for Harmful Delay:
The rule's emphasis on prolonged evaluation and counseling periods before initiating treatment will harm patients by delaying access to care. Studies have shown that early intervention and affirmation of gender identity are crucial for mitigating mental health risks and improving overall well-being.

Unlawful

U.S. Constitution:
These rules will fail a constitutionality test under the U.S. Constitution's Equal Protection Clause, as well as the First and Fourth Amendments.

Ohio Constitution:
These rules will fail a constitutionality test under the state constitution's rights to privacy, Equal Protection, and the new voter-approved right to reproductive health.

State Laws:
These rules may violate regional anti-discrimination laws in Ohio.

Federal Law:
These rules violate the Affordable Care Act and the Health Insurance Portability and Accountability Act.

Public Policy:
These rules directly conflict with modern behavioral and physical health ethics and values, as well as current standards of care, resulting in increased legal and licensure liabilities. Professionals will not be able to ethically practice in our state if these

proposed rules become Ohio law, resulting in even more restricted availability of knowledgeable providers to patients who are already underserved.

Individual Policies:
These rules will frustrate existing and ongoing contracts within the medical field and will force health care systems to abandon their non-discrimination policies and guarantees of exceptional care.

Unethical

Cruel:
Denying care to any particular group of people is cruel in and of itself, especially as Ohio has some of the best health care in the country.

Stigmatization:
Requiring a detransition plan may contribute to the stigmatization of transgender individuals and perpetuate harmful stereotypes. It could send a message that detransitioning is the norm or preferred outcome, disregarding the diverse experiences and identities within the transgender community and potentially discriminating against those who choose to transition.

No Valid Legal Defense:
Ohio residents will ultimately be left with the burden of financing futile legal defenses to these unconstitutional laws, wasting taxpayer dollars as well as the valuable time of the court.

Conclusion

These rules do not improve or promote care for trans patients. TransOhio urges the Ohio Department of Health to rescind and withdrawal proposed rules O.A.C. 3701-3-17, O.A.C. 3701-59-07, and O.A.C. 37-1-83-61, as well as proposed rules O.A.C. 3701-59-06 and O.A.C. 37-1-83-61, which were filed as an emergency pursuant to Governor DeWine's executive order for the same reasons. If rules must be adopted, we ask that you seriously review and adopt Model Rules (attached, Appendix A-B).

Respectfully submitted,

James Knapp, Esq.
Board of Directors, Chair
TransOhio

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About TransOhio:

TransOhio is Ohio's first and largest state-wide trans-focused equality group. Founded in 2005, TransOhio is a 501(C)(3) nonprofit organization comprised entirely of

volunteers dedicated to education, advocacy, support, and providing community to trans people and their allies.

For more information, please visit https://transohio.org

Appendix A: Model Definitions

(1) “Sex” means one's assigned sex at birth based on physical structures, reproductive characteristics, and traditional assumptions of male and female bodies. While most people are assigned male or female at birth based on a visual inspection of their physical anatomy, sex characteristics exist on a spectrum, and many individuals' combination of physical anatomy and genetics do not fit neatly into binary categories.

(2) “Gender-affirming hormonal treatment,” also known as “hormone replacement therapy (HRT),” means bioidentical hormonal supplements like testosterone, estrogen, or progesterone given to an individual to better align one’s secondary sex characteristics with their gender identity.

(3) “Gender-affirmation surgery” means any surgical procedure that alters a person’s physical characteristics to better align their body with their gender identity.

(4) “Gender transition” means social, physical, and/or legal changes to reduce incongruence between one’s sex assigned at birth and gender identity.

(5) “Gender affirmation services” means any medical, psychological, and social support services provided for the purpose of affirming one’s gender identity.

(6) "Gender identity" means one's internal and personal sense of their own gender; as man, woman, both, or neither. Gender identity exists on a spectrum and can be in congruence with, or contrast, one's sex assigned at birth.

(7) “Health care provider” means a physician authorized under Chapter 4731 of the Revised Code to practice medicine or surgery.

(8) “Health care facility” means a health care facility licensed pursuant to Section 3702.30 of the Revised Code.

(9) “Detransition” means the process of halting or reversing gender affirming services and gender transition because the individual self-identifies solely as their sex assigned at birth and not another gender identity.

Appendix B: Model Rules

3701-3-17 Reporting Gender-Related Condition Diagnoses and Gender Transition Care

(A) *See model definitions (provided in Appendix A).*

(B) A health care provider may report to the Department of Health annually any:
- (1) initiation of gender affirming services including:
  - (a) gender-affirming hormonal treatment, or
  - (b) gender-affirmation surgery,
- (2) cessation of gender affirming treatment and the reason for such cessation; or
- (3) treatment plan for the purpose of detransitioning, if applicable, including:
  - (a) any mental health counseling provided or suggested, including documented refusal of such services,
  - (b) medication management, and
  - (c) the patient's specific health care needs and health management goals.

(C) A health care provider may submit reports identified in paragraph (B) of this rule using forms and formats approved by the director of health.
- (1) At minimum, the forms and formats approved by the director of health will include:
  - (a) age range of the individual receiving gender affirming services;
  - (b) sex of the individual receiving gender affirming services;
  - (c) an estimation of how long the individual sought gender affirming services before receiving a diagnosis or treatment; and
  - (d) general, non-personally identifiable information concerning relevant treatment and services provided to the individual.

(D) Information reported pursuant to this rule is protected health information subject to section 3701.17 of the Revised Code.

(E) This data shall only be used for the purpose of improving gender-affirming care for Ohioans and shall not be used to the detriment of any communities or to target any individuals or health care facilities providing gender-affirming care.

Model Form

This form is confidential – no identifying information about individuals who obtain gender-affirming services is collected except the medical record number. Statistics are summarized in an annual "Gender Transition Services in Ohio" report series. Annual report tables contain demographic and statistical information related to sex and age range at the county level.

Confidential Gender Transition Services Report
Ohio Department of Health
(Pursuant to O.A.C. 3701-3-17)

Health Care Facility:	Zip Code of Facility:

General Information

Patient Medical Record Number:	Patient State and County of Residence:
Gender-affirming services:	Age range of Patient:
☐ Initiated ☐ Continued / Resumed ☐ Halted ☐ Patient has stated cessation of treatment is due to a desire to detransition	☐ 0-18 ☐ 19-25 ☐ 26-40 ☐ 41-64 ☐ 65-84 ☐ 85+
Treatment Plan for Detransition (if applicable)	Physician Initials:
☐ Mental health counseling was discussed / provided ☐ Medication management was discussed ☐ Patient's specific health care needs and goals were discussed ☐ Patient refused counseling / treatment	_____ By initialing I certify that I reviewed the patient's medical records and all information contained in this form is true and accurate

Comments

3701-59-07 Quality Standards for Gender Transition Treatment at Hospitals and Health Care Facilities

(A) *See model definitions (provided in Appendix A).*

(B) A provider may provide gender affirmation services after:

(1) The provider has a written, comprehensive, multi-disciplinary care plan that includes the following components:

(a) The specific services to be provided,
(b) Acquisition of informed consent from the patient and, if the patient is a minor, the patient's parent or legal guardian. Such informed consent is revocable and should include:

(1) relevant information, provided accurately and sensitively, in keeping with the patient's preferences for receiving medical information, including
(a) description of diagnosis;
(b) the nature and purpose of recommended interventions;
(c) the expected benefits and risks of all options, including forgoing or ceasing treatment; and
(d) a list of side effects, risks, and possible consequences of treatment.

(c) An acknowledgement that what is considered appropriate gender-related care is specific to each patient; and that, as such, decisions made concerning gender-related care should be patient-lead with the advice and guidance from providers.

Appendix C: TransOhio Public Comment February 5, 2024

On behalf of the greater transgender, nonbinary, intersex, and gender nonconforming communities here in Ohio, **TransOhio humbly urges the Ohio Department of Health to not adopt and to rescind proposed rules O.A.C. 3701-3-17, O.A.C. 3701-59-07, and O.A.C. 37-1-83-61 in their entirety.**

Ohio Administrative Code should not discriminate. These proposed rules are not necessary or appropriate, and they will undoubtedly cause more harm than good. While the intentions behind the rules might have been a sincere desire to improve healthcare for trans patients, the outcome—intentional or otherwise—is a *de facto* ban on gender-affirming physical and mental health care for a large portion of trans people seeking care in Ohio, including residents of other states. This directly conflicts with modern behavioral and physical health ethics and values, as well as current standards of care, resulting in increased legal and licensure liabilities. Professionals will not be able to ethically practice in our state if these proposed rules become Ohio law, resulting in even more restricted availability of knowledgeable providers to patients who are already underserved.

TransOhio, a community-focused organization, is connected to virtually every trans support group in the state, as well as groups in other states, and these proposed rules have already caused alarm, confusion, and panic in the greater trans communities throughout Ohio and beyond. The impact of the drastic restructuring of care for patients assumed to be transgender also extends to individuals who are not residents of Ohio but travel here for our exceptional quality of care. Yet, under the direction of Governor DeWine, this department seeks to unilaterally change—restrict—medically appropriate care to children, adolescents, and adults, based on politically-fueled misinformation. *This move is unprecedented.* And we hold genuine apprehension regarding the legal implications of an administrative rule specifically crafted to restrict healthcare for a minority population.

The proposed administrative rules fail to meet even the minimum guidance outlined in current standards of care, as outlined by leading medical associations including the World Professional Association of Transgender Health (WPATH). These rules are counter to both medical science and public policy. Gender-affirming care for trans individuals is evidence-based care and is considered medically-necessary. Implementation of these rules will force hospitals and health care facilities to undergo costly internal restructures in order to comply, will place Ohio providers into ethical dilemmas, and will undoubtedly result in harm to transgender, nonbinary, gender nonconforming, Two-Spirit, and intersex individuals across the state, as well as patients traveling to Ohio from out of state for our world-class care.

The Common Sense Initiative Business Impact Report states that these proposed draft rules are “necessary for the preservation of the life and health of the people of Ohio, including children," yet there is no indication as to how this lofty goal is accomplished through these rules or how success rates will be measured. TransOhio takes exception to this vague explanation. Access to competent gender-affirming health care improves the quality of life of individual trans people as well as the trans community at large. Trans people, in general, are not unhealthy. In fact, it is difficulties finding, obtaining, and continuing mental and physical health care that leads to the disproportionate rates of emotional distress and unmanaged health conditions among trans individuals, particularly those who do not have access to insurance, do not have inclusive insurance policies, and for those who live in rural areas.

According to the 2015 Ohio State Report,[1] a portion of the 2015 Trans Survey performed by the National Center for Transgender Education, a national equality group that advocates to change policies and society to increase understanding and acceptance of transgender people, nearly one-third (33%) of trans patients has at least one negative interaction or experience while attempting to access gender-affirming care, including being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to explain/teach the provider about transgender people in order to get appropriate care. An estimated twenty-six percent (26%) of trans patients avoid or delay necessary medical treatment due to fear of being denied care or fear of mistreatment due solely to their transgender status. Additionally, thirty-three percent (33%) can not afford basic medical care. A staggering fifteen percent (15%) of respondents to that survey reported that a medical professional tried to stop them from transitioning.

In 2022, according to Statistica,[2] a global data collection and intelligence platform, around eighty percent (80%) of trans adults in the United States have considered suicide, while around forty percent (40%) have attempted suicide. There has been an upward trend in both the considered and attempted suicide rate since 2000, corresponding with the introduction of anti-transgender legislation, regulation, rules, and policies. These rules do not address these serious health risks; in fact, they exacerbate them by creating unnecessary barriers to obtaining care.

Gender-affirming care has openly been provided for trans patients in the United States for decades, and Ohio has become world-renowned for our competent and compassionate care. Plastic surgeon Dr. Richard D. Murray performed gender-affirming

[1] “U.S. Trans Survey Ohio State Report,” https://transequality.org/sites/default/files/docs/usts/USTSOHStateReport(1017).pdf
[2] “U.S. Trans Suicide Rate,” https://www.statista.com/statistics/1388565/us-trans-suicide-rate

surgeries in Youngstown, Ohio, as early as 1972. The area of transgender medicine is not novel or experimental. Gender-affirming care has a long history of successfully treating and/or managing gender dysphoria.

The proposed draft rules should not be adopted and should be rescinded for a number of reasons, but most importantly: 1) it is unnecessary and intrusive government overreach into the personal medical decisions of families and individuals, 2) the rules create arbitrary restrictions and unnecessary barriers on appropriate and medically necessary care, 3) the mandated reporting is an invasion of patient privacy and an undue burden on providers, 4) the rules are vague, confusing, and impossible to implement, and 5) there will be unprecedented harm to the greater trans communities if this text is codified in state administrative code.

Unnecessary and Intrusive Government Overreach

Individuals should have the personal autonomy to make decisions about their own bodies and health care. Limiting access to gender-affirming care is infringing upon an individual's right to make decisions about their own well-being. In fact, Ohio voters overwhelmingly approved a constitutional amendment on November 7, 2023, guaranteeing “every individual a right to make and carry out one's own reproductive decisions.” And public testimony against H.B.68 outnumbered testimony in its favor by hundreds. Ohio citizens have spoken and they do not want government interference or involvement in their personal medical decisions.

Major medical and mental health professional organizations support gender-affirming care as a medically necessary and ethical approach for individuals with gender dysphoria. Rules restricting such care is interference with the professional judgment of healthcare providers and the established standards of care, with no involvement from the various medical boards. Providers will be restricted from providing their professional opinions and will be barred from providing–or continuing to provide–certain care, despite the negative health outcomes of ceasing that care. Appropriate gender-affirming care has been shown to improve mental health outcomes for transgender individuals. Restricting access to this care could potentially lead to serious adverse mental health consequences.

Frankly, the state has no rational interest in restricting Ohio providers from providing gender-affirming care to trans patients in accordance with best practices and standards of care, or for keeping records on trans individuals who seek gender-affirming care in Ohio. The discriminatory intention here is clear because these rules restrict treatment to transgender patients only, and not cisgender (not transgender) patients seeking the same or substantially similar health care, including surgical procedures and prescription medications.

Arbitrary Restrictions on Appropriate and Medically Necessary Care

These rules restrict providers from following best practices and current standards of care, which will undoubtedly lead to subpar medical care. They arbitrarily prohibit those patients under twenty-one (21) years of age from receiving gender-affirming healthcare in Ohio without first receiving "a comprehensive mental health evaluation at the health care facility seeking to provide treatment over a period of not less than six months." This takes away agency from patients in at least two (2) ways: 1) requiring potentially costly and medically unnecessary therapy sessions, and 2) also requiring that patients see a mental health care provider in the same facility where they are requesting gender-affirming care, removing their choice of preferred provider.

There is also no indication of what should be considered appropriately comprehensive, leaving open large loopholes for ill-intended providers to promise gender-affirming care to vulnerable patients with no intention of providing same but rather to require "further mental health evaluation" indefinitely. There is nothing in these rules to protect patients, transgender or otherwise, or to ensure that they receive quality health care. The quality or quantity of mental health evaluation is not mentioned, only a period of time of "not less than" six (6) months. The six (6) month requirement is clearly just an added "wait time" to deter and delay care.

This rule has a "grandfather clause" for patients between the ages of eighteen (18) and twenty (20) but does not provide the same courtesy to grandfathers–the rules fail to address geriatric psychiatry at all, potentially overlooking the unique mental health needs of older trans adults. There is no grandfather clause for patients twenty-one (21) years of age and older, regardless of how long they have already been receiving gender-affirming care, their past or present diagnosis or care plan, or what mental health evaluations they have already undergone. Further, the rules fail to adequately address the continued education of providers and instead only focuses on when care should be withheld from trans patients.

Reporting is an Invasion of Patient Privacy and Unduly Burdensome on Providers

Though Governor DeWine assured the public that data reported under these rules would be de-identified, we live in a world of constant data breaches. Trans individuals and their families are already facing an increase of credible threats from extremists. Hospital systems providing gender-affirming care in Ohio and elsewhere have already been targeted by violent threats.[3] TransOhio has serious concerns about the data collection and reporting provisions. Ohio's trans population is small compared to the general population. The accumulation of so much detailed data increases the likelihood

[3] "Gender-Affirming Clinics Subject to Onslaught of Threats, Harassment," https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2023.03.2.5

that individuals–and providers–could easily be identified and targeted, which potentially *puts their lives in danger*. These individuals already face stigmatization or discrimination, and frequent reporting could potentially expose sensitive information without clear justifications.

We also fear purposeful targeting by lawmakers. Partisan politicians should not be the reservoir for sensitive health data surrounding care for trans people when a majority of those politicians have publicly stated that trans people do not exist, are “mentally ill” or “perverted,” and that their care is at best “optional” and at worst, “depraved.” They may demand this information, but it is not their right to have it.

Requiring healthcare providers to report specific data on trans patients within thirty (30) days, particularly in the context of changes in care or the cessation of care, is confusing because it is not clear what type of visit qualifies as a mandatory reporting visit, and it is overly burdensome for several reasons.

Health care providers are already tasked with various administrative responsibilities, including patient record-keeping, billing, and compliance with existing reporting requirements. Mandating extra detailed reports every thirty (30) days could significantly increase the administrative workload, diverting resources and time away from patient care. Some facilities may even find it necessary to take on additional staff just to complete the required reporting. Requiring reporting at such a high frequency is unnecessary and disproportionate to the nature of health care services. This type of reporting is excessive and creates a false sense of urgency. Additionally, requiring data reporting at such short intervals may compromise the accuracy and quality of the information provided. Rushed or frequent reporting cycles might result in errors or incomplete data, diminishing the reliability of the information collected, which already has a high potential to be misinterpreted due to the small population size.

Frequent reporting requirements may also negatively impact the trust and rapport between health care providers and their patients. Trans patients might feel uneasy knowing that detailed information about their care is being reported so frequently, potentially affecting open communication and the quality of the provider-patient relationship. Cis patients may feel intimidated to even mention questions about their own gender identity or sexual orientation, for fear of being misidentified as transgender.

In summary, the burden imposed by requiring healthcare providers to report detailed data on trans patients every 30 days is excessive and will not improve care. The potential negative implications for administrative efficiency, patient privacy, and the overall quality of care outweigh the morbid curiosity of the general assembly.

Proposed Rules are Vague, Confusing, and Impossible to Implement

These proposed rules directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution, Section 1557 of the Affordable Care Act (ACA), and Section 22 of the Bill of Rights of the Ohio Constitution, as well as the Health Insurance Portability and Accountability Act (HIPPA). In addition to being potentially unconstitutional and unenforceable, these rules are vague, confusing, and impossible to implement. These rules raise more questions than answers.

