February 24, 2026

From: Paul Terdal
To: Oregon Senate Committee on Judiciary
Re: HB4088A – Oregon Evidence-based Reviews of Gender Medicine

Dear members of the Senate Committee on Judiciary,

During the February 23rd hearing on HB4088A, many proponents emphasized their view that "gender affirming care" was medically necessary, evidence-based care for treatment of gender distress.

Oregon's Health Evidence Review Commission has examined the evidence for "gender affirming care" twice – in 2012 and 2023. In both cases, HERC found "very poor quality evidence" and a "paucity of data" for children and adolescents. Nevertheless, both times, HERC went on to endorse full, comprehensive coverage of gender medicine procedures, including puberty blockers, cross-sex hormones and even surgical procedures like mastectomies and genital surgeries, for children, with no lower age limit.

A review of data from Oregon's All Payer All Claims database, and from commercially available sources, confirms that Oregon's Medicaid program and commercial insurers have paid for hundreds of mastectomies and dozens of genital surgeries on children under the age of 18 – with little to no evidence of benefit, according to OHA's own internal analysis.

This report summarizes key findings from a review of HERC records and Oregon data, and provides a timeline. Key documents are attached or linked.

Oregon's Evidence-based Medicine Process:

Oregon's Health Evidence Review Commission (HERC) has long had an international reputation for excellence in evidence-based medicine, and is required by Oregon law [ORS 414.690(4)] and the Oregon Health Plan Section 1115 Medicaid Demonstration Waiver with considering "both the clinical effectiveness and cost-effectiveness of health services … using peer-reviewed medical literature" in developing the prioritized list of health services for coverage in Oregon's Medicaid program. HERC's Quality of Evidence Statement explains that it "relies heavily on high-quality evidence … in making prioritization decisions…." HERC uses the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system as described in its methodology and a presentation.

HERC frequently contracts with the OHSU Center for Evidence-based Policy (CEbP) to conduct health technology assessments and clinical effectiveness reviews of health care

interventions. HERC then takes public comment and holds hearings to gather additional evidence and information before making a final decision.

HERC Reviews of "Gender-Affirming" Medical Interventions:

HERC has conducted evidence-based reviews of "Gender-Affirming" medical interventions with support from the OHSU Center for Evidence-based Policy twice – in 2012, and again in 2023.

In both cases, HERC and CEbP found the evidence to be lacking:

- In 2012, the report found "very poor evidence of the benefit of puberty suppressing therapy for transgendered youth, based on the existing literature." The limited evidence the report did find was primarily about adults over the age of 30.
    - Despite this lack of evidence, HERC voted in 2014 to provide Medicaid coverage of comprehensive sex-change procedures, including genital surgery. After a debate, HERC specifically voted to remove any lower age limit on any procedures to allow children to transition, even surgically, despite the lack of evidence. The committee noted that Oregon law allowed children age 15 and older to make their own medical decisions without parent consent.
- In 2023, HERC staff commissioned a new, more comprehensive report from the OHSU Center for Evidence-based Policy.
    - In an unusual departure from standard practice, CEbP consulted with four physicians at OHSU who provide "gender affirming treatment" throughout development of the report. OHSU has withheld the names of the authors and the physicians consulted. The "conflict of interest" section of the report denied any conflicts, even though the consulting physicians all directly benefitted from Medicaid reimbursement for their services.
    - Oregon Health Authority staff also invited Dr. Eli Green, a transgender advocate with no medical education or licensure to edit the draft report.
    - Even with this direct input from physicians practicing gender medicine and a transgender advocate, CEbP was unable to "identify any SRs" [Systematic Reviews] "with extractable data on gender affirming medical interventions among adolescents and youth." Decrying this "paucity of data" the report explained that all of its findings for adolescents or youth were based on a single lower quality systematic review and two small cohort studies.
    - The report found no data at all regarding reduction in youth suicide attempts, or gender dysphoria symptoms from use of gender affirming hormones or surgeries.

    - In a significant departure from the standard evidence-based processes for HERC and CEbP, the report did not use the GRADE methodology to assess the quality of evidence or strength of recommendations
- Upon passage of HB2002(2023) – which mandated Medicaid coverage of the "accepted standard of care" for "gender affirming treatment" – Oregon Health Authority staff abruptly cancelled the nearly-complete report on "Receipt of Gender-affirming Medical Interventions" and withheld it both from the members of HERC and the general public
    - OHA had already spent more than $100,000 in consulting fees for CEbP's work on the 39 page report
- OHA staff advised HERC to endorse a third-party guideline, the "WPATH Standard of Care version 8" as the officially "accepted standard of care" under HB2002.
    - HERC members were never provided with the draft evidence-based report or a summary of its findings about the weak state of evidence – nor were they provided any analysis of the WPATH document (or even a copy to review)
- In December 2023, Paul Terdal obtained a copy of the unfinished CEbP report through a public records request, and submitted a letter and written testimony to HERC urging them to finish and publish their report to provide patients, providers, and policy makers a clear and impartial summary of the evidence
- As reported by the Lund Report and Oregon Public Broadcasting, Mr. Terdal's letter spurred significant internal debate between HERC leadership and OHA staff throughout 2024
    - HERC Leadership repeatedly asked OHA staff to prepare recommendations to either retract their endorsement of WPATH as the "accepted standard of care," or to provide additional alternatives
    - Although OHA staff internally acknowledged that there was "very little evidence" for "gender affirming treatment" they did not comply with HERC Leadership requests to develop alternatives to the WPATH endorsement.
    - In April 2024, the Oregon Department of Justice issued a confidential legal opinion advising OHA to remove WPATH from the "prioritized list" to "reduce risk." OHA chose not to follow this legal advice, as HERC Director Jason Gingerich reported to OHA Director Sejal Hathi in November 2024
    - In November 2024, after the New York Times reported that Dr. Johanna Olson-Kennedy, a key researcher, had withheld publication of evidence showing a lack of benefit from gender-affirming treatment, HERC leadership frustration was escalated to OHA Director Hathi, with several recommendations to either withdraw or quality the endorsement of WPATH

on the prioritized list. All recommendations from HERC leadership were rejected.

- The Oregon Health Authority posted the incomplete draft report on their website after inquiries from the Lund Report.

Refer to the attachments for key documents described above.

Prevalence of "Gender Affirming Treatment" in Oregon

Oregon Health Authority Analysis of Prevalence:

When HERC originally adopted comprehensive coverage of "gender-affirming treatment," the Oregon Health Authority expected very little demand, as reported by All Things Considered in January 2015:

> "Oregon estimates at least 175 people will use the coverage this year."
>
> "But what about the cost? [Dr. Ariel Smits, HERC Medical Director] best estimate is up to $200,000 — for the whole state."

Public records provided by the Oregon Health Authority to the Oversight Project (Request No. 2025-0712) show that actual Medicaid costs in 2015 were $721,954 – more than 3.5 times the initial upper-bound estimate – and rose to $12,344,069 by 2024 – more than 60 times the initial cost estimate.

The number of patients seeking "gender affirming treatment" was also much higher than expected – with 1,964 patients in 2015, rising to 14,149 patients in 2023.

Analysis of 2019 APAC Public Use File Data:

Independent analysis of the 2019 APAC Public Use File provided by the Oregon Health Authority shows the following:

- 7,585 individual patients had received Oregon-based insurance, Medicaid, or Medicare reimbursement for services with a gender-identity diagnostic code
- 160 children under the age of 18 were using puberty blockers to treat gender distress
- 33 girls under the age of 18 had mastectomies (CPT 19303) or breast reductions (CPT 19318) to treat gender distress:
    - 4 girls age 15
    - 12 girls age 16
    - 17 girls age 17
- 2 girls age 17 had hysterectomies with removal of fallopian tubes and ovaries (CPT 58571 or 58552)

Note: one 17 year old girl had both a hysterectomy and mastectomy in 2019, so the total number of children with gender surgeries in 2019, according to the 2019 APAC Public Use File, is 34.

Analysis of Commercially Available Insurance Claims Data:

I have also reviewed insurance claims data from an independent commercial source for Oregon for the years 2019 through 2023. During that time period:

- 26 children under the age of 18 underwent genital surgeries for gender distress –
  - 3 boys with orchiectomy (CPT 54520) [surgical removal of testicles]
  - 23 natal girls with hysterectomies (CPT 58542, 58552, or 58571).
- 244 girls underwent mastectomies (CPT 19303 or 19304)
- An additional 94 girls underwent breast reductions (CPT 19318)

In all of these cases, the surgeries were reported with a gender dysphoria related diagnostic code (F64.x).

Conclusion:

The State of Oregon's own evidence-based medicine experts have consistently concluded that "there is very little evidence" to support "gender-affirming treatment" – but have been reluctant to voice that opinion in public. The 2023 report finding "a paucity of data" to support these gender treatments for youth and adolescents was cancelled, and withheld from both the public and the medical experts appointed by the Governor and confirmed by the Senate to serve on Oregon's Health Evidence Review Commission. In their private conversations - documented in email messages – they are very free with their concerns about the lack of evidence, and ethical improprieties by researchers.