For instance: what type of doctor visit prompts reporting? What type of reporting is required if a patient leaves a certain provider but continues care elsewhere? What type of reporting is required if a provider leaves a practice but their patients continue care? What type of reporting is required if the course of treatment is changed but the diagnosis remains the same? There simply aren't clear definitions of "initiation," "diagnosis," or "cessation." There could potentially be dozens of reports on the same individual, especially if that individual is having difficulty accessing care (every first visit is reported, even if that visit is the only visit).

The required restructuring of health care systems, by mandating the participation of psychiatrists, endocrinologists, and medical ethicists will be costly and time consuming: facilities will have to find, employ/contract, and train these providers. Another possibility, which is more likely than not due to Ohio's short supply of these types of providers, is that there will only be a small few, or even just one, medical ethicist responsible for reviewing the care plans of every hospital or health care facility, drastically increasing wait times. These rules are simply impossible to implement.

3701-3-17 Reporting Requirements

TransOhio strongly recommends the revocation of this entire rule. As previously stated, we have serious concerns about the collection, storage, and distribution of private medical information. We also question the intent behind requiring medical providers to report when they treat trans patients, as well as when they stop treating trans patients. With no contextual information–or in the wrong hands–a list of medications, a list of providers, and aggregate patient data can easily be used to target specific providers of gender-affirming care as well as potentially trans patients who receive, inquire about, or cease gender-affirming care. There is simply no compelling state interest in collecting and reporting this information.

3701-59-07 & 37-1-83-61 Quality Standards for Gender Transition Treatment

TransOhio strongly recommends the revocation of both "quality standards" rules. These proposed rules should be rescinded for the following reasons: 1) the mandatory minimum of six (6) months of mental health counseling for trans patients under

twenty-one (21) is an unnecessary and cruel barrier to care, 2) the prohibition on referrals for gender-affirming care is counter to medical standards, and 3) the required reporting creates serious concerns about individual privacy as well as potential misuses of data points.

The requirements for psychiatrists, endocrinologists, and medical ethicists to be involved in a medical facility through both a contractual relationship and a direct, in-person “active role” before that location can provide gender-affirming transitional care won’t just further restrict appropriate care for trans patients; it will also compel Ohio medical systems to restructure and force smaller facilities to close their doors. This will significantly impact the trans and nonbinary communities, but this radical change will also affect cis (not trans) individuals by limiting the number of providers available to see patients.

Psychiatrists, in general, are not involved in care of individuals simply because they’re transgender. In fact, psychiatrists do not evaluate patients for gender dysphoria and there is very little precedent for psychiatric practitioners prescribing medications to treat gender dysphoria. This is often well within the purview of general practitioners, who usually have longer and better-established relationships with patients as their primary care provider. Legally requiring that a trans person see a psychiatrist is cruel for two reasons: 1) there simply are not enough practicing in Ohio to meet the needs of trans patients, and 2) insurance often will not pay for psychiatric visits, especially if there are other options available.

Endocrinologists, doctors who specialize in hormonal disorders, are not necessarily better-equipped to treat trans patients. In fact, the number of endocrinologists in Ohio who currently see trans patients is very low. The inclusion of this specific type of physician makes very little sense in this mental health rule, primarily because endocrinologists do not counsel patients.

The mandatory inclusion of bioethicists or medical ethicists to review care plans implies that the treatment of trans patients is somehow unethical and that providers and hospital systems need to be constantly monitored. This perpetuates the harmful myth that affirming doctors are transitioning cisgender patients against their wishes for some personal gain, which has absolutely no basis in reality. It is very rare that medical ethicists are directly involved in the care of transgender patients, especially when no concerns were raised by patients or their families. There is no other diagnosis that requires the involvement of a medical ethicist in the Ohio Administrative Code, and it should not be required here either. Just as with psychiatrists and endocrinologists, there simply are not enough ethicists to meet this requirement. But unlike those doctors, medical ethicists are not physicians. In fact, there is no legal requirement that medical ethicists be certified or boarded in Ohio.

The language used through this rule is outdated, pathologizing, and offensive; and this is even more true for the “exception” to these anti-trans restrictions. Intersex individuals are not “abnormal.” This language implies that medical intervention is necessary based on the perception of a "disorder" rather than respecting an individual's right to make informed choices about their own bodies. There is no explicit consideration here for the autonomy of intersex individuals in making decisions about their own health, even when they are adults. This reinforces the notion that intersex traits need medical intervention or correction, which is emphatically untrue. To date, over 50 countries have signed an agreement with the United Nations condemning unnecessary surgeries on intersex infants as barbaric. Forced or coerced surgeries on intersex infants, children, and adolescents continue to this day, and these rules do nothing to mitigate that harm.

TransOhio also takes offense to the language surrounding the requirement for care plans for the purpose of detransition. The rules seem to indicate that detransitioning is a goalpost. The focus should be on appropriate care for individual patients. Just as there is no “right” way to transition, there is no right way to detransition. Frankly, we are unwilling to allow cis politicians and administrators to attempt to hold up people who have detransitioned as a “gotcha” against the trans community, as if the legitimacy of one identity cancels the other. Less than one percent (<1%) of trans patients report regretting receiving gender-affirming care.[4] It should also be noted that these rules do not protect or improve health care for “detransitioners,” either. Trans patients often slow, delay, and halt their medical transitions for a number of reasons completely unrelated to a desire to detransition–which is to stop and reverse gender transition to identify solely as sex assigned at birth–including inadequate health care, social pressure, lack of financial resources, and threats/intimidation. People detransition, retransition, or take alternative approaches to gender-affirming care and transition for a variety of complex reasons. These rules do not address this and instead focus on requiring providers create a care plan for detransitioning.

Gender identity can be complex, which is precisely why it should not be legislated or regulated. Our detransitioned community deserves better care than these rules can provide, and so does our intersex, Two-Spirit, and nonbinary community. We recommend an increase in education for providers, not restrictions.

Unprecedented Harm

These proposed rules, aimed at restricting gender-affirming care for trans people, will have far-reaching consequences extending beyond the transgender community. Anyone seeking care from a psychiatrist or an endocrinologist throughout the state will be

[4] “Transgender regret? Research challenges narratives about gender-affirming surgeries,” https://theconversation.com/transgender-regret-research-challenges-narratives-about-gender-affirming-surgeries-220642

impacted by undue burdens placed on these professions mandating their demonstrable involvement in treatment. Health care providers offering gender-affirming care also offer primary care and various services; creating bureaucratic hurdles and onerous reporting requirements will delay all kinds of medical treatment provided through these offices. The increased administrative burden will lead to longer wait times and delays in receiving necessary medical attention, impacting not only Ohioans, but anyone traveling here for our medical expertise. Our state's endocrinology and mental health professions have endured long-standing shortages already; with such overwhelming administrative requirements and restrictions on evidence-based practices, this shortage will only be exacerbated.

In general, policies that limit access to gender-affirming care not only harm transgender individuals but also have broader societal and economic repercussions, affecting health care providers, patients, and communities at large. Ohio should emphasize the importance of equal access to health care for everyone, regardless of gender identity, instead of targeting and restricting one type of care. Restrictions may lead to decreased demand for gender-affirming care services, impacting Ohio's health care revenue and potentially resulting in job losses. Skilled health care professionals specializing in gender-affirming care may choose to leave the state in response to these rules, leading to a loss of expertise within the local health care workforce and diminishing the overall quality of care provided to patients. The rules and forthcoming additional restrictive policies may set a precedent for limiting access to various health care services, potentially harming cisgender patients who also benefit from gender-affirming care practices, such as mental health services, surgeries, and hormone therapy. Trans individuals seeking gender-affirming care may choose to relocate to states with more inclusive policies, causing a loss of diverse talent and workforce within the state. Those patients who have been traveling to Ohio for care, including families, will undoubtedly seek care elsewhere, taking their contributions to Ohio's local economy with them.

These rules undermine Ohio values and send a negative message about inclusivity and diversity, contributing to an unwelcoming environment for trans individuals, which can impact community cohesion and overall well-being. Negative mental health outcomes, including increased rates of depression, anxiety, and thoughts of suicide have increased at an alarming–but not unsurprising–rate since the announcement of these proposed rules. TransOhio and other community groups have been fielding crisis calls and scrambling to provide adequate resources to community members in distress. This crisis has been manufactured and was mitigatable, if not preventable. The increased politicalization of gender-affirming care has only increased discrimination towards our most vulnerable community members, including children. These rules perpetuate harm.

Conclusion

The creation of these rules coincides with the unfortunate passage of HB68, which prevents transgender student athletes from participating on school sports teams consistent with their gender identity and also prohibits the medical treatment of trans and nonbinary minors in Ohio. Governor DeWine vetoed that bill, stating at a press conference that government does not know better than patients and families. Yet, at that same press conference, Governor DeWine announced these new proposed rules, which he admitted are more restrictive than the legislation. At the time, he claimed that there was a fear of “pop-up,” “fly-by-night” clinics that provide hormonal treatments and surgeries “on a walk-in basis” to transgender minors, without the knowledge or consent of their parents. Governor DeWine admitted to having no knowledge of such clinics, and this is because *it doesn’t happen* and *it won’t*. This is a prosperous rumor based on a misunderstanding of what “informed consent” means and what kind of care is taking place in Ohio. Ohio has some of the best gender-affirming care in the nation. These expert medical providers will leave the state, devastating not just transgender patients but their cisgender patients as well. The world-class medical institutions in Ohio that treat patients who travel to here from out of state for care will also suffer, and so will Ohio’s economy because they will no longer be contributing to it.

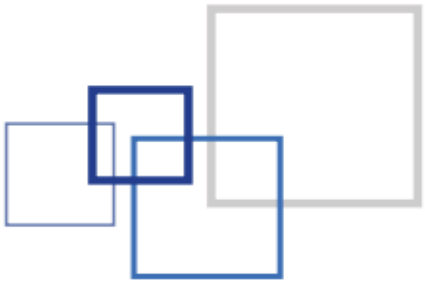
The field of healthcare is always evolving. We should not codify outdated standards developed by politicians or administrators. As individuals navigate the complexities of health and medicine, relying on guidelines that were shaped by non-medical experts poses significant drawbacks. Medical science progresses rapidly, embracing new technologies, methodologies, and insights. By codifying regulations based on outdated standards, we risk hindering the integration of cutting-edge medical practices that could significantly enhance patient care, treatment efficacy, and overall health outcomes. Moreover, healthcare is an intricate field that demands nuanced and specialized knowledge. Crafting regulations in consultation with healthcare professionals who are immersed in the field ensures a more accurate, comprehensive, and responsive approach to the ever-changing landscape of health. The involvement of healthcare experts in the formulation of standards enables regulations to adapt seamlessly to emerging challenges, scientific breakthroughs, and the diverse needs of patients. There are already standards of care, and they are not reflected in these rules. These rules do not improve or promote care for trans patients. Instead, they create even more barriers that will disproportionately affect minority patients, particularly people of color, people with various disabilities, people for whom English is a second language, people who live in rural areas, people living in poverty, and the elderly.

TransOhio urges the Ohio Department of Health to rescind these proposed rules. If rules must be adopted, we ask that you review and adopt Model Rules (attached). We thank you for the opportunity to raise our concerns, and we welcome a meeting with

department representatives to discuss further. There should be no decisions made about the health care of trans patients without the input of those patients and their providers, who are often experts in their field.

Additionally, we urge the Ohio Department of Health to also rescind Rule 3701-59-06, which was filed as an emergency filing pursuant to Governor DeWine's executive order for the same reasons as set forth above for proposed rules O.A.C. 3701-3-17, O.A.C. 3701-59-07, and O.A.C. 37-1-83-61.

Appendix D: U.S. Trans Survey



2015 U.S. Transgender Survey

Ohio State Report

April 2017

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

Recommended Citation: *2015 U.S. Transgender Survey: Ohio State Report*. (2017). Washington, DC: National Center for Transgender Equality.

Updated October 2017

USTransSurvey.org | TransEquality.org

2015 U.S. TRANSGENDER SURVEY

Ohio State Report

The 2015 U.S. Transgender Survey (USTS) is the largest survey examining the experiences of transgender people in the United States, with 27,715 respondents nationwide. The USTS was conducted by the National Center for Transgender Equality in the summer of 2015. Of respondents in the USTS, 941 were Ohio residents.[1] This report discusses the experiences of respondents living in Ohio.

Income and Employment Status

- 16% of respondents in Ohio were unemployed.[2]
- 26% were living in poverty.[3]

Employment and the Workplace

- 17% of respondents who have ever been employed reported losing a job in their lifetime because of their gender identity or expression.
- In the past year, 30% of those who held or applied for a job during that year reported being fired, being denied a promotion, or not being hired for a job they applied for because of their gender identity or expression.
- Respondents who had a job in the past year reported being verbally harassed (19%) and sexually assaulted (1%) at work because of their gender identity or expression.
- 26% of those who had a job in the past year reported other forms of mistreatment based on their gender identity or expression during that year, such as being forced to use a restroom that did not match their gender identity, being told to present in the wrong gender in order to keep their job, or having a boss or coworker share private information about their transgender status with others without their permission.
- Overall, 34% of respondents who had a job in the past year reported being fired, being denied a promotion, or experiencing some other form of mistreatment related to their gender identity or expression during that year.

Education

- 80% of those who were out or perceived as transgender at some point between Kindergarten and Grade 12 (K–12) experienced some form of mistreatment, such as being verbally harassed, prohibited from dressing according to their gender identity, disciplined more harshly, or physically or sexually assaulted because people thought they were transgender.
  - 57% of those who were out or perceived as transgender in K–12 were verbally harassed, 27% were physically attacked, and 15% were sexually assaulted in K–12 because of being transgender.
  - 20% faced such severe mistreatment as a transgender person that they left a K–12 school.

- 28% of respondents who were out or perceived as transgender in college or vocational school were verbally, physically, or sexually harassed because of being transgender.

Housing, Homelessness, and Shelter Access

- 25% of respondents experienced some form of housing discrimination in the past year, such as being evicted from their home or denied a home or apartment because of being transgender.
- 33% have experienced homelessness at some point in their lives.
- 15% experienced homelessness in the past year because of being transgender.
- 28% of respondents who experienced homelessness in the past year avoided staying in a shelter because they feared being mistreated as a transgender person.

Public Accommodations

- Respondents reported being denied equal treatment or service, verbally harassed, or physically attacked at many places of public accommodation—places that provide services to the public, like retail stores, hotels, and government offices.
- Of respondents who visited a place of public accommodation where staff or employees thought or knew they were transgender, 32% experienced at least one type of mistreatment in the past year. This included 16% who were denied equal treatment or service, 26% who were verbally harassed, and 1% who were physically attacked because of being transgender.

Restrooms

- 10% of respondents reported that someone denied them access to a restroom in the past year.
- In the past year, respondents reported being verbally harassed (13%) and sexually assaulted (1%) when accessing a restroom.
- 60% of respondents avoided using a public restroom in the past year because they were afraid of confrontations or other problems they might experience.
- 32% of respondents limited the amount that they ate or drank to avoid using the restroom in the past year.

Police Interactions

- Respondents experienced high levels of mistreatment and harassment by police. In the past year, of respondents who interacted with police or other law enforcement officers who thought or knew they were transgender, 55% experienced some form of mistreatment. This included being verbally harassed, repeatedly referred to as the wrong gender, physically assaulted, or sexually assaulted, including being forced by officers to engage in sexual activity to avoid arrest.
- 55% of respondents said they would feel uncomfortable asking the police for help if they needed it.

Health

- 25% of respondents experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender.
- 32% of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender. This included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.
- In the past year, 26% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 33% did not see a doctor when needed because they could not afford it.
- 42% of respondents experienced serious psychological distress in the month before completing the survey (based on the Kessler 6 Psychological Distress Scale).[4]
- 15% of respondents reported that a professional, such as a psychologist, counselor, or religious advisor, tried to stop them from being transgender.

Identity Documents

- Only 9% of respondents reported that *all* of their IDs had the name and gender they preferred, while 68% reported that *none* of their IDs had the name and gender they preferred.
- The cost of changing IDs was one of the main barriers respondents faced, with 42% of those who have not changed their legal name and 38% of those who have not updated the gender on their IDs reporting that it was because they could not afford it.
- 36% of respondents who have shown an ID with a name or gender that did not match their gender presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted.

ENDNOTES | OHIO STATE REPORT

1. The number of respondents in Ohio (n=941) is an unweighted value. All reported percentages are weighted. For more information on the weighting procedures used to report 2015 U.S. Transgender Survey data, see the full survey report, available at www.USTransSurvey.org.
2. For reference, the U.S. unemployment rate was 5% at the time of the survey, as reported by the Bureau of Labor Statistics. See the full report for more information about this calculation.
3. For reference, the U.S. poverty rate was 12% at the time of the survey. The research team calculated the USTS poverty measure using the official poverty measure, as defined by the U.S. Census Bureau. USTS respondents were designated as living in poverty if their total family income fell under 125% of the official U.S. poverty line. See the full report for more information about this calculation.
4. For reference, 5% of the U.S. population reported experiencing serious psychological distress during the prior month as reported in the 2015 National Survey on Drug Use and Health. See the full report for more information about this calculation.

Early Insights: A Report of the 2022 U.S. Transgender Survey

by:

Sandy E. James, Jody L. Herman, Laura E. Durso,
and Rodrigo Heng-Lehtinen

February 2024

HEALTH AND HEALTH CARE

Impact of the COVID-19 Pandemic

Respondents were asked questions about their experiences with the COVID-19 pandemic to determine how it impacted the ways in which they move through the world and interact with others.

- Most respondents reported that, in the last 12 months, they went out in public places (such as a grocery store, restaurant, or shopping mall) less than they did before the COVID-19 pandemic, including 27% who went out "somewhat less" than before, 33% who went out "a lot less" than before, and 1% that did not go out at all. Twenty-seven percent (27%) of respondents went out "about the same amount" as before the pandemic, 7% went out "somewhat more" than before, and 5% went out "a lot more" than before.
- Most respondents wore a mask at least some of the time when out in public in the last 12 months, including 28% who wore a mask "all of the time," 33% who wore one "most of the time," and 24% who wore one "some of the time." Twelve percent (12%) wore a mask "a little of the time," and 4% wore a mask "none of the time."

General Health and Experiences with Health Care Providers

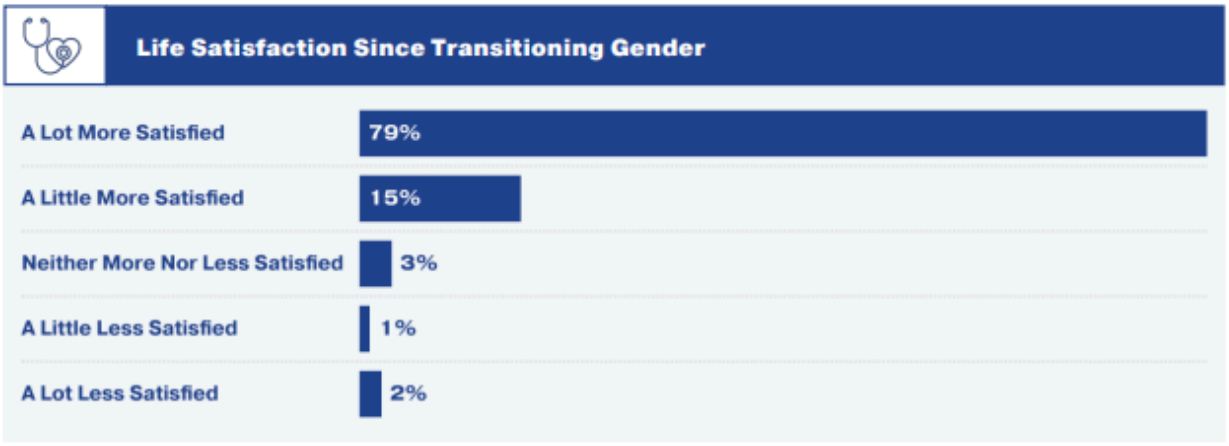
- Approximately two-thirds of respondents reported that their health status was "good" (36%), "very good" (24%), or "excellent" (6%). One-quarter (25%) rated their health status as "fair," and 9% said it was "poor."
- More than one-quarter of respondents (28%) did not see a doctor when they needed to in the last 12 months due to cost.
- Nearly one-quarter of respondents (24%) did not see a doctor when they needed to in the last 12 months due to fear of mistreatment.
- Forty-four percent (44%) of respondents experienced serious psychological distress in the last 30 days (based on the Kessler 6 Psychological Distress Scale).
- Seventy-nine percent (79%) of respondents saw a doctor or health care provider within the last 12 months, and 9% saw a provider between 1 and 2 years ago.
- Of those who saw a health care provider within the last 12 months, nearly one-half (48%) reported having at least one negative experience because they were transgender, such as being refused health care, being misgendered, having a provider use harsh or abusive language when treating them, or having a provider be physically rough or abusive when treating them.

Health Insurance

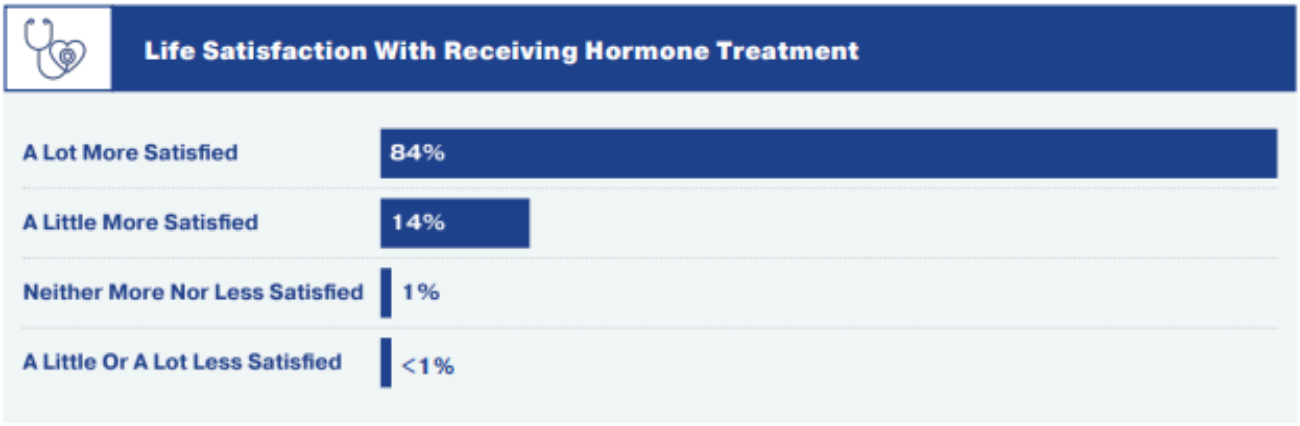
- Eighty-seven (87%) percent of respondents had health insurance coverage.
- Approximately 1 in 4 respondents (26%) had at least one issue with their insurance company in the last 12 months, such as being denied coverage for hormone therapy, surgery, or another type of health care related to their gender identity/transition; gender-specific health care because they were transgender; or routine health care because they were transgender.

Gender Identity and Transition

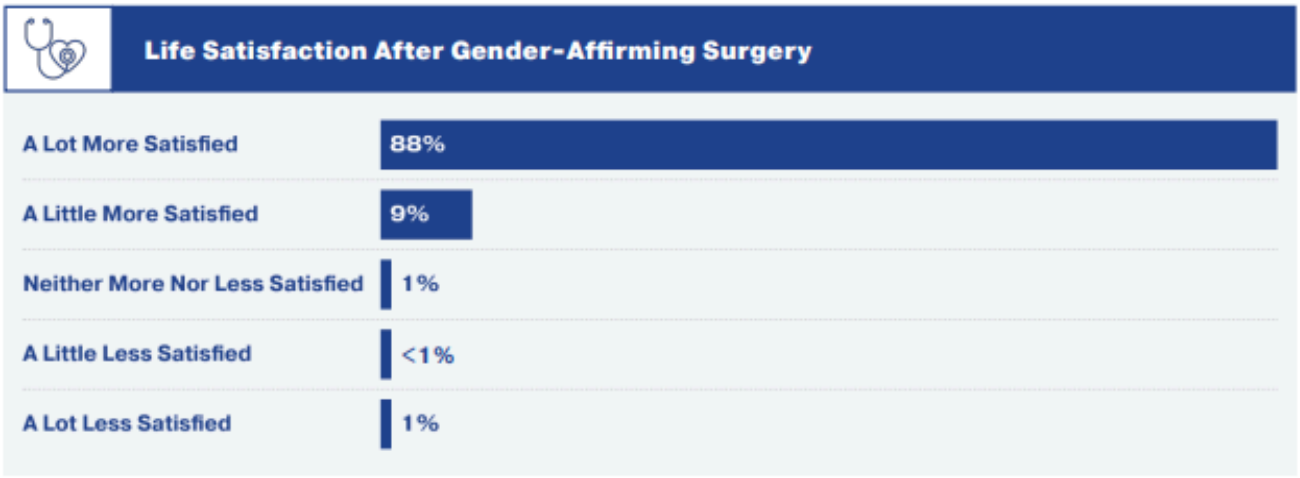
- Nearly all respondents (94%) who lived at least some of the time in a different gender than the one they were assigned at birth ("gender transition") reported that they were either "a lot more satisfied" (79%) or "a little more satisfied" (15%) with their life. Three percent (3%) reported that transitioning gender made them "neither more nor less satisfied" with their life, 1% were "a little less satisfied," and 2% were "a lot less satisfied" with their life.



- Nearly all respondents (98%) who were currently receiving hormone treatment reported that receiving hormones for their gender identity/transition made them either "a lot more satisfied" (84%) or "a little more satisfied" (14%) with their life. One percent (1%) reported that hormones made them "neither more nor less satisfied" with their life, and less than 1% said that they were "a little less satisfied" or "a lot less satisfied" with their lives after receiving hormones.



- Nearly all respondents (97%) who had at least one form of surgery for their gender identity/ transition reported that they were either "a lot more satisfied" (88%) or "a little more satisfied" (9%) with their life. One percent (1%) reported that surgery made them "neither more nor less satisfied" with their life, less than 1% were "a little less satisfied," and 1% were "a lot less satisfied" with their life.



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February 5, 2024

Comment on Gender Transition Rules

On behalf of the greater transgender, nonbinary, intersex, and gender nonconforming communities here in Ohio, **TransOhio humbly urges the Ohio Department of Health to not adopt and to rescind proposed rules O.A.C. 3701-3-17, O.A.C. 3701-59-07, and O.A.C. 37-1-83-61 in their entirety.**

Ohio Administrative Code should not discriminate. These proposed rules are not necessary or appropriate, and they will undoubtedly cause more harm than good. While the intentions behind the rules might have been a sincere desire to improve healthcare for trans patients, the outcome—intentional or otherwise—is a *de facto* ban on gender-affirming physical and mental health care for a large portion of trans people seeking care in Ohio, including residents of other states. This directly conflicts with modern behavioral and physical health ethics and values, as well as current standards of care, resulting in increased legal and licensure liabilities. Professionals will not be able to ethically practice in our state if these proposed rules become Ohio law, resulting in even more restricted availability of knowledgeable providers to patients who are already underserved.

TransOhio, a community-focused organization, is connected to virtually every trans support group in the state, as well as groups in other states, and these proposed rules have already caused alarm, confusion, and panic in the greater trans communities throughout Ohio and beyond. The impact of the drastic restructuring of care for patients assumed to be transgender also extends to individuals who are not residents of Ohio but travel here for our exceptional quality of care. Yet, under the direction of Governor DeWine, this department seeks to unilaterally change—restrict—medically appropriate care to children, adolescents, and adults, based on politically-fueled misinformation. *This move is unprecedented.* And we hold genuine apprehension regarding the legal implications of an administrative rule specifically crafted to restrict healthcare for a minority population.

The proposed administrative rules fail to meet even the minimum guidance outlined in current standards of care, as outlined by leading medical associations including the World Professional Association of Transgender Health (WPATH). These rules are counter to both medical science and public policy. Gender-affirming care for trans individuals is evidence-based care and is considered medically-necessary. Implementation of these rules will force hospitals and health care facilities to undergo costly internal restructures in order to comply, will place Ohio providers into ethical dilemmas, and will undoubtedly result in harm to transgender, nonbinary, gender nonconforming, Two-Spirit, and intersex individuals across the state, as well as patients traveling to Ohio from out of state for our world-class care.

The Common Sense Initiative Business Impact Report states that these proposed draft rules are “necessary for the preservation of the life and health of the people of Ohio, including children," yet there is no indication as to how this lofty goal is accomplished through these rules or how success rates will be measured. TransOhio takes exception to this vague explanation. Access to competent gender-affirming health care improves the quality of life of individual trans people as well as the trans community at large. Trans people, in general, are not unhealthy. In fact, it is difficulties finding, obtaining, and continuing mental and physical health care that leads to the disproportionate rates of emotional distress and unmanaged health conditions among trans individuals, particularly those who do not have access to insurance, do not have inclusive insurance policies, and for those who live in rural areas.

According to the 2015 Ohio State Report,[5] a portion of the 2015 Trans Survey performed by the National Center for Transgender Education, a national equality group that advocates to change policies and society to increase understanding and acceptance of transgender people, nearly one-third (33%) of trans patients has at least one negative interaction or experience while attempting to access gender-affirming care, including being refused treatment, being verbally harassed, being physically or sexually assaulted, or having to explain/teach the provider about transgender people in order to get appropriate care. An estimated twenty-six percent (26%) of trans patients avoid or delay necessary medical treatment due to fear of being denied care or fear of mistreatment due solely to their transgender status. Additionally, thirty-three percent (33%) can not afford basic medical care. A staggering fifteen percent (15%) of respondents to that survey reported that a medical professional tried to stop them from transitioning.

[5] “U.S. Trans Survey Ohio State Report,” https://transequality.org/sites/default/files/docs/usts/USTSOHStateReport(1017).pdf

In 2022, according to Statistica,[6] a global data collection and intelligence platform, around eighty percent (80%) of trans adults in the United States have considered suicide, while around forty percent (40%) have attempted suicide. There has been an upward trend in both the considered and attempted suicide rate since 2000, corresponding with the introduction of anti-transgender legislation, regulation, rules, and policies. These rules do not address these serious health risks; in fact, they exacerbate them by creating unnecessary barriers to obtaining care.

Gender-affirming care has openly been provided for trans patients in the United States for decades, and Ohio has become world-renowned for our competent and compassionate care. Plastic surgeon Dr. Richard D. Murray performed gender-affirming surgeries in Youngstown, Ohio, as early as 1972. The area of transgender medicine is not novel or experimental. Gender-affirming care has a long history of successfully treating and/or managing gender dysphoria.

The proposed draft rules should not be adopted and should be rescinded for a number of reasons, but most importantly: 1) it is unnecessary and intrusive government overreach into the personal medical decisions of families and individuals, 2) the rules create arbitrary restrictions and unnecessary barriers on appropriate and medically necessary care, 3) the mandated reporting is an invasion of patient privacy and an undue burden on providers, 4) the rules are vague, confusing, and impossible to implement, and 5) there will be unprecedented harm to the greater trans communities if this text is codified in state administrative code.

Unnecessary and Intrusive Government Overreach

Individuals should have the personal autonomy to make decisions about their own bodies and health care. Limiting access to gender-affirming care is infringing upon an individual's right to make decisions about their own well-being. In fact, Ohio voters overwhelmingly approved a constitutional amendment on November 7, 2023, guaranteeing “every individual a right to make and carry out one's own reproductive decisions.” And public testimony against H.B.68 outnumbered testimony in its favor by hundreds. Ohio citizens have spoken and they do not want government interference or involvement in their personal medical decisions.

Major medical and mental health professional organizations support gender-affirming care as a medically necessary and ethical approach for individuals with gender dysphoria. Rules restricting such care is interference with the professional judgment of healthcare providers and the established standards of care, with no involvement from the various medical boards. Providers will be restricted from providing their professional

[6] “U.S. Trans Suicide Rate,” https://www.statista.com/statistics/1388565/us-trans-suicide-rate

opinions and will be barred from providing–or continuing to provide–certain care, despite the negative health outcomes of ceasing that care. Appropriate gender-affirming care has been shown to improve mental health outcomes for transgender individuals. Restricting access to this care could potentially lead to serious adverse mental health consequences.

Frankly, the state has no rational interest in restricting Ohio providers from providing gender-affirming care to trans patients in accordance with best practices and standards of care, or for keeping records on trans individuals who seek gender-affirming care in Ohio. The discriminatory intention here is clear because these rules restrict treatment to transgender patients only, and not cisgender (not transgender) patients seeking the same or substantially similar health care, including surgical procedures and prescription medications.

Arbitrary Restrictions on Appropriate and Medically Necessary Care

These rules restrict providers from following best practices and current standards of care, which will undoubtedly lead to subpar medical care. They arbitrarily prohibit those patients under twenty-one (21) years of age from receiving gender-affirming healthcare in Ohio without first receiving “a comprehensive mental health evaluation at the health care facility seeking to provide treatment over a period of not less than six months.” This takes away agency from patients in at least two (2) ways: 1) requiring potentially costly and medically unnecessary therapy sessions, and 2) also requiring that patients see a mental health care provider in the same facility where they are requesting gender-affirming care, removing their choice of preferred provider.

There is also no indication of what should be considered appropriately comprehensive, leaving open large loopholes for ill-intended providers to promise gender-affirming care to vulnerable patients with no intention of providing same but rather to require “further mental health evaluation” indefinitely. There is nothing in these rules to protect patients, transgender or otherwise, or to ensure that they receive quality health care. The quality or quantity of mental health evaluation is not mentioned, only a period of time of “not less than” six (6) months. The six (6) month requirement is clearly just an added “wait time” to deter and delay care.

This rule has a “grandfather clause” for patients between the ages of eighteen (18) and twenty (20) but does not provide the same courtesy to grandfathers–the rules fail to address geriatric psychiatry at all, potentially overlooking the unique mental health needs of older trans adults. There is no grandfather clause for patients twenty-one (21) years of age and older, regardless of how long they have already been receiving gender-affirming care, their past or present diagnosis or care plan, or what mental health evaluations they have already undergone. Further, the rules fail to adequately

address the continued education of providers and instead only focuses on when care should be withheld from trans patients.

Reporting is an Invasion of Patient Privacy and Unduly Burdensome on Providers

Though Governor DeWine assured the public that data reported under these rules would be de-identified, we live in a world of constant data breaches. Trans individuals and their families are already facing an increase of credible threats from extremists. Hospital systems providing gender-affirming care in Ohio and elsewhere have already been targeted by violent threats.[7] TransOhio has serious concerns about the data collection and reporting provisions. Ohio's trans population is small compared to the general population. The accumulation of so much detailed data increases the likelihood that individuals–and providers–could easily be identified and targeted, which potentially *puts their lives in danger*. These individuals already face stigmatization or discrimination, and frequent reporting could potentially expose sensitive information without clear justifications.

We also fear purposeful targeting by lawmakers. Partisan politicians should not be the reservoir for sensitive health data surrounding care for trans people when a majority of those politicians have publicly stated that trans people do not exist, are "mentally ill" or "perverted," and that their care is at best "optional" and at worst, "depraved." They may demand this information, but it is not their right to have it.

Requiring healthcare providers to report specific data on trans patients within thirty (30) days, particularly in the context of changes in care or the cessation of care, is confusing because it is not clear what type of visit qualifies as a mandatory reporting visit, and it is overly burdensome for several reasons.

Health care providers are already tasked with various administrative responsibilities, including patient record-keeping, billing, and compliance with existing reporting requirements. Mandating extra detailed reports every thirty (30) days could significantly increase the administrative workload, diverting resources and time away from patient care. Some facilities may even find it necessary to take on additional staff just to complete the required reporting. Requiring reporting at such a high frequency is unnecessary and disproportionate to the nature of health care services. This type of reporting is excessive and creates a false sense of urgency. Additionally, requiring data reporting at such short intervals may compromise the accuracy and quality of the information provided. Rushed or frequent reporting cycles might result in errors or incomplete data, diminishing the reliability of the information collected, which already has a high potential to be misinterpreted due to the small population size.

[7] "Gender-Affirming Clinics Subject to Onslaught of Threats, Harassment," https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2023.03.2.5

Frequent reporting requirements may also negatively impact the trust and rapport between health care providers and their patients. Trans patients might feel uneasy knowing that detailed information about their care is being reported so frequently, potentially affecting open communication and the quality of the provider-patient relationship. Cis patients may feel intimidated to even mention questions about their own gender identity or sexual orientation, for fear of being misidentified as transgender.

In summary, the burden imposed by requiring healthcare providers to report detailed data on trans patients every 30 days is excessive and will not improve care. The potential negative implications for administrative efficiency, patient privacy, and the overall quality of care outweigh the morbid curiosity of the general assembly.

Proposed Rules are Vague, Confusing, and Impossible to Implement

These proposed rules directly conflict with several areas of existing federal and state law, such as the Equal Protection Clause of the 14th Amendment of the U.S. Constitution, Section 1557 of the Affordable Care Act (ACA), and Section 22 of the Bill of Rights of the Ohio Constitution, as well as the Health Insurance Portability and Accountability Act (HIPPA). In addition to being potentially unconstitutional and unenforceable, these rules are vague, confusing, and impossible to implement. These rules raise more questions than answers.