While Oregon's medical experts have internally acknowledged some of the risks and side effects of gender medicine, there has been no formal analysis of the balance between desirable and undesirable effects – as HERC would normally do for any other health condition, in its published process.

Transgender-identifying patients are entitled to the same diligence and care in their health services as everyone else. While Oregon officials may feel that they are supporting transgender patients by approving every possible treatment recommended by advocates, they are in reality providing a huge disservice by endorsing aggressive treatment and disregarding evidence of risk.

Oregon should engage in a thorough medical technology assessment of "gender-affirming treatment" following the same process and standards used for any other condition, evaluating evidence and recommendations with the GRADE methodology, so that patients,

providers, and policy makers can have an unbiased assessment and make sound decisions.

HB4088A in its current form will actually harm patients by hiding Oregon's robust data set from researchers. It should be amended with the -A9 amendment to ensure that the public can still access information about reproductive and gender affirming health care services, and researchers can access Oregon's data.

Attachments

HERC Meeting Materials:

1. 2012 HERC Materials on Gender Dysphoria, with OHSU Center for Evidence-based Policy report
2. HERC Meeting Minutes from August 14, 2014, when the decision to add comprehensive "gender affirming treatment" coverage, including surgery without minimum age, was approved
3. Excerpts from draft 2023 Rapid Review of Gender-affirming Medical Interventions. Note: the full report is available at this link.

Internal OHA Emails Regarding "Gender Affirming Treatment"

4. Internal OHA emails
    a. Jason Gingerich, HERC Director, 2/9/2024, "Everyone I am talking to agrees there is little evidence"
    b. Margaret Cary, OHP BH Medical Director, 5/7/2024, outlining risks and noting "paucity of research on long-term impacts of GnRH agnosts as GAC in adolescents" … "unknown impact on brain, metabolism, and bone development, potential increase in PCOS…."
    c. Jason Gingerich, HERC Director, 5/14/2024, describing DOJ legal opinion and concerns about WPATH
    d. Devan Kansagara, HERC Chair, 10/30/2024, "… I shudder to think that providers conducting shared decision making with their patients about these really complex decisions don't have a full set of information to work from. We can do better as a medical community."

OHA Reports on Prevalence:

5. OHA report on Gender-affirming Treatment for OHP Members, 2015-2014, prepared for the Oversight Project, August 7, 2025
6. OHA report Gender Affirming Care for OHP Members with Gender Dysphoria Diagnosis – Response to request; June 16, 2023
7. OHA memorandum on Gender Affirming Care Utilization and Cost to Commercial Insurers in Oregon for Rep. Yunker, December 16, 2024

Attachment 1: 2012 HERC Materials on Gender Dysphoria, with OHSU Center for Evidence-based Policy report

Puberty Suppression Therapy for Transgender Youth

Question: What is the evidence supporting the use of puberty suppression therapy for transgender youth?

Question Source: VbBS

Issue: The HSC considered the evidence supporting the use of puberty suppression therapy for transgendered youth in August, 2011. This discussion was continued at the VbBS in March, 2012 and again in August, 2012.

During the ICD-10 review, gender dysphoria was separated from several inappropriate diagnoses and made into its own line which is in a covered area of the Prioritized List. Currently, the only treatments on this line are psychotherapy. Advocacy groups for transgendered persons has requested that puberty suppressing therapy be added to this line.

The evidence for the benefits of puberty suppression therapy was reviewed at the October, 2011 and March, 2012 meetings. The decision at the March meeting was to add coverage for puberty suppressing therapy for youth; however, later questions from committee members about the safety of this therapy put this decision on hold. At the August, 2012 VbBS meeting, evidence regarding the safety of this type of treatment was reviewed. The decision at that meeting was to have HERC staff summarize all of the evidence of effectiveness for this therapy, and represent this topic at a later meeting for a more informed discussion.

There was discussion at the March and the August VbBS meetings about a guideline for puberty suppressing therapy, to include psychiatric evaluation prior to initiation, and ongoing psychiatric care while receiving such treatment.

Description:
Puberty suppressing therapy is started in a child at the onset of biologic puberty to suppress the natural increase in birth-sex hormones which would lead to physical changes which are not consistent with the child's perceived gender. The goal of this therapy is to delay puberty until the adolescent can clarify which gender he/she identifies with (with the help of psychotherapy).

Expert Testimony
In August, 2011, TransActive submitted extensive testimony regarding the need for, benefits of, and harms of puberty suppressing therapy. At the October, 2011 HSC meeting and at the March and August 2012 VbBS meetings, testimony was heard from various advocates and experts regarding the need for and effectiveness of this therapy.

Further written testimony has been received from TransActive, in response to HERC staff proposed guideline.

> "TransActive staff and advisors have reviewed the evidence summary and the proposed recommendations pertaining to inclusion of coverage for pubertal suppression treatment in transgender adolescents and we have concerns about only one aspect of the proposed guidelines for pubertal suppression coverage on OHP. We object to the requirement that

youth continue psychiatric treatment as a prerequisite for receiving pubertal suppression with GnRH analogues.

The degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

To summarize our concerns, we believe that requiring transgender youth to be under psychiatric care in order to receive puberty suppressing treatment exceeds existing professional guidelines, intrudes on the patient/doctor, client/therapist relationship and subjects youth who may have no need for psychiatric care to suffer from the assumption that they are, in some way, "psychologically disordered" even though neither they nor their therapist may be of that opinion. It also subjects the youth and their parents to (potentially) unnecessary financial burden."

Evidence summary

No evidence from NICE, SIGN, or Cochrane available

1) Evidence based reviews
    - **a. MED 2012**
        - **i. Puberty suppression in gender-questioning children/adolescents**
            - **1.** Our core sources did not identify any systematic reviews or technology assessments addressing puberty suppression in children or adolescents with gender identity disorder (GID). However, the identified guideline by The Endocrine Society (Hembree 2009) does make recommendations on this point.
    - **b. Murad, 2010**
        - i. Systematic review and meta-analysis of impact of hormonal therapy and sex reassignment on health outcomes
        - ii. Included 28 observational studies, N = 1833 participants with GID (1093 male-to-female, 801 female-to male) who underwent sex reassignment that included hormonal therapies.
        - iii. Results: after sex reassignment, 80% of individuals with GID reported significant improvement in gender dysphoria (95% CI = 68–89%; 8 studies; I2 = 82%); 78% reported significant improvement in psychological symptoms (95% CI = 56–94%; 7 studies; I2 = 86%); 80% reported significant improvement in quality of life (95% CI = 72–88%; 16 studies; I2 = 78%); and 72% reported significant improvement in sexual function (95% CI = 60–81%; 15 studies; I2 = 78%).
        - iv. Conclusions: Very low quality evidence suggests that sex reassignment that includes hormonal interventions in individuals with GID likely improves gender dysphoria, psychological functioning and co-morbidities, sexual function and overall quality of life.
        - v. Limitations – uncontrolled studies, all subjective outcomes, co-administered interventions of sex reassignment surgery, psychotherapy, and hormonal therapy.

c. Elamin, 2010

i. Systematic review of harms of hormone therapy in transgender persons
ii. N = 16 uncontrolled studies (very low quality)
iii. Conclusions: cross-sex hormone therapies increase serum triglycerides in MF and FM and have a trivial effect on HDL-cholesterol and systolic blood pressure in FM. Data about patient important outcomes are sparse and inconclusive.

2) Clinical guidelines

a. Endocrine Society, 2009

i. 1.1 We recommend that the diagnosis of gender identity disorder (GID) be made by a mental health professional (MHP). For children and adolescents the MHP should also have training in child and adolescent developmental psychopathology.
ii. 1.2 Given the high rate of remission of GID after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children with GID.
iii. 1.3. We recommend that physicians evaluate and ensure that applicants understand the reversible and irreversible effects of hormone suppression (*e.g.*, GnRH analogue treatment) and cross-sex hormone treatment before they start hormone treatment.
iv. 1.4. We recommend that all transsexual individuals be informed and counseled regarding options for fertility prior to initiation of puberty suppression in adolescents and prior to treatment with sex hormones of the desired sex in both adolescents and adults.
v. 2.1. We recommend that adolescents who fulfill eligibility and readiness criteria for gender reassignment initially undergo treatment to suppress pubertal development.
vi. 2.2. We recommend that suppression of pubertal hormones start when girls and boys first exhibit physical changes of puberty (confirmed by pubertal levels of estradiol and testosterone, respectively), but no earlier than Tanner stages 2–3.
vii. 2.3. We recommend that GnRH analogues be used to achieve suppression of pubertal hormones.
viii. 2.4. We suggest that pubertal development of the desired opposite sex be initiated at about the age of 16 years, using a gradually increasing dose schedule of cross-sex steroids.
ix. 2.5. We recommend referring hormone-treated adolescents for surgery when 1) the real-life experience (RLE) has resulted in a satisfactory social role change; 2) the individual is satisfied about the hormonal effects; and 3) the individual desires definitive surgical changes.
x. 2.6. We suggest deferring surgery until the individual is at least 18 years old.