For instance: what type of doctor visit prompts reporting? What type of reporting is required if a patient leaves a certain provider but continues care elsewhere? What type of reporting is required if a provider leaves a practice but their patients continue care? What type of reporting is required if the course of treatment is changed but the diagnosis remains the same? There simply aren't clear definitions of "initiation," "diagnosis," or "cessation." There could potentially be dozens of reports on the same individual, especially if that individual is having difficulty accessing care (every first visit is reported, even if that visit is the only visit).

The required restructuring of health care systems, by mandating the participation of psychiatrists, endocrinologists, and medical ethicists will be costly and time consuming: facilities will have to find, employ/contract, and train these providers. Another possibility, which is more likely than not due to Ohio's short supply of these types of providers, is that there will only be a small few, or even just one, medical ethicist responsible for reviewing the care plans of every hospital or health care facility, drastically increasing wait times. These rules are simply impossible to implement.

3701-3-17 Reporting Requirements

TransOhio strongly recommends the revocation of this entire rule. As previously stated, we have serious concerns about the collection, storage, and distribution of private

medical information. We also question the intent behind requiring medical providers to report when they treat trans patients, as well as when they stop treating trans patients. With no contextual information–or in the wrong hands–a list of medications, a list of providers, and aggregate patient data can easily be used to target specific providers of gender-affirming care as well as potentially trans patients who receive, inquire about, or cease gender-affirming care. There is simply no compelling state interest in collecting and reporting this information.

3701-59-07 & 37-1-83-61 Quality Standards for Gender Transition Treatment

TransOhio strongly recommends the revocation of both “quality standards” rules. These proposed rules should be rescinded for the following reasons: 1) the mandatory minimum of six (6) months of mental health counseling for trans patients under twenty-one (21) is an unnecessary and cruel barrier to care, 2) the prohibition on referrals for gender-affirming care is counter to medical standards, and 3) the required reporting creates serious concerns about individual privacy as well as potential misuses of data points.

The requirements for psychiatrists, endocrinologists, and medical ethicists to be involved in a medical facility through both a contractual relationship and a direct, in-person “active role” before that location can provide gender-affirming transitional care won’t just further restrict appropriate care for trans patients; it will also compel Ohio medical systems to restructure and force smaller facilities to close their doors. This will significantly impact the trans and nonbinary communities, but this radical change will also affect cis (not trans) individuals by limiting the number of providers available to see patients.

Psychiatrists, in general, are not involved in care of individuals simply because they’re transgender. In fact, psychiatrists do not evaluate patients for gender dysphoria and there is very little precedent for psychiatric practitioners prescribing medications to treat gender dysphoria. This is often well within the purview of general practitioners, who usually have longer and better-established relationships with patients as their primary care provider. Legally requiring that a trans person see a psychiatrist is cruel for two reasons: 1) there simply are not enough practicing in Ohio to meet the needs of trans patients, and 2) insurance often will not pay for psychiatric visits, especially if there are other options available.

Endocrinologists, doctors who specialize in hormonal disorders, are not necessarily better-equipped to treat trans patients. In fact, the number of endocrinologists in Ohio who currently see trans patients is very low. The inclusion of this specific type of physician makes very little sense in this mental health rule, primarily because endocrinologists do not counsel patients.

The mandatory inclusion of bioethicists or medical ethicists to review care plans implies that the treatment of trans patients is somehow unethical and that providers and hospital systems need to be constantly monitored. This perpetuates the harmful myth that affirming doctors are transitioning cisgender patients against their wishes for some personal gain, which has absolutely no basis in reality. It is very rare that medical ethicists are directly involved in the care of transgender patients, especially when no concerns were raised by patients or their families. There is no other diagnosis that requires the involvement of a medical ethicist in the Ohio Administrative Code, and it should not be required here either. Just as with psychiatrists and endocrinologists, there simply are not enough ethicists to meet this requirement. But unlike those doctors, medical ethicists are not physicians. In fact, there is no legal requirement that medical ethicists be certified or boarded in Ohio.

The language used through this rule is outdated, pathologizing, and offensive; and this is even more true for the “exception” to these anti-trans restrictions. Intersex individuals are not “abnormal.” This language implies that medical intervention is necessary based on the perception of a "disorder" rather than respecting an individual's right to make informed choices about their own bodies. There is no explicit consideration here for the autonomy of intersex individuals in making decisions about their own health, even when they are adults. This reinforces the notion that intersex traits need medical intervention or correction, which is emphatically untrue. To date, over 50 countries have signed an agreement with the United Nations condemning unnecessary surgeries on intersex infants as barbaric. Forced or coerced surgeries on intersex infants, children, and adolescents continue to this day, and these rules do nothing to mitigate that harm.

TransOhio also takes offense to the language surrounding the requirement for care plans for the purpose of detransition. The rules seem to indicate that detransitioning is a goalpost. The focus should be on appropriate care for individual patients. Just as there is no “right” way to transition, there is no right way to detransition. Frankly, we are unwilling to allow cis politicians and administrators to attempt to hold up people who have detransitioned as a “gotcha” against the trans community, as if the legitimacy of one identity cancels the other. Less than one percent (<1%) of trans patients report regretting receiving gender-affirming care.[8] It should also be noted that these rules do not protect or improve health care for “detransitioners,” either. Trans patients often slow, delay, and halt their medical transitions for a number of reasons completely unrelated to a desire to detransition–which is to stop and reverse gender transition to identify solely as sex assigned at birth–including inadequate health care, social pressure, lack of financial resources, and threats/intimidation. People detransition, retransition, or take

[8] “Transgender regret? Research challenges narratives about gender-affirming surgeries,” https://theconversation.com/transgender-regret-research-challenges-narratives-about-gender-affirming-surgeries-220642

alternative approaches to gender-affirming care and transition for a variety of complex reasons. These rules do not address this and instead focus on requiring providers create a care plan for detransitioning.

Gender identity can be complex, which is precisely why it should not be legislated or regulated. Our detransitioned community deserves better care than these rules can provide, and so does our intersex, Two-Spirit, and nonbinary community. We recommend an increase in education for providers, not restrictions.

Unprecedented Harm

These proposed rules, aimed at restricting gender-affirming care for trans people, will have far-reaching consequences extending beyond the transgender community. Anyone seeking care from a psychiatrist or an endocrinologist throughout the state will be impacted by undue burdens placed on these professions mandating their demonstrable involvement in treatment. Health care providers offering gender-affirming care also offer primary care and various services; creating bureaucratic hurdles and onerous reporting requirements will delay all kinds of medical treatment provided through these offices. The increased administrative burden will lead to longer wait times and delays in receiving necessary medical attention, impacting not only Ohioans, but anyone traveling here for our medical expertise. Our state's endocrinology and mental health professions have endured long-standing shortages already; with such overwhelming administrative requirements and restrictions on evidence-based practices, this shortage will only be exacerbated.

In general, policies that limit access to gender-affirming care not only harm transgender individuals but also have broader societal and economic repercussions, affecting health care providers, patients, and communities at large. Ohio should emphasize the importance of equal access to health care for everyone, regardless of gender identity, instead of targeting and restricting one type of care. Restrictions may lead to decreased demand for gender-affirming care services, impacting Ohio's health care revenue and potentially resulting in job losses. Skilled health care professionals specializing in gender-affirming care may choose to leave the state in response to these rules, leading to a loss of expertise within the local health care workforce and diminishing the overall quality of care provided to patients. The rules and forthcoming additional restrictive policies may set a precedent for limiting access to various health care services, potentially harming cisgender patients who also benefit from gender-affirming care practices, such as mental health services, surgeries, and hormone therapy. Trans individuals seeking gender-affirming care may choose to relocate to states with more inclusive policies, causing a loss of diverse talent and workforce within the state. Those patients who have been traveling to Ohio for care, including families, will undoubtedly seek care elsewhere, taking their contributions to Ohio's local economy with them.

These rules undermine Ohio values and send a negative message about inclusivity and diversity, contributing to an unwelcoming environment for trans individuals, which can impact community cohesion and overall well-being. Negative mental health outcomes, including increased rates of depression, anxiety, and thoughts of suicide have increased at an alarming–but not unsurprising–rate since the announcement of these proposed rules. TransOhio and other community groups have been fielding crisis calls and scrambling to provide adequate resources to community members in distress. This crisis has been manufactured and was mitigatable, if not preventable. The increased politicalization of gender-affirming care has only increased discrimination towards our most vulnerable community members, including children. These rules perpetuate harm.

Conclusion

The creation of these rules coincides with the unfortunate passage of HB68, which prevents transgender student athletes from participating on school sports teams consistent with their gender identity and also prohibits the medical treatment of trans and nonbinary minors in Ohio. Governor DeWine vetoed that bill, stating at a press conference that government does not know better than patients and families. Yet, at that same press conference, Governor DeWine announced these new proposed rules, which he admitted are more restrictive than the legislation. At the time, he claimed that there was a fear of “pop-up,” “fly-by-night” clinics that provide hormonal treatments and surgeries “on a walk-in basis” to transgender minors, without the knowledge or consent of their parents. Governor DeWine admitted to having no knowledge of such clinics, and this is because *it doesn’t happen* and *it won’t*. This is a prosperous rumor based on a misunderstanding of what “informed consent” means and what kind of care is taking place in Ohio. Ohio has some of the best gender-affirming care in the nation. These expert medical providers will leave the state, devastating not just transgender patients but their cisgender patients as well. The world-class medical institutions in Ohio that treat patients who travel to here from out of state for care will also suffer, and so will Ohio’s economy because they will no longer be contributing to it.

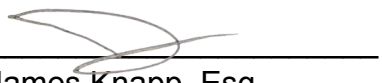
The field of healthcare is always evolving. We should not codify outdated standards developed by politicians or administrators. As individuals navigate the complexities of health and medicine, relying on guidelines that were shaped by non-medical experts poses significant drawbacks. Medical science progresses rapidly, embracing new technologies, methodologies, and insights. By codifying regulations based on outdated standards, we risk hindering the integration of cutting-edge medical practices that could significantly enhance patient care, treatment efficacy, and overall health outcomes. Moreover, healthcare is an intricate field that demands nuanced and specialized knowledge. Crafting regulations in consultation with healthcare professionals who are immersed in the field ensures a more accurate, comprehensive, and responsive

approach to the ever-changing landscape of health. The involvement of healthcare experts in the formulation of standards enables regulations to adapt seamlessly to emerging challenges, scientific breakthroughs, and the diverse needs of patients. There are already standards of care, and they are not reflected in these rules. These rules do not improve or promote care for trans patients. Instead, they create even more barriers that will disproportionately affect minority patients, particularly people of color, people with various disabilities, people for whom English is a second language, people who live in rural areas, people living in poverty, and the elderly.

TransOhio urges the Ohio Department of Health to rescind these proposed rules. If rules must be adopted, we ask that you review and adopt Model Rules (attached). We thank you for the opportunity to raise our concerns, and we welcome a meeting with department representatives to discuss further. There should be no decisions made about the health care of trans patients without the input of those patients and their providers, who are often experts in their field.

Additionally, we urge the Ohio Department of Health to also rescind Rule 3701-59-06, which was filed as an emergency filing pursuant to Governor DeWine's executive order for the same reasons as set forth above for proposed rules O.A.C. 3701-3-17, O.A.C. 3701-59-07, and O.A.C. 37-1-83-61.

Respectfully submitted,



James Knapp, Esq.
Board of Directors, Chair
TransOhio, Inc.

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About TransOhio:

TransOhio is Ohio's first and largest state-wide trans-focused equality group. Founded in 2005, TransOhio is a 501(C)(3) nonprofit organization comprised entirely of volunteers dedicated to education, advocacy, support, and providing community to trans people and their allies.

For more information, please visit https://transohio.org

Appendix A: Model Definitions

(1) “Sex” means one's assigned sex at birth based on physical structures, reproductive characteristics, and traditional assumptions of male and female bodies. While most people are assigned male or female at birth based on a visual inspection of their physical anatomy, sex characteristics exist on a spectrum, and many individuals' combination of physical anatomy and genetics do not fit neatly into binary categories.

(2) “Gender-affirming hormonal treatment,” also known as “hormone replacement therapy (HRT),” means bioidentical hormonal supplements like testosterone, estrogen, or progesterone given to an individual to better align one’s secondary sex characteristics with their gender identity.

(3) “Gender-affirmation surgery” means any surgical procedure that alters a person’s physical characteristics to better align their body with their gender identity.

(4) “Gender transition” means social, physical, and/or legal changes to reduce incongruence between one’s sex assigned at birth and gender identity.

(5) “Gender affirmation services” means any medical, psychological, and social support services provided for the purpose of affirming one’s gender identity.

(6) "Gender identity" means one's internal and personal sense of their own gender; as man, woman, both, or neither. Gender identity exists on a spectrum and can be in congruence with, or contrast, one's sex assigned at birth.

(7) “Health care provider” means a physician authorized under Chapter 4731 of the Revised Code to practice medicine or surgery.

(8) “Health care facility” means a health care facility licensed pursuant to Section 3702.30 of the Revised Code.

(9) “Detransition” means the process of halting or reversing gender affirming services and gender transition because the individual self-identifies solely as their sex assigned at birth and not another gender identity.

Appendix B: Model Rules

3701-3-17 Reporting Gender-Related Condition Diagnoses and Gender Transition Care

(A) *See model definitions (provided in Appendix A).*

(B) A health care provider may report to the Department of Health annually any:
- (1) initiation of gender affirming services including:
  - (a) gender-affirming hormonal treatment, or
  - (b) gender-affirmation surgery,
- (2) cessation of gender affirming treatment and the reason for such cessation; or
- (3) treatment plan for the purpose of detransitioning, if applicable, including:
  - (a) any mental health counseling provided or suggested, including documented refusal of such services,
  - (b) medication management, and
  - (c) the patient's specific health care needs and health management goals.

(C) A health care provider may submit reports identified in paragraph (B) of this rule using forms and formats approved by the director of health.
- (1) At minimum, the forms and formats approved by the director of health will include:
  - (a) age range of the individual receiving gender affirming services;
  - (b) sex of the individual receiving gender affirming services;
  - (c) an estimation of how long the individual sought gender affirming services before receiving a diagnosis or treatment; and
  - (d) general, non-personally identifiable information concerning relevant treatment and services provided to the individual.

(D) Information reported pursuant to this rule is protected health information subject to section 3701.17 of the Revised Code.

(E) This data shall only be used for the purpose of improving gender-affirming care for Ohioans and shall not be used to the detriment of any communities or to target any individuals or health care facilities providing gender-affirming care.

Model Form

This form is confidential – no identifying information about individuals who obtain gender-affirming services is collected except the medical record number. Statistics are summarized in an annual "Gender Transition Services in Ohio" report series. Annual report tables contain demographic and statistical information related to sex and age range at the county level.

Confidential Gender Transition Services Report
Ohio Department of Health
(Pursuant to O.A.C. 3701-3-17)

Health Care Facility:	Zip Code of Facility:

General Information

Patient Medical Record Number:	Patient State and County of Residence:
Gender-affirming services:	Age range of Patient:
☐ Initiated ☐ Continued / Resumed ☐ Halted ☐ Patient has stated cessation of treatment is due to a desire to detransition	☐ 0-18 ☐ 19-25 ☐ 26-40 ☐ 41-64 ☐ 65-84 ☐ 85+
Treatment Plan for Detransition (if applicable)	Physician Initials:
☐ Mental health counseling was provided ☐ Medication management was discussed ☐ Patient's specific health care needs and goals were discussed ☐ Patient refused counseling / treatment	_____ By initialing I certify that I reviewed the patient's medical records and all information contained in this form is true and accurate

Comments

3701-59-07 Quality Standards for Gender Transition Treatment at Hospitals and Health Care Facilities

(A) *See model definitions (provided in Appendix A).*

(B) A provider may provide gender affirmation services after:

(1) The provider has a written, comprehensive, multi-disciplinary care plan that includes the following components:

(a) The specific services to be provided,
(b) Acquisition of informed consent from the patient and, if the patient is a minor, the patient's parent or legal guardian. Such informed consent is revocable and should include:

(1) relevant information, provided accurately and sensitively, in keeping with the patient's preferences for receiving medical information, including
(a) description of diagnosis;
(b) the nature and purpose of recommended interventions;
(c) the expected benefits and risks of all options, including forgoing or ceasing treatment; and
(d) a list of side effects, risks, and possible consequences of treatment.

(c) An acknowledgement that what is considered appropriate gender-related care is specific to each patient; and that, as such, decisions made concerning gender-related care should be patient-lead with the advice and guidance from providers.

Appendix C: Medical Association Statements Supporting Gender-Affirming Care

is a lack of formal education on gender dysphoria/gender incongruence among clinicians trained in the United States. A 2016 survey of endocrinologists, the physicians most likely to care for these patients, found that over 80% have never received training on care of transgender patients.[7]

This can have an adverse impact on patient outcomes, particularly in rural and underserved areas. In fact, studies have indicated that 70% of transgender individuals have experienced maltreatment by medical providers, including harassment and violence.[7] Many transgender individuals have been subjected to conversion therapy, or efforts to change a transgender person's gender identity using psychological interventions; this is known to be associated with adverse mental health outcomes, including suicidality, and is banned in 20 states and the District of Columbia.[8]

Transgender individuals who have been denied care show an increased likelihood of dying by suicide and engaging in self-harm.[7] Transgender/gender incongruent youth who had access to pubertal suppression, a treatment which is fully reversible and prevents development of secondary sex characteristics not in alignment with their gender identity, have lower lifetime odds of suicidal ideation compared to those youth who desired pubertal suppression but did not have access to such treatment.[9] Youth who are able to access gender-affirming care, including pubertal suppression, hormones and surgery based on conservative medical guidelines and consultation from medical and mental health experts, experience significantly improved mental health outcomes over time, similar to their cis-gender peers.[10-12] Pre-pubertal youth who are supported and affirmed in their social transitions long before medical interventions are indicated, experience no elevation in depression compared to their cis-gender peers.[12] It is critical that transgender individuals have access to the appropriate treatment and care to ensure their health and well-being.

FUTURE CONSIDERATIONS

While the data are strong for both a biological underpinning to gender identity and the relative safety of hormone treatment (when appropriately monitored medically), there are gaps in knowledge that are necessary to address in order to optimize care. Comparative effectiveness research in hormone regimens is needed to determine: the best endocrine and surgical protocols[13], as it is not yet known if certain regimens are safer or more effective than others; the degree of improvement as a result of the intervention (e.g. decrease in mental health diagnoses); the need for training of health care providers and the most effective training methods; and to build the body of evidence pertaining to cardiovascular, malignancy, or other long-term risks from hormone interventions, particularly as the transgender individual ages. Additional studies are needed to elucidate the biological processes underlying gender identity; such studies may lead to destigmatization and may also decrease health disparities for gender minorities. In addition, further studies are needed to determine strategies for fertility preservation and to investigate long-term outcomes of early medical intervention, including pubertal suppression, gender-affirming hormones and gender-affirming surgeries for transgender/gender incongruent youth. To successfully establish and enact these protocols requires long-term, large-scale studies across countries that employ similar care protocols.