Puberty Suppression Therapy for Transgender Youth

Summary

There is very poor evidence of the benefit of puberty suppressing therapy for transgendered youth, based on the existing literature. Use of puberty suppressing therapy is based on expert opinion. The Endocrine Society recommends treatment of transgendered youth be treated with puberty suppressing medications at the first physical changes of puberty with GnRH analogues.

HSC Staff Recommendations

1) Cover puberty suppressing therapy on the new Gender Dysphoria line with the following guideline
    a. These changes will be effective with the **October, 2014 ICD-10 Prioritized List**

GUIDELINE XXX GENDER DYSPHORIA

Line XXX

Hormone treatment is included on this line only for use in delaying the onset of puberty and/or continued pubertal development with GnRH analogues for gender questioning children and adolescents. This therapy should be initiated at the first physical changes of puberty, confirmed by purbertal levels of estradiol or testosterone, but no earlier than Tanner stages 2-3. Prior to initiation of puberty suppression therapy, adolescents must fulfill eligibility and readiness criteria, and must have a full psychiatric evaluation. Ongoing psychological care is strongly encouraged for continued puberty suppression therapy.

Treatments for Gender Identity Disorder

Participant Request

March 2012

Center for Evidence-based Policy
Medicaid Evidence-based Decisions Project (MED)
Oregon Health & Science University
3455 SW US Veterans Hospital Road
Mailstop SN-4N, Portland, OR 97239-2941
Phone: 503.494.2182
Fax: 503.494.3807
http://www.ohsu.edu/ohsuedu/research/policycenter/med/index.cfm

About the Center for Evidence-based Policy and the Medicaid Evidence-based Decisions (MED) Project

The Center for Evidence-based Policy (Center) is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring diverse and relevant perspectives are considered, and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.

The Medicaid Evidence-based Decisions (MED) Project is housed at the Center. Its mission is to create an effective collaboration among Medicaid programs and their state partners for the purpose of making high quality evidence analysis available to support benefit design and coverage decisions made by state programs. Further information about the MED project and the Center is available at www.ohsu.edu/policycenter.

Nature and Purpose of Participant Requests

MED Participant Requests provide a brief description of evidence and/or policy in response to participant state inquiries. These inquiries are on topics that have not been prioritized for full reports through the formal topic selection process. Research for a Participant Request is based on a limited search of high-quality health care and academic journals, as well as policy core sources relevant to the topic. Participant Requests do not reflect a comprehensive search of literature, nor a formal review, critical appraisal, or synthesis of evidence.

Suggested citation:
Bunker, K. and Kriz, H. (2011). *Treatments for Gender Identity Disorder.* Portland, OR: Center for Evidence-based Policy, Oregon Health and Science University.

Date of Request: February 22, 2012

State Requesting Information: Oregon

State Contact: Cat Livingston, MD MPH

Prepared by: Kendra Bunker, MPH

Request:

Oregon requested evidence on the following treatments for gender identity disorder:

1) Puberty suppression in gender-questioning children/adolescents;
2) Cross sex hormone treatment; and
3) Sex reassignment surgery.

Outcomes needed would be quality of life impacts of each treatment, and harms.

MED Project Response:

MED core sources were scoped, and the following scoping results were provided to Oregon. Oregon opted not to proceed with a larger report at that time.

Evidence Scoping – Treatments for Gender Identity Disorder – March 2012

Inclusion criteria: English
Exclusion criteria: Publication prior to 2002

1) Puberty suppression in gender-questioning children/adolescents

Our core sources did not identify any systematic reviews or technology assessments addressing puberty suppression in children or adolescents with gender identity disorder (GID). However, the identified guideline by The Endocrine Society (Hembree 2009) does make recommendations on this point.

2) Cross sex hormone treatment

- Evidence identified by core sources
  - Systematic reviews
    - Murad (2010), commissioned by The Endocrine Society to inform clinical practice guideline (Hembree 2009)
  - Technology assessments
    - Hayes (2004) – 2009 search update available

- Populations
  - Primarily adult populations > 30 years old
  - Some data on individuals in late adolescence and young adulthood
- Outcomes
  - Resolution of gender dysphoria
  - Quality of life
  - Sexual function
  - Psychiatric comorbidities pre-treatment and post-treatment
- Other notes
  - Few of the studies included in the reviews are controlled

3) Sex reassignment surgery

- Evidence identified by core sources
  - Systematic reviews
    - Murad (2010), commissioned by The Endocrine Society to inform clinical practice guideline (Hembree 2009)
  - Technology assessments
    - Hayes (2004) – 2009 search update available
    - Day (2002), New Zealand Health Technology Assessment
- Populations
  - Primarily adult populations > 30 years old
  - Some data on individuals in late adolescence and young adulthood
    - Day (2002) TA excluded studies with participants under age 16
- Outcomes
  - Resolution of gender dysphoria
  - Quality of life
  - Sexual function
  - Psychiatric comorbidities pre-treatment and post-treatment
- Other notes
  - Few of the studies included in the reviews are controlled

References:

Day, P. (2002). *Trans-gender reassignment surgery*. Christchurch: New Zealand Health Technology Assessment (NZHTA).

Hayes, Inc. (2004). *Sex reassignment surgery and associated therapies for the treatment of gender identify disorder.* Lansdale, PA: Hayes, Inc. [Directory - Search updated through 2009]

Hassan Murad, M., Elamin, M.B., Zumaeta Garcia, M., Mullan, R.J., Murad, A., Erwin, P.J., et al. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, *72*(2), 214-231.

Hembree, W.C., Cohen-Kettenis, P., Delemarre-van de Waal, H.A., Gooren, L.J., Meyer, W.J. III, Spack, N.P., et al. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology and Metabolism, 94*(9), 3132-54.

Attachment 2: HERC Meeting Minutes from August 14, 2014

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Meridian Park Hospital
Community Health Education Center Room 117B&C
Tualatin, OR 97062
August 14, 2014

Members Present: Som Saha, MD, MPH, Chair; James Tyack, DMD; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Irene Croswell, RPh; Mark Gibson; Leda Garside, RN, MBA; Susan Williams, MD; Gerald Ahmann, MD, PhD.

Members Absent: None.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Wally Shaffer, MD; Jason Gingerich; Denise Taray, RN; Daphne Peck.

Also Attending:
Alison Little, MD, MPH, OHSU CeBP; Kevin Olson, MD, VbBS Chair; Kent Benner & Kaitlan Benner, The Oregon Clinic; Kerri Fowler, Umpqua Health Alliance; Christie & Eric Riehl; Adrienne Scavera, MHAO; Rebekah Brewis, PDX Trans* Pride; Jo Ann Sowers, Portland State University; Paul Neilson, Astra Zeneca (Medimmune); Ashlen Strong, Health Share of Oregon; Shannon Beatty, Medimmune; Seth Johnstone and Jenn Burleton, TransActive; Eric Larsson, Lovaas Institute; Laura Hill and Becky Reynolds, Abbvie; BJ Cavnor, One in Four Chronic Health; Seth Adams, WVP Health Authority; Cory Bradley, CareOregon; Tobi Rates, Autism Society; Dr. Maria Gilmour, Wynne Solutions; Alex Shebiel, Lindsay Hart; Camille Kerr and Deirdre Monroe, Allergan; Danielle Askini, Maura C. Roche, Alex Lausen, Peter Molof, Ryannah Quigley, Curtis Espinoza, & Amanda Spencer, Basic Rights Oregon; Ellen Miller, CFM/PHS; Lea Forsman, OHA/DMAP; Maria Wynne Gilmour, Wynne Solutions; Stacy Aria, Family Care; Amy Burn, All Care CCO; Jesse Little, OHA Actuarial Services Unit; Lorren Sandt, Caring Ambassadors.

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order. Role was called.

Approval of Minutes

MOTION: To approve the minutes of the June 12, 2014 meeting as presented. CARRIES 10-0.

Director's Report

Darren Coffman confirmed there will be an interim modifications Prioritized List published October 1, 2014. The new biennial list will be published January 1, 2015. Going forward, we will produce lists each January and October 1st. The implementation of the next biennial list will be

on either October 1, 2015 or January 1, 2016, depending on CMS's final decision on the implementation of ICD-10.

Coffman reported that he and Saha held conversations with two potential osteopathic physician candidates for the DO HERC vacancy and there has been a strong candidate for the consumer representative who has indicated interest in that vacancy as well. The Governor's Office may hold off making appointments until October for a November Senate confirmation.

Value-based Benefits Subcommittee (VbBS) Report
Meeting materials handout

Treatments for Hepatitis C

Saha announced that the Commission is tabling the discussion of this topic after hearing the recommendation that came out of the VbBS's meeting that morning, along with input from CCOs and legislators and new reports/guidelines that will need to be reviewed.

Miscellaneous recommended changes to the Prioritized List

Ariel Smits, Cat Livingston and Kevin Olson, MD, VbBS Chair, each helped to summarize a number of topics discussed at recent meetings.

Smits reported the recommendations from the May 8, 2014 VbBS meeting not reported at the June HERC meeting:

May 8th recommendations for interim changes, effective 10/1/14 include:

- Add a surgical code to the colon cancer line
- Add a surgical code to the vascular insufficiency of intestines line
- Combine open and closed hip fracture diagnoses on the hip fracture line
- Add transurethral prostatic implants for treatment of benign prostatic hypertrophy
- Remove multiple surgical codes from the covered sleep apnea line
- Revise the rehabilitation guideline to reflect criteria for rehabilitation services rather than limits based on the number of visits
- Revise the sleep apnea guideline to further define daytime sleepiness and to specify that tonsillectomy/adenoidectomy surgical codes on that line are for treatment of children only
- Add a new diagnostic guideline specifying that computer-aided mammography for both screening and diagnostic purposes is not a covered service

August 14th recommendations for interim changes, effective 10/1/14 include:

- Remove certain nerve block procedure codes from the Prioritized List and advise DMAP to place these codes in the Ancillary File
- Add diagnosis codes for diabetic retinopathy to the diabetic retinopathy line
- Add ICD-10 diagnosis codes for certain types of diabetes to the appropriate diabetes lines
- Delete diagnosis codes for chiropractic and osteopathic manipulation from the migraine headache line
- Add a new coding specification to the tension headache line specifying that chiropractic and osteopathic manipulation are on this line only for pairing with cervicogenic headache.

- Add codes for chemodenervation of the anal sphincter to the uncovered chronic anal fissure line
- Delete codes for chemodenervation of extraocular muscles from the covered amblyopia line; those codes will remain on two covered strabismus lines
- Modify the nerve block guideline to include the CPT codes for certain procedures and remake it into an ancillary guideline
- Add a new guideline which specifies that removal of tympanostomy tubes is a covered service
- Modify the spinal disorders guideline to require objective evidence of neurologic injury or radiculopathy
- Modify the rehabilitation guideline to limit the total number of therapy visits for all conditions to 30 per year, except for certain neurological conditions or when in an inpatient rehabilitation facility.
- Modify the lymphedema guideline to specify that compression dressings/garments are covered for treatment of lymphedema even in the absence of complications.
- Delete the Synagis guideline for RSV prophylaxis
- Add several new coding specifications regarding use of botulinum toxin; delete the guideline note regarding botulinum toxin use for bladder indications

August 14th recommendations for interim changes, effective 1~~0~~/1/1~~4~~5 include:

- Add several surgical codes for sex reassignment surgery to the gender dysphoria line along with new guideline on when hormone therapy and surgical treatment is appropriate

May 8th and August 14th recommendations for the 2016 biennial list include:

- Move the diagnostic code for unspecified myopathy from the covered dysfunction lines to the uncovered fibromyalgia line.
- Add the diagnostic code for chronic fatigue syndrome to the new fibromyalgia line and retitle it
- Remove the diagnosis codes for injuries to the major blood vessels of the neck from one covered line to a more appropriate covered line
- Create a new lymphedema line and prioritize it in the covered region of the Prioritized List
- Create a new line for miscellaneous conditions requiring no treatment and prioritize it to the last line on the Prioritized List
- Merge the somatization and factitious disorder lines; prioritize into the non-covered region of the Prioritized List
- Combine the two hyperbaric oxygen lines (merge line 373 into line 336)

Other recommendations were developed related to the prioritization of hyperbaric oxygen therapy, but those will be presented for discussion at the November meeting along with the coverage guidance that they were based on.

VbBS Chair Kevin Olson and staff then asked for clarification about incorporating coverage guidances into the List, specifically what to do with weak recommendations *for* and *against*. Saha clarified that VbBS has other considerations to weigh, including cost, public input, etc. They should use the entire document, including the GRADE-informed framework, to make an appropriate recommendation for placement on the Prioritized List of Health Services.

MOTION: To accept the VbBS recommendations on changes to upcoming Prioritized Lists as stated. See the VbBS minutes of 5/8/14, 8/8/14 and 8/14/14 for a full description. Carries: 10-0.

Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD)
Meeting Materials page 143-264

Dr. Cat Livingston reviewed the background on the Commission's evaluation of the evidence of ABA for ASD, which began in August of 2013.

Oregon Senate Bill 365 (2013) requirments.

- Requires state-regulated commercial health plans to approve and manage autism treatment, including ABA therapy and any other medical or mental health services identified in an individualized treatment plan.
    - Law applies to patients who seek care before age nine, minimum coverage of up to 25 hours of ABA per week, continuing as long as medically necessary.
    - Health plans that provide coverage to OEBB and PEBB must begin coverage in 2015
    - Other health plans are required to begin coverage in 2016.
- The bill required HERC to evaluate the evidence for ABA and make a coverage decision for OHP.

EbGS reviewed the evidence and adopted summary conclusions based on the modified GRADE methodology used in the coverage guidance development process. Expert input and public comment was solicited and reviewed. In addition to specific comments, a total of 336 unduplicated citations were provided by public commenters. Each citation was evaluated to determine study design or article type and population characteristics (number and ages of included individuals), the abstract was retrieved and a link to the article provided when available.

Given that the focus of most of the public comment pertained to requesting that ABA be recommended for coverage in individuals over age 12, a detailed review of citations was limited to those studies. A random sample of 10% of single-subject research design (SSRD) study types were reviewed in additional detail. In addition, all systematic reviews and meta-analyses of SSRDs were reviewed in more detail.

EbGS met April 24, 2014, having reviewed the evidence, public written comment, in-person public comment and expert input and approved a modified evaluation of the evidence to send to VbBS.

On further review of what is allowed under the Mental Health Parity and Addiction Equity Act, staff suggested and VbBS agreed to modify the language to be more descriptive of the studies and not include specific hour or duration limits of the treatment.

Proposed scoring would place treatment of autism at approximately line 199, up from the current prioritization of 313.

Coffman added that the implementation date, as determined by OHA leadership, will be January 1, 2015. This coincides with a new CCO contract/rate period and with the date when providers can be licensed/certified to provide this care.

In June 2014, VbBS approved a new guideline on treatment of autistic spectrum disorder with applied behavioral analysis. Many of the studies and discussion centered around self-injurious behavior. There was some concern expressed that the guideline being recommended only impacted patients diagnosed with autism and did not include treatment for non-autistic patients with self-injurious behaviors. This condition responds in the same way to ABA as does a person with an ASD diagnosis.

Public Comment

Christie & Eric Riehl, as a parents of a child with autism and self-injurious behavior, offered their perspective and advocated to allow coverage of ABA for patients outside of an ASD diagnosis. She urged the commission to include codes for inpatient treatment and to include other comorbid conditions.

Tobi Rates, Executive Director of the Autism Society of Oregon and parent of two children on the autism spectrum who receive OHP services, expressed her gratitude to the Commission for taking on this complex issue, for the recommendations presented today and announcing a clear implantation date. She expressed concern with conclusion that the evidence for ABA for children 13 years and older is inconclusive. She said her advocacy group would continue to examine this issue.

Maria Wynne Gilmour, Wynne Solution, an ABA provider and board certified behavior analyst of 15 years from Portland, added some statistics regarding self-injurious behavior. In the last 30 days, she has received 18 referrals for this condition of which 8 were children over 12 or adults.

Gibson asked if ABA for self-injurious behavior, in the absence of an ASD diagnosis, is effective. Saha stated that the subcommittee determined it is effective. Chan, the subcommittee chair, suggested the evidence summary be reframed for clarity. Saha agreed, the subcommittee may look at editing their work but that would not preclude a vote today.

Audience member Christie Riehl, asked additional implementation questions about coding problem behaviors vs. primary diagnosis, citing the guideline that is being replaced. Livingston assured all that ABA treatment will need prior authorization and will be considered by a medical reviewer.

MOTION: To accept the VbBS recommendations to add codes and a guideline to the Prioritized List based on the EbGS evidence evaluation on applied behavior analysis for autism spectrum disorder and approve the staff recommendation to add ABA to Line 442 of the 1/1/15 list including self-injurious behavior (see Attachment A). CARRIES: 10-0.

Cross-Sex Hormone Therapy & Sex Reassignment Surgery for Gender Dysphoria
Meeting Materials pages 265-269

Dr. Ariel Smits explained, the January 1, 2015 Prioritized List includes gender dysphoria as a new, covered line (413).