POSITIONS

- There is a durable biological underpinning to gender identity that should be considered in policy determinations.
- Medical intervention for transgender youth and adults (including puberty suppression, hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care.[6] Federal and private insurers should cover such interventions as prescribed by a physician as well as the appropriate medical screenings that are recommended for all body tissues that a person may have.
- Increased funding for national pediatric and adult transgender health research programs is needed to close the gaps in knowledge regarding transgender medical care and should be made a priority.

[7]Davidge-Pitts C, Nippoldt TB, Danoff A, Radziejewski L, Natt N. Transgender Health in Endocrinology: Current Status of Endocrinology Fellowship Programs and Practicing Clinicians. *J Clin Endocrinol Metab*. Apr 1 2017;102(4):1286-1290. doi:10.1210/jc.2016-3007

[8]Turban JL, Beckwith N, Reisner SL, Keuroghlian AS. Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*. Sep 11 2019;77(1):1-9. doi:10.1001/jamapsychiatry.2019.2285

[9]Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics*. Feb 2020;145(2)doi:10.1542/peds.2019-1725

[10]de Vries AL, McGuire JK, Steensma TD, Wagenaar EC, Doreleijers TA, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*. Oct 2014;134(4):696-704. doi:10.1542/peds.2013-2958

[11]Kuper LE, Stewart S, Preston S, Lau M, Lopez X. Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy. *Pediatrics*. Apr 2020;145(4)doi:10.1542/peds.2019-3006

[12]Achille C, Taggart T, Eaton NR, et al. Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *Int J Pediatr Endocrinol*. 2020;2020:8. doi:10.1186/s13633-020-00078-2

[13]Safer JD, Tangpricha V. Care of the Transgender Patient. *Ann Intern Med*. Jul 2 2019;171(1):Itc1-Itc16. doi:10.7326/aitc201907020

As the leading clinical endocrinology association, we at AACE are an inclusive community with thousands of endocrine-focused clinical members, affiliates, and partners from every walk of professional life. Our mission is elevating the practice of clinical endocrinology to improve global health, and our vision is achieving healthier communities through endocrine innovation, education, and care. We are committed to embracing diversity, and believe that inclusion, representation, and equal access to opportunities for all make our global community stronger and better.

Transgender and gender diverse people represent a sizable and growing segment of the U.S. and world Population. It is estimated that over 1 million people in the U.S. alone are transgender or gender diverse. Many transgender and gender diverse people seek hormone therapy under the supervision of an endocrinologist or other medically trained health care professional to better align their bodies with their gender identities. Being transgender is widely accepted to require medical treatment for those patients who seek it. Medical treatment may include behavioral assessment, hormone therapy, and surgery. These treatments are well established in the relevant established, international professional society guidelines including those from the Endocrine Society co-sponsored by the American Association of Clinical Endocrinology (AACE) and the World Professional Association for Transgender Health (WPATH).

The current Endocrine Society/AACE guidelines recommend hormone therapy for:

- Transgender and gender diverse adults with persistent gender identity (typically of which they've been aware for at least 6 months) that does not align with sex recorded at birth who seek treatment, who have capacity to make medical decisions, and in whom potential confounding mental health conditions are addressed.
- Transgender and gender diverse adolescents with persistent gender identity (typically of which they've been aware for at least 6 months) that does not align with sex recorded at birth who seek treatment, who have capacity to make medical decisions, in whom potential confounding mental health conditions are addressed, and who have been evaluated by trained mental health professionals who have expertise in gender incongruence in children/adolescents. Decisions regarding both puberty blockade and hormone therapy in adolescents should be made with the input of the qualified mental health professional, the endocrinologist or clinician with experience in hormone therapy/puberty blockade in children, the child, and the family.

Endocrine patients:

Endocrine patients who are transgender or gender diverse should seek medical professionals with experience in gender affirming hormone treatment for transgender and gender diverse people. Transgender and gender diverse children should seek specialized care which includes a multi-specialty team approach with professionals with expertise in gender incongruence in children and adolescents.

We at the American Association of Clinical Endocrinology (AACE) recommend endocrine patients who are transgender or gender diverse seek medical professionals with experience in gender affirming hormone treatment for transgender and gender diverse people.

We also strongly recommend that transgender and gender diverse adolescents seek gender affirming hormone therapy and/or puberty blockers from multi-specialty care teams that include 1. an endocrinologist or other health specialist who has medical knowledge of the advantages and disadvantages of hormone therapy and/or puberty blockers and 2. a mental health specialist with expertise in the care of children and adolescents who are transgender or gender diverse.

We strongly oppose legislation that limits access of endocrine patients to established medical therapies recommended for treatment of transgender and gender diverse youth. AACE strongly believes that decisions impacting health care of endocrine patients are best left to the health professional, the patient, and the patient's families like for all medical care.

Endocrine care teams:

We strongly oppose legislation that criminalizes physicians and other health professionals who provide medically appropriate endocrine care as recommended by established medical guidelines.

The Endocrine Society and AACE have published peer-reviewed, evidence-based guidelines that support endocrine care of transgender and gender diverse patients. Criminalizing provision of endocrine care will further increase the health disparities of this very vulnerable population.

medical services [5]. The challenges and barriers create significant health disparities for TGD individuals [6]. In addition, individuals are often stigmatized and experience discrimination (eg, transphobia), harassment, and victimization (eg, physical and sexual violence) [1]. The lack of access to care and mistreatment of transgender individuals contribute to poor reproductive and sexual health outcomes (ie, increased rates of sexually transmitted infections including HIV) and significant mental health morbidity including increased rates of depression, anxiety, and somatization as well as substance abuse and suicide [1]. In addition, transgender individuals who have been exposed to reparative (conversion) therapy have adverse mental health outcomes and are 4 times more likely to attempt suicide in their lifetime [7]. A recent 2021 national community survey of nearly 1000 Australian TGD people found 43% had attempted suicide [8]. Similarly, a 2020 study examining an Amsterdam cohort (1972-2017) found transgender individuals had a 3- to 4-fold higher risk of suicide compared to the general population of the Netherlands [9]. In terms of annual risk, a recent study of transgender individuals in the United States found 48.5% reported having suicidal ideation in the past year [10]. Moreover, 10.7% of transgender individuals report having attempted suicide in the past year [11].

While many TGD individuals are aware of their gender incongruence in childhood, most individuals present in late adolescence or early adulthood having lived with incongruence (gender dysphoria) for years [12]. Healthcare for TGD persons falls into 2 broad categories. First, care relates to the sex at birth (and intact organs) that follows established primary care guidelines for health maintenance and promotion of physical, psychological, and sexual health as well as prevention practices (ie, screening for prostate, breast, and genitourinary cancers) [13]. The other aspect of care relates to gender-affirming care, an approach that validates and aligns with the individual's gender identity and expression [12-15]. Gender-affirming care includes sensitive communication and may include nonmedical interventions (eg, binding to compress the breasts of a trans male) and may also include medical interventions.

Gender-affirming interventions may include halting pubertal development with gonadotropin-releasing hormone analogs after Tanner II development in adolescents to alleviate gender dysphoria that increases with pubertal progression [16]. Gender-affirming hormone therapy for transgender women (male to female) includes feminizing estrogen treatment (ie, 17-β estradiol tablets, patches, or injections) while transgender men (female to male) use testosterone to induce virilization (ie, testosterone gels or injections of long-acting testosterone esters) [15]. Some transgender individuals may also pursue surgical intervention including "top surgery" (ie, masculinizing mastectomy/chest reconstruction and feminizing breast augmentation) and/or "bottom surgery" (ie, hysterectomy, oophorectomy, vaginectomy, phalloplasty, metoidioplasty, scrotoplasty) [2]. Long-term regret for undergoing gender confirming surgery is quite low (1%-2%) [2]. Importantly, evidence supports that gender-affirming hormone and gender-confirming surgery are correlated with improved mental health and quality of life [2,14].

Evaluating psychological outcomes to gender-affirming surgery are challenging given the variability in outcome measures between studies—highlighting the need for more harmonized, systematic evaluation [17]. Despite methodologic differences between studies and the variety of measures employed, a 2019 systematic review concluded that surgical intervention can lead to multiple, significant improvements in psychological functioning. Importantly, the strength of the evidence is limited by the lack of validated measures that are specific to gender-affirming surgeries [18]. A 2021 systematic review examining the psychological effects of gender-affirming hormone therapy identified 20 reports that employed a range of study designs (ie, randomized controlled trial, before-after trial, prospective/retrospective cohort, and cross-sectional studies) [19]. While the strength of the evidence is limited by methodologic differences across studies, authors concluded that gender-affirming hormone therapy may be associated with improvements in quality-of-life measures and decreased depression and anxiety symptoms. Consistent with these conclusions, a 2020 publication reporting longitudinal data on 50 transgender individuals found significantly decreased depressive symptoms following initiation of gender-affirming hormone therapy [20]. Concurrently, quality of life increased and suicidal ideation decreased (yet these measures did not reach statistical significance). Thus, the benefits of gender-affirming treatment may outweigh the risks.

Guidelines for gender-affirming care have been published by the World Professional Association for Transgender Health (WPATH) [21] and the Endocrine Society [14]. It is worthwhile to note that these guidelines are based on relatively low-quality evidence (ie, expert opinion), and there is a need for more robust studies to strengthen evidence-based approaches to care.

Transgender hormone therapy may reduce fertility, and surgery such as gonadectomy causes irreversible infertility. Accordingly, discussions of fertility preservation (ie, sperm or oocyte/embryo cryopreservation) are important [22]. Informed consent is a legal and ethical basis for most healthcare decisions [23], and the Fenway Institute has advocated for an informed consent model to respect patient autonomy and respect self-determination regarding

gender-affirming hormonal treatment and surgery decisions [24,25]. However, evidence suggests the informed consent model is far from universal implementation [26]. Decisions surrounding care are individual and may be challenging when weighing social, financial, and health implications. Thus, mental health professionals as well as supportive family and peers can be useful in promoting a person-centered approach to care [24].

Given the unique health needs of TGD individuals, care should reflect local needs/culture and be individualized with interprofessional collaboration from a multidisciplinary team (ie, primary care providers, endocrinologists, nurses, pharmacists, surgeons, social workers, and mental health specialists) [2]. Notably, a recent review and synthesis of the literature notes the greatest barrier to healthcare for TGD individuals is the lack of access to providers who are knowledgeable in the health needs of this patient population [27]. Thus, there is a need to inform and train the current and next generation of healthcare professionals. Broadly, training falls into 2 categories. The first involves training clinical and ancillary staff on sensitive communication practices to foster trusting, respectful relationships and create a welcoming environment [28,29]. The second focuses on developing clinical competencies that are specific to TGD individuals (ie, gender-affirming hormone therapy) [28].

Reviews have highlighted the lack of knowledge and training among practicing healthcare providers as well as in curricular gaps in education for future providers [2,30,31]. Training programs have been shown to increase knowledge, confidence, and comfort in TGD care in students and practicing providers alike [32,33]. Endocrinology plays a key role in gender-affirming hormone therapy. As such, endocrine nurses play a central role in delivering comprehensive care that includes health maintenance, health promotion as well as disease prevention and advocacy for TGD patients. Moreover, endocrine nurses are frequently involved in the care of patients with differences in sex development (DSD) (Box 1), previously termed "intersex" [34].

Most patients with DSD do not experience gender dysphoria. Across the broad spectrum of diagnoses constituting DSD, 8.5% to 20% of patients experience gender dysphoria [35]. Notably, a 2018 report on 1040 participants in the dsd-LIFE study reported 5.1% experienced a change of gender in their lives [36]. Excluding individuals with Klinefelter syndrome/Turner syndrome, 3% of individuals reported a gender change after puberty. Investigators concluded that clinicians should be sensitive to gender dysphoria in patients with DSD and should consider counseling support when appropriate. Thus, patients with DSD may identify as TGD and merit consideration for gender-affirming care in the context of endocrine nursing practice.

The American Nurses Association [37], the National Association of Nurse Practitioners in Women's Health [38], National Association of Pediatric Nurse Practitioners [39], and the Pediatric Endocrinology Nursing Society [40] have developed position statements addressing the needs of transgender individuals. While the Endocrines Nurses Society (ENS) supports many of the positions of our fellow nursing societies, we feel there is a need to establish positions specific to endocrine nursing practice for young adult and adult TGD patients receiving endocrine care. We undertook an extensive literature review and engaged with community and interprofessional stakeholders to identify 9 position points and a list of resources (Box 2) for nurses seeking to increase their knowledge, comfort and confidence in delivering comprehensive, affirming care for TGD individuals.

Position

We, the Endocrine Nurses Society

1. Endorse care for transgender and gender diverse (TGD) people that relies on best available evidence, such as the World Professional Association for Transgender Health (WPATH) Standards of Care [21] and the Endocrine Society Clinical Practice Guidelines [14], to inform individualized care.
2. Advocate that all TGD individuals have access to culturally sensitive, interprofessional care provided by qualified healthcare providers (ie, physicians, nurses, advanced practice nurses, physician assistants, pharmacists, mental health professionals and surgeons) that is personalized and includes
   - Appropriate screening based on age and sex assigned at birth (organs present);
   - Trauma-informed care (Box 1);
   - Substance use/abuse screening and counseling;
   - Sexually transmitted infection screening; and
   - Screening for suicidal ideation/attempts and self-harm.
3. Support an informed consent process prior to initiating hormonal therapy and gender-affirming surgeries that includes discussion of social and financial repercussions as well as the impact on fertility to promote shared decision-making and informed decisions that are aligned with patient values and preferences.

gender-affirming hormonal treatment and surgery decisions [24,25]. However, evidence suggests the informed consent model is far from universal implementation [26]. Decisions surrounding care are individual and may be challenging when weighing social, financial, and health implications. Thus, mental health professionals as well as supportive family and peers can be useful in promoting a person-centered approach to care [24].

Given the unique health needs of TGD individuals, care should reflect local needs/culture and be individualized with interprofessional collaboration from a multidisciplinary team (ie, primary care providers, endocrinologists, nurses, pharmacists, surgeons, social workers, and mental health specialists) [2]. Notably, a recent review and synthesis of the literature notes the greatest barrier to healthcare for TGD individuals is the lack of access to providers who are knowledgeable in the health needs of this patient population [27]. Thus, there is a need to inform and train the current and next generation of healthcare professionals. Broadly, training falls into 2 categories. The first involves training clinical and ancillary staff on sensitive communication practices to foster trusting, respectful relationships and create a welcoming environment [28,29]. The second focuses on developing clinical competencies that are specific to TGD individuals (ie, gender-affirming hormone therapy) [28].

Reviews have highlighted the lack of knowledge and training among practicing healthcare providers as well as in curricular gaps in education for future providers [2,30,31]. Training programs have been shown to increase knowledge, confidence, and comfort in TGD care in students and practicing providers alike [32,33]. Endocrinology plays a key role in gender-affirming hormone therapy. As such, endocrine nurses play a central role in delivering comprehensive care that includes health maintenance, health promotion as well as disease prevention and advocacy for TGD patients. Moreover, endocrine nurses are frequently involved in the care of patients with differences in sex development (DSD) (Box 1), previously termed "intersex" [34].

Most patients with DSD do not experience gender dysphoria. Across the broad spectrum of diagnoses constituting DSD, 8.5% to 20% of patients experience gender dysphoria [35]. Notably, a 2018 report on 1040 participants in the dsd-LIFE study reported 5.1% experienced a change of gender in their lives [36]. Excluding individuals with Klinefelter syndrome/Turner syndrome, 3% of individuals reported a gender change after puberty. Investigators concluded that clinicians should be sensitive to gender dysphoria in patients with DSD and should consider counseling support when appropriate. Thus, patients with DSD may identify as TGD and merit consideration for gender-affirming care in the context of endocrine nursing practice.

The American Nurses Association [37], the National Association of Nurse Practitioners in Women's Health [38], National Association of Pediatric Nurse Practitioners [39], and the Pediatric Endocrinology Nursing Society [40] have developed position statements addressing the needs of transgender individuals. While the Endocrines Nurses Society (ENS) supports many of the positions of our fellow nursing societies, we feel there is a need to establish positions specific to endocrine nursing practice for young adult and adult TGD patients receiving endocrine care. We undertook an extensive literature review and engaged with community and interprofessional stakeholders to identify 9 position points and a list of resources (Box 2) for nurses seeking to increase their knowledge, comfort and confidence in delivering comprehensive, affirming care for TGD individuals.

Position

We, the Endocrine Nurses Society

1. Endorse care for transgender and gender diverse (TGD) people that relies on best available evidence, such as the World Professional Association for Transgender Health (WPATH) Standards of Care [21] and the Endocrine Society Clinical Practice Guidelines [14], to inform individualized care.
2. Advocate that all TGD individuals have access to culturally sensitive, interprofessional care provided by qualified healthcare providers (ie, physicians, nurses, advanced practice nurses, physician assistants, pharmacists, mental health professionals and surgeons) that is personalized and includes
   - Appropriate screening based on age and sex assigned at birth (organs present);
   - Trauma-informed care (Box 1);
   - Substance use/abuse screening and counseling;
   - Sexually transmitted infection screening; and
   - Screening for suicidal ideation/attempts and self-harm.
3. Support an informed consent process prior to initiating hormonal therapy and gender-affirming surgeries that includes discussion of social and financial repercussions as well as the impact on fertility to promote shared decision-making and informed decisions that are aligned with patient values and preferences.

AAP News™

AAP reaffirms gender-affirming care policy, authorizes systematic review of evidence to guide update

August 4, 2023
Alyson Sulaski Wyckoff, Associate Editor
Article type: News
Topics: Advocacy, Diversity, equity and inclusion

The AAP Board of Directors voted to reaffirm the 2018 AAP policy statement on gender-affirming care and authorized development of an expanded set of guidance for pediatricians based on a systematic review of the evidence.

An updated policy statement, plus companion clinical and technical reports, will reflect data and research on gender-affirming care since the original policy was released and offer updated guidance. The board recognized the value of additional detail with five more years of experience since the 2018 policy statement was issued.

The decision to authorize a systematic review reflects the board's concerns about restrictions to access to health care with bans on gender-affirming care in more than 20 states.

AAP CEO/Executive Vice President Mark Del Monte, J.D., is speaking today at the AAP Leadership Conference in Itasca, Ill.

He emphasizes that policy authors and AAP leadership are confident the principles presented in the original policy, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, remain in the best interest of children.

As part of its mission, the AAP will continue to "ensure young people get the reproductive and gender-affirming care they need and are seen, heard and valued as they are," Del Monte said.