- Currently, the only treatments approved for inclusion on that line are office visits, psychotherapy and puberty suppression medication for transgender and gender-questioning youth.
- Other treatments include cross-sex hormone therapy and sex reassignment (gender reassignment) surgery.
    - Additional evidence was reviewed about the efficacy of treatment, particularly in reducing suicide attempts, IV drug abuse, and other high-risk behavior.
    - Treatment significantly reduces depression and anxiety in patients.
    - The total cost to OHP of adding additional treatments is expected to be minimal.
    - Evidence supports adding cross-sex hormone therapy and sex reassignment surgery, excluding the more cosmetic-focused procedures (breast augmentation, facial bone reconstruction).
    - Proposed scoring would place treatment of autism at approximately line 312, up from the current prioritization of 413.

At the VbBS meeting earlier in the day, there was considerable discussion about the lack of an age restriction for surgical procedures. Smits confirmed that the Oregon age of consent for surgical procedures is age 15. Dr. Olson explained that these types of procedures should not be singled out for restriction until age 18 or even higher, as many other procedures which have life-long impact can be consented to at age 15.

Tyack explained his position by saying there are so many things a 15-year-old cannot do. They cannot drive, serve in the armed forces, vote, ingest alcohol, smoke, etc. In general, he supports the procedure and feels sympathy for people who need the surgery but cannot get passed the issue of age of medical consent. Ahmann added his agreement and concern.

Saha discussed whether anyone under the age of 18 should be able to consent to any surgery and stated that is a question for lawmakers in Oregon. He thought it would be a dangerous precedent to single out an exception for this one surgery.

Williams discussed her understanding is that surgery itself comes near end of a long treatment plan. No one rushes into this irreversible surgery lightly or without preparation. Smits added the evidence shows there is a very low rate of regret recorded. Saha believes the stipulations in the guideline preclude one making a rash decision.

Public Comment

> *Danielle Askini*, policy director for Basic Rights Oregon, asserted that this invasive, life-altering treatment is only given as part of a lengthy continuum of care. Youth are required to have extensive evaluations by qualified mental health professionals and that the year of hormone therapy required in the guideline acts as another safeguard against rash decisions by youth.
>
> *Jenn Burleton*, Executive Director of TransActive, agreed with Ms. Askini, adding details about the lengthy path to surgery: assessments, reassessment, evaluation, referral and many other steps throughout the growth cycle.

Saha asked if families often support youths with gender dysphoria. Burleton responded affirmatively. Moreover, those living outside the home have advocacy and support as well.

Ahmann wanted to know how many surgeries are completed per year in Oregon. Burleton and Askini stated there are two physicians in Oregon who perform gender-confirming surgeries and estimated a very small percentage would undergo genital reconstruction. Burleton added, with access to puberty suppressing drugs, many procedures will become unnecessary, as the undesired sex characteristics will never fully develop.

Smits added many individuals do well with certain medications and counseling and never pursue surgical interventions. She added, among California government employees, a study showed that 42 surgeries were performed over a 6.5-year period.

Gibson commented that while he shares the concerns about age, we cannot rewrite the state statute about age of medical consent though the HERC process.

MOTION: To approve the line rescoring, updated treatment description, and the addition of cross-sex hormone therapy and various surgical procedures to the gender dysphoria line, and the new guideline as recommended by VbBS (see Attachment B). CARRIES 8-2 (Opposed:Tyack, Abstained: Ahmann).

Retreat Planning

Coffman mentioned the HERC retreat is scheduled for October 30, 2014 at a location TBD.

Some commissioners expressed a wish to have the retreat be a closed meeting, feeling that would foster more open conversation. Coffman explained what constituted a public meeting; in part, a public body with quorum discussing or deliberating towards a decision. Saha advocated for a public meeting, commenting that a core HERC principle is *transparency*. Further, he argued, limiting the discussion to meet the restrictions of a closed meeting would effectively limit the Commission's ability for meaningfully discussion, necessitating another public meeting to rehash topics to allow for public deliberations. All agreed using a facilitator with familiarity with the HERC process and products makes sense.

Staff suggested the possibility of a compromise, with half of the meeting closed, then opened as a public meeting to allow deliberation. Members would like participation in discussion limited to staff, commissioners, subcommittee members and advisory panel members. They clearly expressed their desire to hear *no* public comment that day. Staff will review public meeting laws to see what is possible.

Public Comment

There was no other public comment at this time.

Adjournment

Meeting was adjourned at 3:30 pm. Next scheduled regular meeting – November 13, 2014, Meridian Park Room 117 B&C.

ATTACHMENT A

Changes to Prioritized List Involving Applied Behavior Analysis

Add codes as follows to Line 313 and 442 of 1/1/15 Prioritized List:

Code	Description	Action
0359T	Behavior identification assessment	**Add to 313 & 442**
Follows 0359T 0360T 16-45 min 0361T each additional 30 min	Observational behavioral follow-up assessment	**Add to 313 & 442**
Follows 0359T 0362T 16-45 min 0363T each additional 30 min	Exposure behavioral follow-up assessment	**Add to 313 & 442**
0364T first 30 min 0365T each additional 30 min	Adaptive behavior treatment by protocol	**Add to 313 & 442**
0366T first 30 min 0367T each additional 30 min	Group adaptive behavior treatment by protocol	**Add to 313 & 442**
0368T first 30 min 0369T each additional 30 min	Adaptive behavior treatment with protocol modification	**Add to 313 & 442**
0370T	Family adaptive behavior treatment guidance	**Add to 313 & 442**
0373T first 60 minutes of technicians' time, 0374T each additional 30 minutes of technicians' time	Exposure adaptive behavior treatment with protocol modification	**Add to 313 & 442**

Revise Guideline Note 75 as follows effective 1/1/15:

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER

Line 313

~~There is limited evidence of the effectiveness of treatment (e.g., Applied Behavioral Analysis) for Autism Spectrum Disorders (ASD). However, effective treatments may be available for co-morbid conditions such as mood disorders. When treating co-morbid conditions, that condition, not an ASD diagnosis, should be the primary diagnosis for billing purposes. The treatment of co-morbid mental health conditions should be consistent with the treatment methods, frequency, and duration normally applied to those diagnoses. Treatment of neurologic dysfunctions that may be seen in individuals with an ASD diagnosis are prioritized according to the four dysfunction lines found on the Prioritized List (Lines 78, 318, 375 and 407). Treatment for associated behaviors, such as agitation, that do not meet the criteria for co-morbid mental health diagnoses should be limited in frequency to a maximum of 8 hours of behavioral health service per month, subject to utilization management review by the mental health organization (MHO) or other relevant payer.~~

Applied behavior analysis (ABA), including early intensive behavioral intervention (EIBI), represented by CPT codes 0359T-0374T, is included on line 313 for the treatment of autism spectrum disorders.

ATTACHMENT A

Changes to Prioritized List Involving Applied Behavior Analysis

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER (Cont'd)

ABA services are provided in addition to any rehabilitative services (e.g. physical therapy, occupational therapy, speech therapy) included in guideline note 6, REHABILITATIVE THERAPIES that are indicated for other acute qualifying conditions.

Individuals ages 1-12

Specifically, EIBI (for example, UCLA/Lovaas or Early Start Denver Model), is included on this line.

For a child initiating EIBI therapy, EIBI is included for up to six months. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives (objectives should be achieved as a result of the EIBI, over and beyond gains that would be expected to arise from maturation alone) using a standardized, multimodal assessment, no more frequently than every six months. Examples of such assessments include Vineland, IQ tests (Mullen, WPPSI, WISC-R), language measures, behavior checklists (CBCL, ABC), and autistic symptoms measures (SRS).

The evidence does not lead to a direct determination of optimal intensity. Studies of EIBI ranged from 15-40 hours per week. Through Oregon's Senate Bill 365, other payers are mandated to cover a minimum of 25 hours per week of ABA. There is no evidence that increasing intensity of therapy yields improves outcomes. Studies for these interventions had a duration from less than one year up to 3 years.

If EIBI is not indicated, has been completed, or there is not sufficient progress toward multidimensional goals, then less intensive ABA-based interventions (such as parent training, play/interaction based interventions, and joint attention interventions) are included on this line to address core symptoms of autism and/or specific problem areas. Initial coverage is provided for six months. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives, with demonstration of medical appropriateness and/or emergence of new problem behaviors.

Effective interventions from the research literature had lower intensity than EIBI, usually a few hours per week to a maximum of 16 hours per week, divided into daily, twice-daily or weekly sessions, over a period of several months.

Parent/caregiver involvement and training is recommended as a component of treatment.

Individuals ages 13 and older

Intensive ABA is not included on this line.

Targeted ABA-based behavioral interventions to address problem behaviors, are included on this line. The quality of evidence is insufficient to support these

ATTACHMENT A

Changes to Prioritized List Involving Applied Behavior Analysis

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER (Cont'd)

interventions in this population. However, due to strong caregiver values and preferences and the potential for avoiding suffering and expense in dealing with unmanageable behaviors, targeted interventions may be reasonable. Behaviors eligible for coverage include those which place the member at risk for harm or create significant daily issues related to care, education, or other important functions. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives, with demonstration of medical appropriateness and/or emergence of new problem behaviors.

Very low quality evidence is available to illustrate needed intensity and duration of intervention. In the single-subject research design literature, frequency and duration of interventions were highly variable, with session duration ranging from 30 seconds to 3 hours, number of sessions ranging from a total of three to 8 times a day, and duration ranging from 1 to 20 weeks. These interventions were often conducted in inpatient or residential settings and studies often included patients with intellectual disabilities, some of which were not diagnosed with autism.

Parent/caregiver involvement and training is encouraged.

Add the following guideline note to the 1/1/15 Prioritized List:

GUIDELINE NOTE 126, APPLIED BEHAVIOR ANALYSIS (ABA) INTERVENTIONS FOR SELF-INJURIOUS BEHAVIOR

Line 442

Targeted ABA-based interventions towards self-injurious problem behaviors are included on this line when meeting criteria as defined in guideline note 75 APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER.

Rescore the autism spectrum disorder line as shown below for the 1/1/2016 Prioritized List:

- Category: 3
- HL: 5
- Suffering: 4
- Population effects: 2
- Vulnerable population: 0
- Tertiary prevention: N/A
- Effectiveness: 3
- Need for service: 0.7
- Net cost: 1
- Approximate new line placement: 199

ATTACHMENT B

Changes to Prioritized List Involving Treatments for Gender Dysphoria

Make the following changes to the Prioritized List effective 1-1-2015:

1) Change the treatment description of Line 413 GENDER DYSPHORIA to ~~MEDICAL/PSYCHOTHERAPY~~ MEDICAL AND SURGICAL TREATMENT; PSYCHOTHERAPY
2) Add cross-sex hormone therapy to Line 413
3) Add CPT 19301-19304, 53430, 54125, 54400-54417, 54520, 54660, 54690, 55175-55180, 55970, 55980, 56625, 56800, 56805, 56810, 57106-57107, 57110-57111, 57291-57292, 57335, 58150, 58180, 58260-58262, 58275-58291, 58541-58544, 58550-58554, 58570-58573, 58661, 58720 to Line 413
    a. Advise DMAP to remove CPT 55970 and 55980 from the Excluded List
4) Add the following guideline:

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 413

Hormone treatment is included on this line for use in delaying the onset of puberty and/or continued pubertal development with GnRH analogues for gender questioning children and adolescents. This therapy should be initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, but no earlier than Tanner stages 2-3. Prior to initiation of puberty suppression therapy, adolescents must fulfill eligibility and readiness criteria, and must have a comprehensive mental health evaluation. Ongoing psychological care is strongly encouraged for continued puberty suppression therapy.

Cross-sex hormone therapy is included on this line for treatment of adolescents and adults with gender dysphoria who meet appropriate eligibility and readiness criteria. To qualify for cross-sex hormone therapy, the patient must:

1) have persistent, well-documented gender dysphoria
2) have the capacity to make a fully informed decision and to give consent for treatment
3) have any significant medical or mental health concerns reasonably well controlled
4) have a thorough psychosocial assessment by a qualified mental health professional with experience in working with patients with gender dysphoria

Sex reassignment surgery is included for patients who are sufficiently physically fit and meet eligibility criteria. To qualify for surgery, the patient must:

1) have persistent, well documented gender dysphoria
2) have completed twelve months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual
3) have completed twelve months of living in a gender role that is congruent with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
4) have the capacity to make a fully informed decision and to give consent for treatment
5) have any significant medical or mental health concerns reasonably well controlled

ATTACHMENT B

Changes to Prioritized List Involving Treatments for Gender Dysphoria

GUIDELINE 127, GENDER DYSPHORIA (Cont'd)

6) have two referrals from qualified mental health professionals with experience in working with patients with gender dysphoria who have independently assessed the patient. Such an assessment should include the clinical rationale supporting the patient's request for surgery, as well as the rationale for the procedure(s)

Rescore the gender dysphoria line as shown below for the 1/1/2016 Prioritized List:

- Category: 6
- HL: 6
- Suffering: 4
- Population effects: 0
- Vulnerable population: 0
- Tertiary prevention: 3
- Effectiveness: 2
- Need for service: 1
- Net cost: 2
- Score: 1040
- Approximate new line placement: 312

Attachment 3: Excerpts from draft 2023 Rapid Review of Gender-affirming Medical Interventions

HEALTH EVIDENCE REVIEW COMMISSION (HERC) RAPID REVIEW

Receipt of Gender-affirming Medical Interventions

DRAFT for VbBS & HERC Meetings, August 9, 2023

TABLE OF CONTENTS

summarized findings from 11SRs and 3 cohorts with extractable data.[28-30,36,40-67] For inclusion in this review we prioritized SRs with reproducible search strategies, clear inclusion and exclusion criteria, use of comparative or longitudinal studies, and extractable data. Figure XX is a PRISMA diagram that displays the flow of citations from search to inclusion.[68]

FIGURE XXX

PRISMA 2020 flow diagram.[68]

Several SRs only summarized the outcomes reported by individuals studies in narrative form without any extractable data, or outcomes from a non-validated tool, were not comparative, or not longitudinal in nature.[28,29,43,44,46-49,53,55-57,59,60,63,64] Three publications were included in more recent SRs.[51,62,66] We did not fully cross reference each individual study across the multiple SRs so there is a potential for the same study to be included in multiple SRs.

We identified 10 SRs in adults on gender affirming surgeries (4 SRs, 1 cohort), facial confirmation surgery (2 SRs), breast augmentation (1 SR), vaginoplasty (1 SR), and vocal interventions (2 SRs) in adults.[30,36,40-42,50,52,54,58,61,65] We did not identify any SRs with extractable data for phalloplasty. We identified 1 SR on mental health in adolescents which only summarized data narratively, but given the absence of any other sources meeting inclusion we provide the findings of their narrative review.[45] Two cohort studies on mastectomy in adolescents with smaller sample sizes (< 300) were also included given the absence of any other sources for this intervention in this age group. Table XXX provides an overview of included studies by intevention and outcome.

The current search did not identify any studies reporting outcomes of discrimination or experience of stigma after gender affirming interventions.

TABLE XXX

Overview of Summarized Studies

INTERVENTIONS	Death from Suicide or Suicide Attempt	Gender Dysphoria	Depression or Anxiety Symptoms	Quality of Life	Withdrawal or Revision
ADULTS					
Gender Affirming Surgeries	n 1 SR,			n 1 SR	n 1 SR
Gender Affirming Hormones and Surgery	n 1 cohort				
Gender Affirming Genital Surgery			n 1 SR		
Breast Augmentation					n 1 SR
Facial Gender Confirmation Surgery				n 2 SRs	

INTERVENTIONS	Death from Suicide or Suicide Attempt	Gender Dysphoria	Depression or Anxiety Symptoms	Quality of Life	Withdrawal or Revision
Vaginoplasty				n 1 SR	
Endoscopic Glottoplasty				n 1 SR	
Speech Therapy				n 1 SR	
ADOLESCENTs					
Gender Affirming Hormones and Surgery*			n 1 SR		
Mastectomy		n 2 cohorts			

Note: *all individuals underwent surgery at ≥ 18 years of age

Adults

Death from Suicide or Suicide Attempt

Gender Affirming Surgery

In their SR of studies published through 2015, Marshall and colleagues also only identified 1 longitudinal, comparative study from 2011 on suicide or non-suicidal self-injury after gender affirming surgery (surgical details not specified) from Sweden (from 2011).[52] Rates of suicide deaths and attempts for the transgender population (n = 324) exceeded those from a population cohort matched by age and birth sex or reassigned sex.[52] Suicide deaths for transgender individuals were 2.7% compared to 0.1% for matched controls; with suicide attempts also higher (7.9% vs. 1% matched controls).[52] No statistical analysis was reported.[52] The authors of the SR highlight many potential factors for this observed relationship including isolation, experience of victimization, depression, or lack of social support that may precede surgery and persist following it, along with inadequate support post-surgery from the healthcare system.[52] The authors of the SR did not include details about whether the original study attempted to address potential confounding factors (e.g., pre-existing depression, severe depression).[52]

Gender Affirming Hormone and Surgery

Branstrom and Pachankis analyzed mental health utilization including for care after suicide attempt by time since treatment or surgery for a national cohort of individuals with gender incongruence from 2005 to 2015 in Sweden, compared to remaining population of Sweden.[65] Surgical intervention categories included breast or chest surgery, surgery of the reproductive organs, laryngeal, or dermatological options.[65] Of the overall cohort of 2,697 individuals with gender incongruence, 1,885 (70%) received hormone treatment, 1,018 (37.9%) received surgical treatment, and of those receiving surgery 97% also received hormone treatment.[65]