The board reviews evidence and considers policy renewal on a regular schedule as authorizations expire. Based on the continuing review, the board reaffirmed the current guidance on transgender care until there is an updated version.

To ensure the policy update process is transparent and inclusive, the AAP will invite members and other stakeholders to share input.

The AAP and other major medical organizations — including the American Medical Association, the American College of Obstetricians and Gynecologists and the World Health Organization — support giving transgender adolescents access to the health care they need.

The AAP opposes any laws or regulations that discriminate against transgender and gender-diverse individuals, or that interfere in the doctor-patient relationship.

Additional Leadership Conference coverage

- Leadership Conference: AAP pledges to address payment issues, support pediatrician wellness
- Leadership Conference: Top resolution calls for federal protections of gender-affirming care for patients, doctors
- Reform humanitarian system for migrant children: Leadership Conference speaker

AAP News™

AAP continues to support care of transgender youths as more states push restrictions

January 6, 2022

Alyson Sulaski Wyckoff, Associate Editor

Article type: News

Topics: Adolescent Health/Medicine, Diversity, equity and inclusion, Legislation, Psychosocial Issues

As a record number of state bills targeting the rights of transgender youths were introduced in 2021, the AAP and other medical groups have stepped up efforts to protect them.

States introduced legislation to ban transgender youths from participating on athletic teams according to their gender identity, restrict access to school restrooms that align with students' gender identity and prohibit health care professionals from providing or referring patients for gender-affirming care. Bills also seek to ban changes to birth certificates and uphold the right of religious refusal — allowing providers to refuse care based on claims of religious or moral beliefs.

The AAP has partnered with chapters and other entities to file amicus briefs in support of legal challenges brought by the American Civil Liberties Union (ACLU) in several states. AAP members and leaders also have been reaching out to state lawmakers to express concerns about harmful legislation.

"It is critically important for every child to have access to quality, comprehensive and evidence-based care — transgender and gender-diverse youth are no exception," said AAP Immediate Past President Lee Savio Beers, M.D., FAAP. "As pediatricians, we will continue to speak up and advocate for our patients. We also want transgender and gender-diverse youth to know that not only do we care for them, we care about them, we value them and we will do all we can to ensure they have access to the care they need and deserve."

Here is a look at state legislation on gender-affirming care bans and sports participation bans in 2021.

Gender-affirming care

Last April, Arkansas became the first state to pass a bill banning gender-affirming care for transgender youths and prohibiting health care providers from referring them for gender-affirming care. The law also prohibits public funding for such services and the state Medicaid program from covering it for those under age 18 years; private insurers could refuse to cover gender-affirming care for any youth.

The state legislature overrode the governor's veto of this bill.

In May, the ACLU filed suit challenging the law, followed by a request for a preliminary injunction. The AAP's amicus brief with 18 medical, mental health and educational organizations supported the injunction request. After a federal judge granted the injunction on July 21 halting implementation of the law, the state appealed.

The AAP and partners plan to submit a second amicus brief later this month.

Legislation in several states is being carried over to 2022 legislative sessions, and new bills have been filed in additional states.

In Texas, the governor requested and received a determination from the commissioner of its Department of Family and Protective Services that gender-affirming surgery for youth constitutes child abuse and neglect.

The AAP's 2018 policy statement *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents* defines gender affirmation as developmentally appropriate, nonjudgmental, supportive care provided in a safe clinical space.

The policy states that pediatric providers, often the first medical professionals to discover a child's gender identity concerns, have a special role in caring for these patients who have a high risk of depression, anxiety and suicide.

The care model is not one-size-fits-all, said Brittany Allen, M.D., FAAP, a member of the AAP Section on LGBTQ Executive Committee. It recognizes the wide spectrum of normal, healthy gender identities.

"As I often tell families, gender-affirming care is creating space for children to be able to tell us their gender story, rather than filling in the end of the story for them. In that journey, gender-affirming care may draw on evidence-based medical tools — such as puberty blockers or hormone therapy — at developmentally appropriate ages. These tools have been shown to help reduce gender dysphoria and improve mental health for many transgender, nonbinary and gender-diverse youth.

Washington, D.C. (April 2, 2021) – Several state legislatures across the country have recently introduced or are deliberating bills that would restrict delivery of gender-affirming care for genderdiverse patients, specifically for children and adolescents.

Our organizations, which represent nearly 600,000 physicians and medical students, oppose any laws and regulations that discriminate against transgender and gender-diverse individuals or interfere in the confidential relationship between a patient and their physician. That confidentiality is critical to allow patients to trust physicians to properly counsel, diagnose and treat.

Our organizations are strongly opposed to any legislation or regulation that would interfere with the provision of evidence-based patient care for any patient, affirming our commitment to patient safety. We recognize health as a basic human right for every person, regardless of gender identity or sexual orientation. For gender-diverse individuals, including children and adolescents, this means access to gender-affirming care that is part of comprehensive primary care.

Further, we strongly oppose any effort to criminalize or penalize physicians for providing necessary care for their patients. Physicians must be able to practice medicine that is informed by their years of medical education, training, experience, and the available evidence, freely and without threat of punishment. Patients and their physicians, not policymakers, should be the ones to make decisions together about what care is best for them.

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About the American Academy of Family Physicians

Founded in 1947, the AAFP represents 136,700 physicians and medical students nationwide. It is the only medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine, the AAFP's positions on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit **www.aafp.org/media**. For information about health care, health conditions and wellness, please visit the AAFP's award-winning consumer website, **http://www.familydoctor.org/**.

About the American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.

About the American College of Physicians

The American College of Physicians is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. ACP membership includes 163,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

About the American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization of 60,000 members, ACOG strongly advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's healthcare.

About the American Osteopathic Association

The American Osteopathic Association (AOA) represents more than 151,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages

scientific research; serves as the primary certifying body for DOs; and is the accrediting agency for osteopathic medical schools.

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The American Psychiatric Association, founded in 1844, is the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 37,400 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. APA's vision is to ensure access to quality psychiatric diagnosis and treatment.

Ohio Children's Hospital Association

Saving, protecting and enhancing children's lives

Nick Lashutka
President & CEO, Ohio Children's Hospital Association
House Bill 68 Opponent Testimony before Ohio House Public Health Policy Committee
Wednesday, May 24, 2023

Chairman Lipps, Vice Chair Stewart, Ranking Member Liston, and members of the House Public Health Policy Committee. My name is Nick Lashutka, and I am the President & CEO of the Ohio Children's Hospital Association (OCHA). I also have the privilege of serving as President of Children's Hospitals Solutions for Patient Safety, an international effort that began here in Ohio over a decade ago and has now grown to over 140 children's hospitals around the world dedicated to eliminating patient & employee/staff harm.

I am here today to testify in opposition to HB 68.

Ohio has the world's best statewide network of children's hospitals – Akron Children's Hospital, Cincinnati Children's, Dayton Children's, Nationwide Children's Hospital, UH/Rainbow Babies & Children's Hospital and ProMedica Russell J. Ebeid Children's Hospital. Several of our institutions are ranked among U.S. News & World Report's best children's hospitals, and all our members are ranked best in class in the nation in various aspects of pediatric care. Ohio is the only state in the nation with a flagship children's hospital within a two-hour drive of every family, including our most rural parts of the state.

We serve all of Ohio's 2.6 million children, regardless of their family's ability to pay. Our mission is to save, protect, and enhance children's lives. Our members are committed to improving all aspects of children's health – including behavioral and mental health. We are experiencing a pediatric behavioral health crisis and are working every day to address the growing number of kids in need of inpatient and outpatient behavioral health services. The workforce shortage is severe and is causing families to experience unacceptable wait times and limited access to care. We are extremely concerned with the new mental health restrictions that are included in HB 68.

The allegations made against children's hospitals by supporters of HB 68 are deeply offensive and disappointing. Children's hospitals across Ohio are filled with pediatric experts who have dedicated their lives to caring for kids. We serve the most vulnerable in our state. From the beginning of this legislative process, which began in the last General Assembly, we have been willing to meet with any individuals or legislators who would like to learn more about care for this population.

All service lines within our hospitals follow standards of care to ensure quality, safety, and deliver best outcomes. Our clinics and clinicians who provide gender affirming care are no exception. Every individual and family who comes to one of our facilities does so voluntarily. We have no agenda other than to serve patients and utilize the best available research to optimize their well-being.

We have been accused of establishing gender clinics to make money. This is false. The majority of our care in these clinics is mental health. Any provider can tell you that across **all** types of insurance, behavioral health services are provided at a financial loss.

Akron Children's Hospital · Cincinnati Children's · dayton children's · Nationwide Children's · University Hospitals Rainbow Babies & Children's Hospital · ProMedica Toledo Children's Hospital

American Nurses Association Opposes Restrictions on Transgender Healthcare and Criminalizing Gender-Affirming Care

Oct 26th 2022

SILVER SPRING, MD - The American Nurses Association strongly opposes any legislation or policy action that places restrictions on transgender health care and that criminalizes gender-affirming care. Due to recent state legislative efforts, transgender and gender-diverse youth and their parents or guardians who choose to access gender-affirming care may come under legal assault in many states. Health care professionals, including nurses and advanced practice registered nurses (APRNs) who provide gender-affirming care, may also be subject to judicial process or other legal action. These restrictive laws interfere with the trust and confidentiality between patients, parents or guardians, and clinicians in the delivery of evidence-based care. The legislative intent and medical claims behind these laws are not grounded in reputable science and conflict with the nurse's obligation to promote, advocate, and protect the rights, health, and safety of patients.

ANA's Position Statement Nursing Advocacy for LGBTQ+ Populations (2018) underlines the mandate that nurses "must deliver culturally congruent care and advocate for lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+) populations." Nurses must always stress human rights protection with particular attention to preserving the human rights of vulnerable populations including transgender and gender-diverse youth. Nurses provide gender-affirming care, including social, medical, surgical, and legal affirmation interventions to transgender and gender-diverse individuals across varied settings and in collaboration with other health care professionals. Transgender and gender-diverse individuals report improved health and mental wellbeing after receiving gender-affirming care. To learn more about gender-affirming care, please see the Texas Nurses Association Position Statement on Gender-Affirming Care.

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About the American Nurses Association

The American Nurses Association (ANA) is the premier organization representing the interests of the nation's 4.2 million registered nurses. ANA advances the profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. ANA is at the forefront of improving the quality of health care for all.

Gender-Affirming Health Care Saves Lives

Mar 28, 2023

WASHINGTON, D.C. – The National Association of Social Workers (NASW) asserts that discrimination and prejudice directed against any individuals on the basis of gender identity or expression are damaging to the social, emotional, psychological, physical and economic well-being of transgender and gender diverse (TGD) people and society as a whole.

The unprecedented increase in legislation focused on TGD youth seeking affirming health care, the professionals who provide their medical care, and the families and social supports that offer resources to them is an unfortunate indicator of the lack of understanding and misinformation that currently exists. The Equality Federation is currently tracking 325 anti-transgender pieces of legislation across the nation that continue to threaten the livelihood of TGD people and substantially reduce access to services they need to stay alive. Consequences of misinformed legislation will increase threats of violence, perpetuate prejudice, promote health inequity, and increase incarceration rates for TGD people simply being themselves.

Social determinants affecting the health of TGD people are rooted in discrimination and oppression. Despite increased public awareness, every day TGD individuals and communities experience unprecedented and intolerable amounts of social

judgment, stigma, verbal harassment, physical violence, and trauma. Research tells us that no one is confronted with more hate crimes and intolerance than TGD people who also hold Black, Brown and Indigenous identities.

NASW calls on all members of the social work profession to support, promote, affirm and “protect the rights, legal benefits, and privileges of people of all gender identities and expressions.” NASW will work to repeal discriminatory legislation and regulations that do not honor someone's self-identified gender identity, transgender-inclusive health care access, health insurance options, or use of language promoting health equity and inclusive communication.

NASW participates in coalitions with other professional associations and organizations to advocate for the civil rights of all people of diverse gender expression and identity. We recognize TGD people often experience multiple intersections of oppression based on racism, poverty, heterosexism, cissexism, ageism, ableism, and mental and behavioral health status. Our code of ethics requires that we challenge social injustice and respect the inherent dignity and worth of every person.

Providing holistic care while honoring intersectionality is a foundational element of informed social work practice. To achieve health equity for all, we believe that trauma-informed care, gender-affirming care, and mental and behavioral health care should all be recognized as evidence-based and informed health care in our nation.

NASW acknowledges policy solutions that work in one state might not work, or be possible, in another state. Through its extensive chapter network, NASW is committed to informing, building, and contributing to TGD-led coalitions that work to eliminate inequities experienced by Transgender and Gender Diverse people.

Frontline Physicians Oppose Legislation That Interferes in or Criminalizes Patient Care

Washington, D.C. (April 2, 2021) – Several state legislatures across the country have recently introduced or are deliberating bills that would restrict delivery of gender-affirming care for gender-diverse patients, specifically for children and adolescents.

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Our organizations are strongly opposed to any legislation or regulation that would interfere with the provision of evidence-based patient care for any patient, affirming our commitment to patient safety. We recognize health as a basic human right for every person, regardless of gender identity or sexual orientation. For gender-diverse individuals, including children and adolescents, this means access to gender-affirming care that is part of comprehensive primary care.

Further, we strongly oppose any effort to criminalize or penalize physicians for providing necessary care for their patients. Physicians must be able to practice medicine that is informed by their years of medical education, training, experience, and the available evidence, freely and without threat of punishment. Patients and their physicians, not policymakers, should be the ones to make decisions together about what care is best for them.

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training to enable physicians to increase their knowledge and sensitivity toward transgender people and the unique health issues they face.

Along the transgender spectrum, there are people who, despite having a distinct anatomically identifiable sex, seek to change their primary and secondary sex characteristics and gender role completely in order to live as a member of the opposite sex (transsexual). Others choose to identify their gender as falling outside the sex/gender binary of either male or female (genderqueer). The generic term "transgender" represents an attempt to describe these groups without stigmatisation or pathological characterisation. It is also used as a term of positive self-identification. This statement does not explicitly address individuals who solely dress in a style or manner traditionally associated with the opposite sex (e.g. transvestites) or individuals who are born with physical aspects of both sexes, with many variations (intersex). However, there are transvestites and intersex individuals who identify as transgender. Being transvestite or intersex does not exclude an individual from being transgender. Finally, it is important to point out that transgender relates to gender identity, and must be considered independently from an individual's sexual orientation.

Although being transgender does not in itself imply any mental impairment, transgender people may require counseling to help them understand their gender and to address the complex social and relational issues that are affected by it. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-5) uses the term "gender dysphoria" to classify people who experience clinically significant distress resulting from gender incongruence.

Evidence suggests that treatment with sex hormones or surgical interventions can be beneficial to people with pronounced and long-lasting gender dysphoria who seek gender transition. However, transgender people are often denied access to appropriate and affordable transgender healthcare (e.g. sex hormones, surgeries, mental healthcare) due to, among other things, the policies of health insurers and national social security benefit schemes, or to a lack of relevant clinical and cultural competence among healthcare providers. Transgender persons may be more likely to forego healthcare due to fear of discrimination.

Transgender people are often professionally and socially disadvantaged, and experience direct and indirect discrimination, as well as physical violence. In addition to being denied equal civil rights, anti-discrimination legislation, which protects other minority groups, may not extend to transgender people. Experiencing disadvantage and discrimination may have a negative impact upon physical and mental health.

RECOMMENDATIONS

1. The WMA emphasises that everyone has the right to determine one's own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual's right to self-identification with regards to gender.

2. The WMA asserts that gender incongruence is not in itself a mental disorder; however it can lead to discomfort or distress, which is referred to as gender dysphoria (DSM-5).

3. The WMA affirms that, in general, any health-related procedure or treatment related to an individual's transgender status, e.g. surgical interventions, hormone therapy or psychotherapy, requires the freely given

informed and explicit consent of the patient.

4. The WMA urges that every effort be made to make individualised, multi-professional, interdisciplinary and affordable transgender healthcare (including speech therapy, hormonal treatment, surgical interventions and mental healthcare) available to all people who experience gender incongruence in order to reduce or to prevent pronounced gender dysphoria.

5. The WMA explicitly rejects any form of coercive treatment or forced behaviour modification. Transgender healthcare aims to enable transgender people to have the best possible quality of life. National Medical Associations should take action to identify and combat barriers to care.

6. The WMA calls for the provision of appropriate expert training for physicians at all stages of their career to enable them to recognise and avoid discriminatory practises, and to provide appropriate and sensitive transgender healthcare.

7. The WMA condemns all forms of discrimination, stigmatisation and violence against transgender people and calls for appropriate legal measures to protect their equal civil rights. As role models, individual physicians should use their medical knowledge to combat prejudice in this respect.

8. The WMA reaffirms its position that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation (WMA Statement on Forced and Coerced Sterilisation). This also includes sterilisation as a condition for rectifying the recorded sex on official documents following gender reassignment.

9. The WMA recommends that national governments maintain continued interest in the healthcare rights of transgender people by conducting health services research at the national level and using these results in the development of health and medical policies. The objective should be a responsive healthcare system that works with each transgender person to identify the best treatment options for that individual.

WPATH
WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

USPATH
UNITED STATES PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH

USPATH and WPATH Confirm Gender-Affirming Health Care is Not Experimental; Condemns Legislation Asserting Otherwise

March 22, 2023 - The United States Professional Association for Transgender Health (USPATH) and the World Professional Association for Transgender Health (WPATH) denounces the emergency regulation halting gender-affirming healthcare for transgender and gender diverse (TGD) children and adolescents issued by Missouri Attorney General Andrew Bailey as lacking scientific grounding.

The WPATH Standards of Care for the Health of Transgender and Gender Diverse People, now in its 8th version (SOC8), is the foremost evidence-based guideline for the provision of TGD healthcare. SOC8 is based on the best available science with input from over 100 global medical professionals and experts and represents best-practice guidelines for the provision of gender-affirming healthcare. Gender-affirming interventions are based on decades of clinical experience and research and are not considered experimental. Gender affirming hormone therapy (GAHT) is a component of widely accepted medically necessary care for TGD people.

In addition to WPATH, the largest establishment medical associations (including the American Medical Association, the American College of Physicians, the Endocrine Society, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Psychiatric Association, among others) have supported the provision of gender-affirming care for TGD people as medically necessary care.

Attorney General Bailey's claims were either taken out of context, cherry-picked, or from unverified sources. In some situations, the excerpted statements used in the regulation are later contradicted in the same study or article from which they were pulled. The resulting regulation from the AG's office strings together non sequitur misinformation in their attempt to prohibit safe and legal health care. For example, there are no formal Food and Drug Administration (FDA) approvals for many hormonal therapies across all of endocrinology, not limited to hormone replacement therapies for TGD patients, despite the medications themselves having been approved by the FDA. FDA regulations do not directly or explicitly prohibit the promotion of off-label uses and, per the FDA Modernization Act of 1997, the FDA must review all materials and peer-reviewed articles about off-label use.[1] Off-label use is neither uncommon nor illegal.

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[1] Ventola, C. Lee. "Off-Label Drug Information." *Pharmacy and Therapeutics,* vol.34, no. 8, Aug. 2009, pp. 428–40. *PubMed Central*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2799128/.

AG Bailey's information about brain swelling and blindness as a result of puberty blockers or hormone suppression therapy was taken from a 2022 FDA statement that referenced six patients who identified a plausible association between gonadotropin-releasing hormone (GnRH) and pseudotumor cerebri. Of the six cases that were identified, all were assigned female at birth and five were undergoing treatment for precocious puberty - only one case identified was for transgender care.[2] According to the Mayo Clinic, pseudotumor cerebri can occur in children but is most common in women of childbearing age who are obese. The most common treatment for pseudotumor cerebri is weight loss.[3] Notably, at the time of the FDA's review, symptoms had resolved in three patients and were resolving in another. In the same statement, the FDA asserts that "the incidence rate of pseudotumor cerebri associated with GnRH agonist use in pediatric patients could not be reliably established due to the small number of cases and data limitations."[4] The full FDA statement asserts a lack of information to draw such conclusions, yet AG Bailey has done so in his efforts to ban gender-affirming care.

AG Bailey's reference to Sweden's National Board of Health and Welfare (NBHW) recent declaration about the risks of puberty suppression therapy and gender-affirming hormone replacement therapy outweighing the possible benefits is also taken out of context; in their press release, NBHW recommends restraint and further study regarding GAHT for people under 18, not a total ban on care.[5] Furthermore, this statement includes no citations to literature or studies. In a July 2022 article published by the American Academy of Pediatrics, Dr. Kristina R. Olson et al reports that five years after their initial social transition, 97.5% of TGD youth continued to identify as transgender or nonbinary.[6] A peer-reviewed study from Dr. Jack Turban et al in June 2021 found that among adults who detransition or retransition, 82.5% reported at least one external driving factor including family and social stigma.[7] Instead of issuing blanket bans on gender-affirming care because some TGD people may detransition or retransition, we need fewer invasive laws and policies that further entrench social and cultural stigma about TGD people and identities and more support and resources for those who detransition or retransition.

Further, AG Bailey's emergency regulation incorrectly cites "one scientific study" that claims an exponential increase in individuals identifying as transgender because of "social factors." WPATH is unaware of any scientific study of this nature. Likely, however, the AG's office is referring to a 2018 report by Lisa Littman based upon parent observations and

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[2] *Risk of Pseudotumor Cerebri Added to Labeling for Gonadotropin-Releasing Hormone Agonists*. Food and Drug Administration (FDA), 1 July 2022, https://www.fda.gov/media/159663/download.
[3] "Pseudotumor Cerebri (Idiopathic Intracranial Hypertension) - Symptoms and Causes." *Mayo Clinic*, https://www.mayoclinic.org/diseases-conditions/pseudotumor-cerebri/symptoms-causes/syc-20354031. Accessed 20 Mar. 2023.
[4] *Risk of Pseudotumor Cerebri Added to Labeling for Gonadotropin-Releasing Hormone Agonists*. Food and Drug Administration (FDA), 1 July 2022, https://www.fda.gov/media/159663/download.
[5] "Updated recommendations for hormone therapy for gender dysphoria in young people." *Socialstyrelsen*, 22 Feb. 2022, https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdaterade-rekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/.
[6] Kristina R. Olson, PhD, et al. "Gender Identity 5 Years After Social Transition." *Pediatrics*, vol. 150, no. 2, Aug. 2022, https://doi.org/10.1542/peds.2021-056082.
[7] Turban, Jack L., et al. "Factors Leading to 'Detransition' Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis." *LGBT Health*, vol. 8, no. 4, 2021, pp. 273–80. *PubMed*, https://doi.org/10.1089/lgbt.2020.0437.

perceptions of their TGD child, adolescent, or young adult.[8] At no point during this process did Littman interview, survey, or evaluate any TGD people themselves and in 2019, she issued a correction to the report stating that,

> "Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon."

With this, Littman effectively disproves her own initial report. AG Bailey has used outdated information from a report that was later challenged by the reports' author, yet AG Bailey's inaccurate information remains in the emergency regulation.

Finally, AG Bailey's citation about a study from the Endocrine Society and the rates of gender incongruence in TGD children is also cherry-picked, this time from the 2017 Endocrine Society Guidelines referencing Dr. Peggy Cohen-Kettenis' data that only evaluated gender nonconforming children who were not necessarily transgender.[9] This claim from AG Bailey is therefore not only factually inaccurate but unrepresentative of those who would be affected by this emergency regulation. More accurate data about persistence of gender identity for TGD youth can be found in Dr. Olson's peer-reviewed study which, as noted above, reports that 97.5% of TGD youth continue to identify as transgender or nonbinary 5 years after their initial social transition.[10] Further, a January 2023 longitudinal study from Dr. Diane Chen published in the New England Journal of Medicine shows an increase in positive affect and life satisfaction and a decrease in depression and anxiety for TGD youth after 2 years of hormones.[11]

The emergency regulation issued by Missouri Attorney General Andrew Bailey is based upon manipulated statistics, flawed reports, and incomplete data, and prevents the provision of medically necessary care. Medical decisions must remain between providers and patients and their families. Consistent with earlier statements, WPATH and USPATH condemn any legislative actions to restrict or prohibit access to gender-affirming health care.

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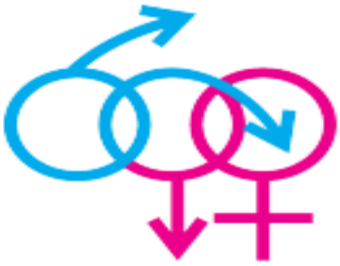
[8] Littman, Lisa. "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria." *PLOS ONE*, vol. 13, no. 8, Aug. 2018, p. e0202330. *PLoS Journals*, https://doi.org/10.1371/journal.pone.0202330.

[9] Hembree, Wylie C. "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline." *The Journal of Clinical Endocrinology & Metabolism*, vol. 102, no. 11, Nov. 2017, pp. 3869–903, https://doi.org/10.1210/jc.2017-01658.

[10] Kristina R. Olson, PhD. "Gender Identity 5 Years After Social Transition." *Pediatrics*, vol. 150, no. 2, Aug. 2022, https://doi.org/10.1542/peds.2021-056082.

[11] Chen, Diane, et al. "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones." *New England Journal of Medicine*, vol. 388, no. 3, Jan. 2023, pp. 240–50. *DOI.org (Crossref)*, https://doi.org/10.1056/NEJMoa2206297.



WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

21 December 2016

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

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

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

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

[1] American Academy of Pediatrics, 1999.

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

are well into adulthood. The various The DSM-5 descriptive criteria for gender dysphoria were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment that is frequently, though not universally, associated with transsexual and transgender conditions.
The WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (SOC) were first issued in 1979, and articulate the "professional consensus about the psychiatric, psychological, medical and surgical management of GD." Periodically revised to reflect evolution in evidence-based clinical practice and scientific research, the Standards also unequivocally reflect this Association's conclusion that treatment is medically necessary. The most recent version of the SOC (Version 7) was published in 2012.[3] WPATH recommends that medical and mental health providers and administrators check www.wpath.org regularly to ensure they are working with the most up-to-date revision of the SOC.

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

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

The current Board of Directors of the WPATH herewith expresses its considered opinion based on clinical and peer reviewed evidence that gender affirming/confirming treatments and surgical procedures, properly indicated and performed as provided by the Standards of Care, have proven to be beneficial and effective in the treatment of individuals with transsexualism or gender dysphoria. Gender affirming/confirming surgery, also known as sex reassignment surgery, plays an undisputed role in contributing toward favorable outcomes. Treatment includes legal name and sex or gender change on identity

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

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

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

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

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

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

The medical procedures attendant to gender affirming/confirming surgeries are not "cosmetic" or "elective" or "for the mere convenience of the patient." These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.[6] In some cases, such surgery is the **only** effective treatment for the condition, and for some people genital surgery is essential and life-saving.

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

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

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

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

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

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

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

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

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

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

[11] Herman JL. (2013).

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

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

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

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

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

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

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

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Appendix D: Ohio Department of Health Data Methodology Standards for Public Health Practice

Disclosure Limitation Standard: Tabulations of confidential Ohio Department of Health data shall be suppressed when the table denominator value minus the table numerator value is less than 10.

A. Overview/Summary of Standard

The standard is adopted to limit disclosure of confidential personal information when tabulating confidential information for the public. A table generally includes the following components: a numerator, a denominator and a rate calculated from these two quantities. The numerator is usually a count of persons with some trait or condition. The denominator represents the population of persons from which the numerator was drawn and may or may not be shown in the table. The table rate allows for comparison across denominator populations. The key feature of the standard that allows public release of tables is the existence of a critical minimum number of persons (10) without the trait or condition among the population of interest. If the denominator minus numerator is at least 10, then we judge the likelihood of identity disclosure to be sufficiently small so as to allow for publication of the table. Non-confidential information need not hold to the standard. The standard is not a test of statistical reliability.

B. Rationale/Description of Problem

This standard has been developed to protect the confidentiality of personal health information released by ODH. As public health workers we have an ethical and legal obligation to provide such protection. This protection will help to ensure that providers of these data continue to participate in these data collection activities.

The disclosure limitation issue is one of numerators and denominators, or of cells in a table. Numerators are typically the cases in a public health statistic and denominators are the population from which the cases arise. In tabular data, one can think of a specific cell as the numerator and the row total as the denominator. The characteristic defining the frequency cells or defining the case is often confidential. The risk of disclosure is greatest when the denominator is small and the ratio of numerator to denominator is high. Small denominators are common in tabulations for smaller geographic areas and for subpopulations (e.g., narrow age ranges, race groups, ethnic groups, small geographic areas). In situations with many cases drawn from a large pool of potential cases the risk of disclosure is small.

We usually report data for fairly large populations (e.g., County). Sometimes we need to report data for smaller areas such as census tracts or neighborhoods or for subpopulations (e.g., race groups). These data for small populations are often exactly what data users need to do their public health work of preventing disease and injury. With this standard, ODH has balanced disclosure limitation objectives against a responsibility to disseminate public health information to a wide variety of users and at a geographic and subpopulation level that supports public health work. In developing a disclosure limitation strategy, ODH has balanced the benefits and risks of cautious vs. liberal approaches to data release. On one hand, a cautious approach would suppress more tables based on small numbers and prevent misuse of the data. On the other hand, a liberal approach would disseminate more tables for the widest possible use at greater risk. The standard ODH has chosen for disclosure limitation is a result of how it weighs the relative benefits of (i) preventing misuse of data and (ii) disseminating data to users.

Local health departments, as the principal public health practitioners in the field, have greater access to detailed confidential information than other users. Tabulations compiled for Local Health Departments and for other program-approved users need not abide by the data suppression methodology outlined in this standard. Those approved users must, however, abide by the ODH standard when they re-release ODH tabulations to the public. Granting greater access to these users presents an added concern of preserving disclosure limitation at a level removed from ODH, and over which ODH has limited control.

The standard has been extensively discussed in the Data and Research Policy Committee of ODH. The standard applies to all tabulations of departmental confidential data, including those produced automatically over the internet in the Information Warehouse. The standard does not apply to the release of observation-level datasets to approved users, except that those users may be expected to adhere to the tabulation standard when producing public reports.

C. Guidelines for Implementation of the Standard

Understand what is confidential

A complete and up-to-date listing of confidential datasets and data elements is an important component of this disclosure limitation standard. Research staff must understand which data elements in each dataset are protected by this standard. The standard does not apply to non-confidential datasets, although ODH may at times wish to prevent disclosure of sensitive information from the non-confidential datasets.

Define the numerator(s) and denominator(s)

Clear understanding and definition of the numerators and denominators in a table is critical for correct application of this standard. Program research staff must determine in advance which elements of a table represent numerators and which represent denominators. For example, a county low birth weight rates table is a series of 88 low birth weight numerators and total birth denominators (one set for each county). A table of pre-term babies by age is a series of age-specific counts of pre-term birth numerators and age-specific total birth denominators (one set for each county). Some indicator tables don't have clear single numerators. For example, in a county table of mother's marital status one must specify whether the married count or the unmarried count or both counts represent numerators. A different sort of numerator/denominator pair occurs when the very existence of a person in a database is confidential. An example of this is the induced terminations registry. A table of abortion rates by county would have abortion counts as the numerator and the population of women as the denominator.

Assess the impact of applying the standard to a table

Once the numerator and denominator are defined, researchers should determine which rows in a table will be suppressed based on the standard. If no suppression is dictated then a single table will meet all needs for the table. If suppression is required the researcher may need to maintain a public version of the table as well as a confidential version for approved users. Researchers should also assess whether suppressed numbers in a table can be calculated from unsuppressed numbers in the same table. Also, researchers need to be aware of other tables already published that may be used to determine suppressed values by subtraction.

Consider changes to tables to increase dissemination of public information

There are several strategies available to reduce data suppression in tables. Since disclosure risk is highest when tables include small denominators, researchers should consider aggregating smaller denominators into fewer and larger denominators. For example, researchers might combine multiple years of data together to increase the counts in table cells. A similar strategy would be to group geographic areas together. For example, if a census tract table is overly suppressed perhaps a zip code table would be adequate to represent the geographic variation in a health indicator. Another example in an age-specific table would be to re-define age into broader categories.

Release data in multiple customized formats when necessary

Some population groups are important to public health but inherently small in size. For example, teen mothers or Hispanic mothers as denominator groups often lack sufficient observations to pass the standard for County level or City level tables. Researchers should consider special reports to allow for release of important public health statistics for smaller groups that are overly suppressed in automated tabulation systems.

Reference: The “denominator – numerator at least 10” rule was originated by Garland Land, Missouri Dept. Health. He presented the rule at the NAPHSIS/CDC Assessment Initiative Conference in January, 2002 at Minneapolis.

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December 6, 2023

RE: Sub HB 68 - the trans youth medical and school sports ban - *oppositional testimony*

Madame Chair Roegner, Ranking Member Hicks-Hudson, and esteemed committee members :

TransOhio is Ohio's state-wide equality group. Founded in 2005, TransOhio is a 501(C)(3) nonprofit organization comprised entirely of volunteers dedicated to education, advocacy, support, and providing community to transgender people and their allies. On behalf of the greater trans, nonbinary, intersex, and gender nonconforming communities here in Ohio, we humbly ask you today-–as we have asked various other committees many times before-–to **stop the unnecessary and unconstitutional legislative assault on trans youth**.

We've heard statements made before Ohio legislative bodies for years now that the concept of "transgender identity" is a brand new phenomenon… one that's being forced upon society at large by shadowy authority figures (teachers, therapists, doctors, social media influencers), intent on tricking unsuspecting cisgender children and "turning" them transgender… for reasons unknown. That absolutely ridiculous claim has no basis in reality, and yet it's consistently been the undermining reason cited for so many anti-transgender bills, just like HB68.

While this feels like a last stop for HB68, we feel like we have to start at the very beginning:

1) Transgender, nonbinary, intersex, and gender nonconforming students are already attending schools and participating in extracurricular activities, like team sports, in Ohio; and this bill would not just force current athletes to sit on the bench and not play, it would require them to either switch teams or quit entirely. That's not fair.
2) Athletic governing bodies like the Ohio High School Athletic Association and the National Collegiate Athletic Association have already implemented policies that allow trans student athletes to play on teams consistent with their gender identity; and this bill would restrict the ability of these associations to regulate sports as they have for years.
3) Nearly all educational facilities in Ohio that accept public funding currently have student policies that specifically protect trans students from discrimination, including primary schools, high schools, trade schools, and institutions of higher education; and this bill would require those schools to change their policies, which might prompt legal action.
4) Courts in Ohio already have a standard for considering the best interest of children in matters of custody, support, and parenting time; and this bill would limit the courts by

forbidding judges and magistrates from considering anti-transgender sentiments of parents, which is relevant when discussing the child's safety and welfare.

5) Gender-affirming transition-related healthcare is standard care; and this bill restricts the rights of medical professionals to provide the best care for their patients, as well as patients (and their parents) from being able to determine their own course of treatment.

The neutral position on transgender children and adolescents is not that you don't know how you feel… it's that policies and regulations regarding the care of trans patients, including minors, and participation of trans students already exist in Ohio. Those policies and regulations are by no means perfect, but most have been in effect for over a decade and they continue to evolve. This bill is wholly unnecessary… and worse, it assumes that no parent would support their trans child; that parental rights only matter when the parent has an anti-trans viewpoint.

The trans community has been referring to HB68 as "the Frankenstein bill." This isn't just because the thought of losing the opportunity to participate in school sports AND the thought of losing access to mental health resources and gender-affirming healthcare is the stuff of nightmares for most trans youth; it's because this bill is a legislative monstrosity, pieced together from previously failed bills. This bill contains a sports ban: SB187, HB61, HB6; tacked into a healthcare ban: HB454; which limits the powers of the courts and creates causes of action. These unrelated pieces are held together with transphobia, the notion that the pieces here are related at all simply because they deal with "the transgender question," a question that does not call for a legislative answer. Governor DeWine has even previously stated that he would veto pieces of this bill.

Gender-affirming medicine is older than the birth control pill, Viagra, insulin, and cortisol (see attached). Many of the gender-affirming medical procedures done today are an established part of endocrinology with over 100 years of international use. It is a fallacy that there are no studies that demonstrate the effectiveness of appropriate medical care for gender nonconforming children and adolescents.

Fairness and good sportsmanlike behavior isn't just learned while playing sports; it's learned while observing as well. This bill has already had devastating effects for the trans community. Families have decided to move away from Ohio, leaving the only home they'd ever known. Discrimination and bullying of trans students–particularly from *parents* at school board meetings–is rising at an alarming pace. Violence against the trans community in general has also risen. And notably, cisgender people, who are not and never have been transgender, have been harassed and attacked due to strangers assuming and misidentifying their gender identity. These problems will not be addressed by this bill – they will be exacerbated by it.

We urge you to **vote no**. Thank you for your time and consideration. Please feel free to contact us with any questions. We welcome further discussion.

Respectfully submitted, TransOhio

Gender-Affirming Care is More than 100 Years Old!

Gender-affirming care — medical care for the purpose of affirming a person's gender regardless of their sex assigned at birth — developed with endocrinology, the study of hormones. This same field of medicine gave us the birth control pill, treatments for menopause, treatments for erectile dysfunction, medications for hair loss, reconstructive surgery, speech therapy, and Insulin, all of which came *after* the 1889 discovery that underpins gender-affirming care: that hormone injections can affect human sex organs.