Compared to the national population without a diagnosis of gender incongruence (N = 9,744,645), individuals with a diagnosis of gender incongruence remained more likely to receive care and treatment for mood or anxiety disorder and to be hospitalized after suicide attempt in the year 2015.[65] However, when comparing rates over time, at 4 to 5 years post- surgery the rate of hospitalization for suicide is similar or lower compared to the general population.[65]

possible score of 120; lower being better)at 2 months after ending therapy but in the other study, there was not sufficient data (only 4 of 25 completed the survey).[50] In the study using the TVQ, scores also improved (from 100/120 to 81/120) post therapy.[50]

Adolescents or Youth

We did not identify any SRs with extractable data on gender affirming medical interventions among adolescents and youth. Given that paucity of data, we summarize the findings from a single identified SR (that includes narrative reports from 2 longitudinal cohorts) and 2 separate individual cohorts with smaller sample sizes (< 300 individuals) reporting outcomes of mental health and a component of gender dysphoria, chest dysphoria.[70,71]

Mental Health Outcomes

Gender Affirming Hormones and Surgery

In an SR of studies published through 2016 reporting mental health outcomes for transgender youth, the authors identified 2 studies providing longitudinal mental health outcomes.[45] The first cohort followed Dutch youth (n = 55) through diagnosis, hormone therapy (at ≥ 16 years), and 1 year after gender affirming surgery (occurred ≥ 18 years of age). The authors of the SR report that outcomes "steadily improved" on the Children's Global Assessment Scale, Child/Adult Behavioral Checklist, and the Youth/Adult self-report.[45] None of the youth reported regret.[45] The second cohort study followed children in the US who self-identified as TGD and who under the age of 13, prior to any medical or surgical intervention, all socially transitioned (n = 73). Compared to their cisgender siblings and a cohort of peers, rates of depression and anxiety were statistically no different.[45]

Chest Dysphoria or Gender Dysphoria

Two studies report on chest dysphoria, a component of gender dysphoria. In the initial publication of this novel assessment tool, researchers at a single center in the US developed a scale to assess chest dysphoria, in trans male youth aged 14 to 25.[71] Chest dysphoria scoring ranges from 0 to 51 (higher scores equating to more distress).[71] The authors reported outcomes for those who underwent chest reconstruction (i.e., mastectomy) compared to similar aged patients at the clinic who had not yet completed surgery.[71] Trans male youth with a history of chest reconstruction reported less distress than those not undergoing surgery (mean 3.3 vs. 29.6; *p* value <.001).[71]

In a subsequent study at a different center, outcomes from 36 post-surgical patients were compared to 34 matched controls (average age 18 for both groups).[70] At 3 months post-surgery the chest dysphoria scores were also lower for the surgical group (3.8 vs. 30.5; no statistical analysis reported).[70] This study also reported outcomes using the Transgender Congruence Scale (TCS). The TCS assesses gender acceptance and congruence with higher scores reflecting greater congruence.[72] At 3 months the TCS scores were higher for the surgery group (44.4) compared to the control (36.9).[70]

Evidence Summary and Limitations

This review prioritized the inclusion of methodologically robust systematic reviews on interventions for gender affirming care in the TGD population to identify the overall impact of these components of gender affirming care. Table XXX provides a cross walk across summarized studies by outcome and specific intervention for both key questions.

TABLE XXX

Overview of Summarized Studies

INTERVENTIONS	Death from Suicide or Suicide Attempt	Gender Dysphoria	Depression or Anxiety Symptoms	Quality of Life	Withdrawal or Revision
ADULTS					
Gender Affirming Surgeries	Unclear			Beneficial	Uncommon (~1%)
Gender Affirming Hormones and Surgery	May improve over time				
Gender Affirming Genital Surgery			Likely beneficial		
Breast Augmentation					Uncommon (< 1%)
Facial Gender Confirmation Surgery				Beneficial	
Vaginoplasty				Mixed	
Endoscopic Glottoplasty				Beneficial	
Speech Therapy				Beneficial	
ADOLESCENTs					
Gender Affirming Hormones and Surgery*			Likely beneficial		
Mastectomy		Beneficial			

Note: *all surgeries occurred at 18 years or older and included outcome is mental health broadly

KQ1: Adults

The current search identified 10 SRs in adults with robust methodologies and extractable data, with each SR reporting at least 1 relevant outcome, including suicide or suicide attempt, anxiety, quality of life, and withdrawal from treatment, request for surgical revision, or regret. None of the included SRs reported on depression, suicidal ideation, or experience of discrimination or stigma.

Death from suicide or suicide attempts remain higher for the TGD population from 1 SR (which found only 1 longitudinal study) while in 1 national registry, over time after surgery rates of suicide or suicide attempts are similar to the overall population.

Overall, there is a trend of improvement in anxiety and quality of life, after gender affirming surgeries overall and in SRs of specific interventions (e.g., facial confirmation, vocal treatments). While rates of withdrawal from treatment or request for revision were not commonly reported, rates of regret were low after gender affirming surgery (1%) and breast augmentation (< 1%).

The absence of benefit to quality of life after vaginoplasty may be limited by the lack of a validated tool in this population and use of a cisgender validated tool to assess outcomes.

The low rates of regret following a complicated and prolonged road to achieve treatment to address gender incongruence likely augments the scarcity of long term outcomes for mental health outcomes following surgical interventions.

KQ2: Adolescents

Mental Health Outcomes

As gender affirming surgeries are rare in adolescents, the search only identified 1 SR on mental health outcomes after gender affirming surgeries that occurred when the individuals were over 18 but their treatment course (e.g., counseling, hormones) started earlier. Overall, in 2 longitudinal cohorts who had experienced chest surgery, mental health outcomes were improved.

Review Limitations

Longitudinal, comparative data in this population is scarce in this population and early studies exclude important confounders, particularly for outcomes like suicide. Practice patterns and research methodologies have changed over time so earlier cohorts may use older tools or definitions not in current use, limiting comparisons over time. Many of the authors of the included SRs addressed the methodological limitations of this body of literature, including small sample sizes, reliance on small cohorts or case series, absence of randomized controlled trials, variable length of follow-up, lack of standardized assessment tools or reporting standards, and the use of PROMs not validated in this population. Many authors highlight the need for greater standardization in outcome reporting.[40,44,55]

Additionally, this body of literature largely takes place in high income countries, with less economic, racial, and ethnic diversity compared to the US. Many of the European centers require extensive (e.g. months to years) of evaluation and counseling prior to receipt of services. The outcomes of studies from clinics with waitlists or prolonged evaluation procedures may reflect a healthier, more motivated, or more socially supported population which could be at lower risk of both procedural and psychosocial complications.

Not all studies specifically address the inclusion of non-binary or gender diverse individuals, a growing proportion of the TGD population.[16,17] Future work is needed to understand the impact of gender affirming interventions on this specific population.

While several SRs pooled all gender affirming surgery together, for the purpose of this review that may be more applicable to the key questions as the aim was to assess the overall impact of gender affirming interventions. Future work will review the specific procedural complications from individual interventions or surgeries.

REFERENCES

1. Oregon Health Authority. Prioritized list: guideline for gender dysphoria. Frequently asked questions. 2019; https://www.oregon.gov/oha/HPA/DSI-HERC/FactSheets/Gender-dysphoria.pdf. Accessed June 2, 2023.

Attachment 4: Internal OHA Emails

- **Jason Gingerich, HERC Director, 2/9/2024**, “Everyone I am talking to agrees there is little evidence”
- **Margaret Cary, OHP BH Medical Director, 5/7/2024**, outlining risks and noting “paucity of research on long-term impacts of GnRH agonists as GAC in adolescents” … “unknown impact on brain, metabolism, and bone development, potential increase in PCOS….”
- **Jason Gingerich, HERC Director, 5/14/2024**, describing DOJ legal opinion and concerns about WPATH
- **Devan Kansagara, HERC Chair, 10/30/2024**, “… I shudder to think that providers conducting shared decision making with their patients about these really complex decisions don't have a full set of information to work from. We can do better as a medical community.”

From: Jason Gingerich
To: Trilby de Jung (she/hers)
Cc: DeMars Chris; SCHMIDT PHILIP
Subject: Re: Request for Medical Technology Assessment / Evidence-based Guideline of Gender-Affirming Treatment
Date: Friday, February 9, 2024 7:13:39 AM

Yes. I would meet with him and listen and talk briefly about some of the below.
I think listening can go a long way. He has a right to advocate but HERC is not really the right venue. Everyone I am talking to agrees there is little evidence and struggling people who need good care. There is debate (even beyond the poles) about what that should be, as there are in many areas of medicine. Legally, as they always do, Providers need to use their judgment and operate within their scopes of practice except where there is clear evidence of harm and we don't have that here. We have lots of observational evidence of benefit, and some such evidence of regrets which may or may not be harm. And there are regrets and harms from many procedures and medications.
Meanwhile The legislature has spoken about what coverage should be and put significant constraints on the role of payers in this area of controversy.