A Timeline of Gender-Affirming Medicine:

1889: Dr. Charles Edward Brown-Séquard, or the "Father of Endocrinology,"[9] discovers the effects of hormones on human sex organs while trying to treat his own erectile dysfunction. **Today, we would call this gender-affirming care.**[10]

1890s: Merck & Company[11] uses hormones as a medical treatment for symptoms of menopause.

1905: Ernest Starling[12] coins the term "hormone" in a series of lectures at the Royal College of Physicians in London.

1910: Eugen Steinach,[13] an Austrian endocrinologist, discovers that cross-sex hormones change the behavior of lab rats. He begins experimenting with the use of hormones in people.

1916: The Association for the Study of Internal Secretions was established, known today as the Endocrine Society.[14]

1918: Dr. Magnus Herschfeld opens the Berlin Institute for Sexual Science in Berlin, Germany. Hirschfield would later administer the first hormone therapy to patients with the help of **Steinach** and others. **Dr. Harry Benjamin,** who would go on to Found World Professional Association for Transgender Health (WPATH), learned the practice of hormone therapy from both Steinach and Herschfeld in the **1920s** and brought it to the United States.

1921: Discovery of Insulin,[15] **a hormone** produced by the pancreas, by researchers at the University of Toronto.

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[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7334883

[10] https://www.thehastingscenter.org/news/gender-affirming-care-for-cisgender-people-qa-with-theodore-schall-and-jacob-moses

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7334883

[12] https://www.embopress.org/doi/full/10.1038/sj.embor.7400444

[13] https://pubmed.ncbi.nlm.nih.gov/24302628

[14] https://www.news-medical.net/health/Endocrinology-History.aspx

[15] https://pubmed.ncbi.nlm.nih.gov/30405529

1926: Scientists **synthesize hormones** like thyroxine (controls how much energy is used by the body), and thereafter synthesized hormones such as estrogen, testosterone, and progesterone, leading to treatments for menopause as well as **the birth control pill.**[16]

1931: The first male-to-female genital surgery is performed on Dorchen Richter, which is arranged by the Berlin Institute.

1933: Nazis burn down the Sexual Science Institute in Berlin. The Nazis, as well as Hitler himself, targeted Dr. Herschfeld, and once called him "the most dangerous Jew in Germany."[17]

Key Context: The Nazi view of eugenics and white supremacy directly led to the killing of LGBT people, as well as nearly 6 million Jewish people,[18] during the holocaust. **Many of the arguments about the existence of 'the two-sexes' and gender 'purity' developed during the eugenics movements of the 1920s and 30s.**

1941: Dr. George W. Henry, New York Psychiatrist and Director of the Committee of the Study of Sex Variants, wrote Society and the Sex Variant. The study started in 1935 and was one of the first comprehensive scientific studies of homosexual behavior. Dr. Henry saw people as non-binary and thought it was not scientific to classify persons as fully male or female, a vision which was startling at the time.

1942: Wyeth Ayerst introduces Premarin,[19] an estrogen medication used to treat symptoms of menopause.

1945: World War II ends. Phalloplasty, a surgery that takes existing skin, tissue, and nerves from surrounding areas on a patient's body to repair or create a neophallus, begins to be performed on war veterans.

1946: Dr. Harold Giullies performs first documented phalloplasty surgery on a trans man.

1948: The hormone cortisone[20] is used for the first time when treating rheumatoid arthritis.

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[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1369102

[17] https://thetmplanet.com/magnus-hirschfeld-remembering-our-history-so-we-never-forget-what-bigots-are-capable-of-tmplanet

[18] https://encyclopedia.ushmm.org/content/en/article/documenting-numbers-of-victims-of-the-holocaust-and-nazi-persecution

[19] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6780820/#B2-medicina-55-00602

[20] https://msupress.org/9781611860337/the-quest-for-cortisone/

1952: Christine Jorgenson, the first American to become famous for their gender transition, begins her transition using hormone therapy and surgeries. **Dr. Harry Benjamin**, the father of transgender medicine, begins using the word *transsexual* soon after to describe people who seek out medical intervention.

1966: Gender-affirming surgeries are performed on transgender patients openly in the United States.

1972: Dr. Richard D. Murray, plastic surgeon in **Youngstown, Ohio** begins providing 2 decades of gender-affirming surgeries.

1973: Homosexuality is removed from the DSM-5, but transgender identity remained as *Gender Identity Disorder (GID).*

1974: The National Research Act, or "the Common Rule,"[21] is published, outlining Federal regulations for the human subject trials and research. The rule regulated many aspects of human research, including standardized informed consent. All medical research, especially on youth and vulnerable populations, has strict standards upheld by this Federal Law.

1979: Formerly known as the **International Gender Dysphoria Association** (**HBIGDA**), **Dr. Harry Benjamin** founded WPATH – the World Professional Organization for Transgender Health – that sets the international standards and guidelines for the profession.

1981: The term "Gay-Related Immune Deficiency" was coined to describe what we now call AIDS/HIV. The crisis affected Transgender people and Black LGBT people particularly, who often did not have access to medical care, and led to a new focus on LGBT health care.

1991: The National Research Act is published, which identified basic ethical principals in medical studies. Created by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

1993: The U.S. Food and Drug Administration (FDA) approves puberty blockers to treat precocious puberty in children, after being used since 1980.

2014: A U.S. government panel decided that Medicare *must* cover gender-affirmation surgery as part of a patient's necesary primary care.

2015: Gender Dysmorphia replaced Gender Identity Disorder and is added to the DSM5 – stating explicitly that it is not a mental disorder. This definition also changes to specify that **one must have a strong desire to be the other gender – an important addition that was not included in the definition until this time.**

[21] https://www.hhs.gov/ohrp/regulations-and-policy/regulations/common-rule/index.html

Key Context: Studies conducted before 2015 may have different definitions that do not correctly identify transgender people as separate from other kinds of LGBT people, like non-binary people and gay men. ”Homosexuality” was removed as a mental disorder in 1954. Studies conducted from 1973 to 2015 may not have accurate data as a result, as many participants in may have been inaccurately labeled as trans (which leads to skewed reports of “detransitioning” – these people never were transgender).

2018: The first full penis and scrotum transplant is performed at John Hopkins on cisgender war veteran, which is gender-affirming surgery.

2023: In the last year, lawmakers around the United States have introduced more than **500+ anti-LGBT+ bills.** As of November 2023, 14+ have passed legislation banning or limiting access to this care, and many other states are actively considering the legislation; **7+ in Ohio.**

Notes:
Transgender people — including trans and Intersex children[22] — existed long before gender- affirming care. Their long-documented history in the U.S. dates back to as early as the 1700s.

In the US, **the exploitation of Black women** during American slavery developed much of the modern field of gynecology. Much of this knowledge is also used today in American medicine, both in treatment for cisgender and transgender women. However, Black women, including black transgender women,[23] still have significant health disparities that result in higher mortality rates.

Intersex people, specifically Intersex children, were often non-consensually given surgical procedures at birth to align their anatomy during the 1930s and 40s when genital surgeries were first being developed. Many of these procedures, which were done before standardized informed consent in the 1970s, contributed to the development of genital reconstruction today. The United Nations called non-consentual, medically unnecessary surgery on intersex infants and children “torture” in 2013. Today, many Intersex newborns in the U.S. are still given genital surgeries that they cannot consent to. **This is <u>not</u> gender-affirming care.** Instead, these surgeries align the child with one sex or the other at birth based on a doctor's judgment at the time – a practice that many Intersex people reject.[24]

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[22] https://www.upress.umn.edu/book-division/books/histories-of-the-transgender-child

[23] https://www.washingtonpost.com/outlook/2022/03/18/black-trans-women-face-unique-threat-rooted-centuries-history

[24] https://healthlaw.org/surgeries-on-intersex-infants-are-bad-medicine

Read More:

- Transgender History by Susan Stryker[25]
- Histories of the Transgender Child by Julia Gill-Peterson[26]
- Medical Apartheid by Harriet A. Washington[27]
- Black Trans Women Do Not Have A Life Expectancy of 35[28]
- A Queer History of the United States by Michael Bronski[29]

[25] transreads.org/wp-content/uploads/2019/03/2019-03-17_5c8eb1ebaced4_susan-stryker-transgender-history2.pdf

[26] https://www.jgillpeterson.com

[27] https://www.penguinrandomhouse.com/books/185986/medical-apartheid-by-harriet-a-washington

[28] https://19thnews.org/2022/08/black-trans-women-life-expectancy-false

[29] https://archive.org/details/queerhistoryofun0000bron

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Re: Department of Health Rules 3701-3-17 [Reporting Gender-Related Condition Diagnoses and Gender Transition Care]; 3701-59-06 [Hospital Quality Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors]; and 3701-83-60 [Health Care Facility Standards for Gender Reassignment Surgery and Genital Gender Reassignment Surgery for Minors].

TransOhio has taken considerable time, energy, and resources to create meticulous comments submitted to both the the Ohio Department of Health (ODH) and the Ohio Department of Mental Health and Addiction Services (OMHAS). Our comments are backed up by over 30 pages of research, references, and studies from major medical institutions, societies and journals. Today, we ask the Joint Committee on Agency Rule Review to invalidate the "Gender Transition" Rules, 3701-3-17, 3701-59-06, and 3701-83-60.

Founded in 2005, TransOhio is a nonprofit organization dedicated to supporting the trans and allied communities in Ohio. TransOhio works to promote transgender rights, raise awareness about transgender issues, and provide resources and support to transgender individuals and their allies. TransOhio vehemently opposes the proposed "gender transition rules." The trans community has already suffered harm at the mere introduction of these rules. We've heard countless stories from individuals and families who have been told by healthcare professionals that they would have to stop, delay, or rush into establishing care to conform to these rules (which aren't even in place). The mere introduction of these rules has increased the culture of fear and cruelty across the state being experienced by trans people.

Concerns being expressed about doctors rushing to administer care to transgender youth are not based in reality. We have spoken with dozens of families who have children not yet old enough to receive gender affirming care in the form of puberty blockers. Not only have doctors not been rushing to administer care, in accordance with standards of care, but proposed rules now add insult to injury in that

long wait for care. Children and their families that we've spoken to now see the care they need being restricted and banned in many cases, years before they would even have access. Parents have very real concerns about the economic impact of these rules, as well. We have spoken with numerous parents who are moving and taking their business out of state along with their families, numerous medical students who refused to practice in Ohio in the future, multiple conferences with no interest in operating within Ohio, and this is all with the introduction of the rules.

These proposed rules are also not taking place within a vacuum. They were written in haste under the guise of emergency as part of the Governor's response to the passage of HB68, the (un)SAFE Act. The outcry of fear, stress, and direct harm from the proposal of anti-transgender rules led to TransOhio creating an Emergency Fund to help those community members most directly affected relocate or access appropriate gender-affirming health care in other states. In the first month, we distributed over $10,000.00 directly to families of transgender youth, assisted over 200 trans and nonbinary adults in establishing care outside of Ohio, and connected over 300 individuals to resources and community. Additionally, TransOhio also launched a peer support Warm Line to address the current and emerging mental health crisis. In less than 90 days, we received over 60 crisis calls. Our volunteers have addressed dozens of nonemergency calls, provided comfort and community, and connected people to vital resources. Nearly 33% (⅓) of all of our calls have been from cisgender providers currently treating or open to treating transgender patients. These proposed rules are causing confusion, anxiety, and fear in cisgender people, too. We continue to hear in the media that these rules are "common sense" and "will only affect a tiny portion of the population." Both assertions are categorically false.

Our concerns about these rules are many, but TransOhio is alarmed by the data collection and sharing requirements. The full scope and danger of this "trans list" is unknown. It is impossible to safely and truly anonymize data from such a small and specialized subset of the population, and doing so and then sharing that data with legislators rather than medical professionals is a horrifying potential government overreach. This is an overreach that may put people in danger, over burden medical institutions with reporting tasks, and violate HIPAA. The cost of data breaches as outlined in detail by the Harvard Business Review and specifically medical data breaches as outlined by the National Institute of Health are but two studies detailing the negative fiscal impacts to the proposed rules. A data breach is any security incident that results in unauthorized access to confidential information. Confidential information like the easy to deanonymize data of transgender Ohioans. The long-term study done by the NIH "showed that healthcare records were exposed by both internal and external attacks, such as hacking, theft/loss, unauthentic internal disclosure, and the improper disposal of unnecessary but sensitive data." It is based on many sources, including this one that we can not rely on data to be safe from internal actors compromising the safety of the data. "In 2022, the global average cost of a data breach reached $4.35 million, while the number is more than double in the U.S., averaging $9.44 million. These expenses can include everything from ransom payments and lost revenues to business downtime, remediation, legal fees, and audit fees."

The data collection required by these rules will also be highly prone to error and false conclusions about the population. The very commonplace ways that people access healthcare will lead to huge anomalies

and errors. For Example: Let's say I make an appointment with a clinic at hospital network A, when I get my appointment I don't end up liking the bedside manor of the physician. So after that appointment I made an appointment with clinic B. The doctor at clinic B is alright and I see him for 6 months, but then he changes practices and is no longer covered by my insurance. It takes a few months before I can get a new doctor and in that time my original prescription lapses. I later got a new doctor at clinic B. And a month later I got a sore throat and needed antibiotics. I went to a minute clinic affiliated with hospital C and disclosed my HRT meds on my intake form. Based on how the reporting is laid out right now I would be reported at 3 transgender people 2 of whom detransitioned based on having two separate, common and reasonable instances of not having continued treatment with a provider, when I am 1 trans person who has not detransitioned and is just navigating our healthcare system. Why would the government want garbage data like this collected?

TransOhio urges JCARR to recommend the Ohio Department of Health to not adopt *any* rules restricting gender-affirming health care to transgender patients. We ask that you **invalidate** rules O.A.C. 3701-3-17, O.A.C. 3701-59-06, and O.A.C. 37-1-83-60 in their entirety.

For the following additional reasons, in addition to our attached supplemental research and extended comments previously submitted, TransOhio asks JCARR to recommend that all currently proposed ODH rules be invalidated:

1. *These rules exceed the scope of the agency's statutory authority*. The Ohio Department of Health simply does not have the legal authority to propose, enact, or enforce rules that target a minority population in this way. The Department of Health operates Ohio's public health system and "strives to eliminate health disparities." It works to control the spread of infectious diseases, prepares and responds to public health threats, provides access to health care, and regulates health care providers. These rules do not help accomplish any of those goals.

2. *These rules conflict with the intent of the Ohio Administrative Rules*. Chapter 3, for instance, deals with communicable diseases. Under Rule 3-17, physicians are required to report data on patients they presume to be transgender or detransitioning – gender identity is not infectious, and gender-affirming care is not transmittable through contact with other trans individuals. No other medical condition is regulated and/or tracked in this way. Codes that allow for collection of aggregate health data do so with the express intent to reduce the spread of disease. This rule has no clear intent.

   Chapters 59 and 83 regulate Ohio hospitals and health care facilities for the purpose of preserving life and improving care. Restrictions on evidence-based best practices and local standards of care do not improve care. In fact, physicians are required to use their best professional judgment when practicing medicine; and these rules directly interfere.

The rules also conflict with HB68, which will take effect April 24, 2024. The legislative intent of 68–which TransOhio fundamentally disagrees with–was to regulate care in a way that only the General Assembly could. It's clear that Ohio lawmakers who voted for 68 believed that the legislation was the only way to accomplish their goal.

3. These rules will have a negative impact on businesses and the Ohio economy, and *there has not been a good-faith effort to analyze that impact*. The purpose of the required impact review is aimed at modifying or eliminating unnecessary or needlessly burdensome rules while establishing regulatory performance standards that will make Ohio a more competitive place to do business. The analysis did not include any mention of the increased costs to patients, as well as increased healthcare costs in general. The burden of excessive administrative costs is already a problem in Ohio healthcare facilities. The impending loss of specialized healthcare workers who will not be able to continue to practice under these rules, as well as the potential need to hire additional staff just to keep up with the lofty reporting requirement, will be devastating to Ohio. We've already seen huge economic losses in other states that have exercised government action targeting transgender people.

4. These rules are unconstitutional and, as such, cannot be enacted.
    a. *U.S. Constitution:*
    These rules will fail a constitutionality test under the U.S. Constitution's Equal Protection Clause, as well as the First and Fourth Amendments.

    b. *Ohio Constitution:*
    These rules will fail a constitutionality test under the state constitution's rights to privacy, Equal Protection, and the new voter-approved right to reproductive health.

    c. *Federal Law:*
    These rules violate the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act (HIPAA).

    The ACA prohibits sex discrimination– including anti-transgender discrimination– by health providers and insurance companies. Under the ACA, it is also illegal for most insurance companies to have exclusions of transition-related care, and it is illegal for most health providers to discriminate against transgender people, like refusing to treat them in accordance with their gender identity. On May 5th, 2021, the Biden Administration and HHS announced that the Office for Civil Rights will interpret and enforce Section 1557 of the ACA and Title IX's prohibitions on discrimination based on sex to include both discrimination on the basis of sexual orientation and discrimination on the basis of *gender identity*. Further, HIPAA protects patients' privacy related to their personal health

information, including information related to a person's transgender status and details about their medical transition

d. *State Laws:*
These rules violate regional anti-discrimination laws across Ohio.

e. *Public Policy:*
These rules directly conflict with modern behavioral and physical health ethics and values, as well as current standards of care, resulting in increased legal and licensure liabilities. Professionals will not be able to ethically practice in our state if these proposed rules become Ohio law, resulting in even more restricted availability of knowledgeable providers to patients who are already underserved. These rules violate Ohio public policy. Should they be enacted, ethical practice for healthcare professionals in the state would become untenable, exacerbating the scarcity of providers and quality of care for an already underserved patient population. Further, restrictions on access to gender-affirming care, especially for a small, specific group of people, hinder an individual's autonomy, well-being, and access to essential healthcare, leading to increased harm and discrimination. Good public policy fosters societal progress and promotes the common good, and that is not what these rules do.

f. *Individual Contracts and Policies:*
These rules will frustrate existing and ongoing contracts within the medical field and will force health care systems to abandon their non-discrimination policies and guarantees of exceptional care.

Ohio has the right–and obligation–to enact laws, rules, and regulations to promote the health, safety, and welfare of its citizens. Simply put, we know that the state has NO compelling interest in restricting a provider's ability to practice gender-affirming health care or prohibiting a trans patient from receiving appropriate gender-affirming treatment or executing unnecessary and potentially harmful tracking of healthcare data.

Conclusion

These rules do not improve or promote care for trans patients. TransOhio urges this body to recommend the proposed rules be invalidated and withdrawn in their entirety: O.A.C. 3701-3-17,O.A.C. 37-1-83-60, and O.A.C. 3701-59-06.

Respectfully submitted,
TransOhio Board of Directors