Sent from my iPhone

> On Feb 8, 2024, at 5:16 PM, Trilby de Jung (she/hers) <TRILBY.DEJUNG@oha.oregon.gov> wrote:
>
> Agreed – it depends on whether he is concerned that
>
> a. providers won't require the assessments that are incorporated into the WPATH standard or
> b. even if the assessments are provided, the gender-affirming care will actually cause harm to autistic minors or
> c. both (this is where he probably is).
>
> We should encourage him to report instances of either a or b, correct?
>
> Jason – I'm curious, would you meet with him if this were not such a charged topic? Have you met with him in the past?
>
> **Trilby de Jung, JD | she/her**
> Deputy Director
> OREGON HEALTH AUTHORITY
> Health Policy & Analytics Division
> 971/239-2083
> trilby.dejung@oha.oregon.gov
>
> ---
>
> **From:** DeMars Chris <Chris.DEMARS@oha.oregon.gov>
> **Sent:** Thursday, February 8, 2024 4:41 PM
> **To:** Jason Gingerich <JASON.D.GINGERICH@oha.oregon.gov>; Trilby de Jung (she/hers)

From: Cary Margaret
To: Weston Deborah G; Daniels Jason H; Mautner Dawn
Cc: Jason Gingerich; Servid Sarah A; Krueger David; CITRON Roger A; Gibler Andrew N.
Subject: RE: DECISION needed RE: PA for puberty blockers
Date: Tuesday, May 7, 2024 5:06:12 PM
Attachments: image002.png
image003.png

Hi all
Thank you for outlining all of this.
While I completely agree that ready access to GnRH agonists is quite important, and sometimes life preserving, we also want to ensure that best practices are being followed.

- Are there risks and concerns about covering GnRH agonists for youth diagnosed with gender dysphoria? *YES!*
    - There is also a paucity of research on the long-term impacts of GnRH agonists as GAC in adolescents:
        - As presented in P&T – unknown impact on brain, metabolism, and bone development, potential increase in PCOS. Studies still say this.
    - There is increasing requests for GAC in clinic settings. This is both a great sign that people are seeking care, and it increases the diversity of the health status and life experiences of those who are seeking care. I have already seen in my last ~10yrs of providing care and conversations around GAC that the eagerness to ensure access has sometimes resulted in skipping over steps and not considering the developmental and holistic context of the youth.
- **And if yes, are those risks and concerns significant enough for OHA to require additional review**? *Not at this time, but likely in the future*
    - I think at some point we will likely need to do additional review to asses for utilization, equity, and quality, and so the question for me is when and by what mechanism.
        - If we don't have the staff to deny, we don't have the staff to deny.
            - Ought we seek to hire the staff so we can deny in the future? Perhaps but I am good with waiting until we have more utilization data. I think we are moving away from PA being the primary mechanism for ensuring quality of care and instead using utilization, audits, clinician education/ECHOs, etc.
            - I think if we decide we need a PA, we will have more information about what that PA ought to contain after we have some utilization data. I would also love clinicians in the field to help guide those PA criteria
    - As GN 127 says that we cover care when provided in accordance with WPATH 8.0, we've set our expectation. We can lean back on that if it is not happening.
        - I would like to know about the care plans for youth getting GnRH agonists. It seems that they would warrant them.
    - Lastly, is the lack of PA for GnRH opening the door to stimulants for gender dysphoria?
        - In reading HB 2002: "Gender-affirming treatment" means a procedure, service, drug, device or product that a physical or behavioral health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth." -> I am curious how that is being interpreted as I see that as treating the incongruence, not necessarily treating the dysphoria which is a behavioral health condition which may be treated by GAC or may be treated by therapy depending on the wants and circumstances of the individual. To wit, the door is already open for using stimulants for mental health conditions. And I think stimulants could be denied under not meeting med nec/med approp criteria by a clinician and not a GAC clinician. Your thoughts?

Warmly
Meg

Margaret Cary, MD, MPH (she/her)
OHP BH Medical Director
OHA Health Systems Division
Margaret.Cary@oha.oregon.gov
Cell: 971.610.2237
www.oregon.gov/OHA

For scheduling, kindly contact Kelli Broessel, Kelli.K.Broessel@oha.oregon.gov

---

From: Weston Deborah G <DEBORAH.G.WESTON@oha.oregon.gov>
Sent: Monday, May 6, 2024 4:57 PM
To: Daniels Jason H <JASON.H.DANIELS@oha.oregon.gov>; Mautner Dawn <Dawn.Mautner@oha.oregon.gov>; Cary Margaret <Margaret.Cary@oha.oregon.gov>
Cc: Jason Gingerich <JASON.D.GINGERICH@oha.oregon.gov>; Servid Sarah A <Sarah.A.Servid@odhsoha.oregon.gov>; Krueger David <David.Krueger@oha.oregon.gov>; CITRON Roger A <Roger.A.CITRON@odhsoha.oregon.gov>; Gibler Andrew N. <Andrew.N.Gibler@oha.oregon.gov>
Subject: DECISION needed RE: PA for puberty blockers
Importance: High

From: Jason Gingerich
To: Droge Emily
Subject: RE: Due 5/16: GAC News Release and Website Revisions
Date: Tuesday, May 14, 2024 4:46:00 PM
Attachments: ORS 40.225 Attorney Client Privilege
image001.png

Hi Em,
Sorry to have missed the call yesterday; I haven't been attending since HERC's work on this is likely done, but may need to re-engage.

Given the attached DOJ memo (ORS 40.225 Attorney Client Privilege), I'm a little uncomfortable highlighting WPATH 8.0 so prominently. Sending it to you so you can use your judgment with regard to how this fits with the discussion yesterday. I don't want to complicate things unnecessarily, but am a little worried that highlighting WPATH so prominently might not be the best thing at this particular moment. Also a little unclear about why the contact about OHP is PHD?

As you may be aware, WPATH has come under scrutiny recently, including an op ed in the New York Times last weekend, as well as some leaks from WPATH's internal chats that call into question how evidence-based its recommendations are.
There are also activists very focused on this issue (testifying at 3 meetings, prompting the need for this DOJ memo, filing public records requests). See also these public comments, which we received for our Thursday, May 16 public meeting.
https://www.oregon.gov/oha/HPA/DSI-HERC/MeetingDocuments/HERC-Public-Comments-5-16-2024-B.pdf

Given all this it may be worth consider removing the reference to WPATH 8 and replace it with a reference to the provisions of HB 2002, or "accepted standards of care."

Jason Gingerich
Director, Health Evidence Review Commission
Phone: 503-385-3594

From: Droge Emily <Emily.Droge@oha.oregon.gov>
Sent: Tuesday, May 14, 2024 4:34 PM
To: Herb Sarah <Sarah.Herb@oha.oregon.gov>; Mackenzie Carroll (they/them) <Mackenzie.Carroll@oha.oregon.gov>; Walker Charina <CHARINA.WALKER@oha.oregon.gov>; Wang Emily L <EMILY.L.WANG@oha.oregon.gov>; Roberts Nathan W <NATHAN.W.ROBERTS@oha.oregon.gov>; Jason Gingerich <JASON.D.GINGERICH@oha.oregon.gov>; Devlin Prince (He/Him) <Devlin.Prince@oha.oregon.gov>; Emily Elman <EMILY.L.ELMAN@oha.oregon.gov>; Annika Shore <Annika.L.Shore@oha.oregon.gov>; Johnson Shelagh M <SHELAGH.M.JOHNSON@oha.oregon.gov>; Alex R. Freedman (they/them) <Alex.R.Freedman@oha.oregon.gov>; Susan Otter (she/her) <Susan.OTTER@oha.oregon.gov>; Howe Bethany Grace <Bethany.G.Howe@odhs.oregon.gov>; Colin Sanders (He/Him/His)

From: Devan Kansagara
To: Holly Jo Hodges; Jason Gingerich; Smits Ariel; Valerie King; Marcus Bachhuber; Walker Liz; drlynnea@yahoo.com
Cc: Irwin Adriane; Miriam.mcdonell@pacificsource.com; Brian Duty
Subject: Re: Pediatric Gender Medicine: Dispatches From a Deceptive Medical Field
Date: Wednesday, October 30, 2024 7:42:32 AM

Thanks for sending Holly Jo. I read that Times article last week and was dismayed to learn that an NIH funded study (to the tune of $10 million) went unpublished for political considerations. Ultimately suppression, obfuscation, and misrepresentation of evidence will paradoxically do more harm than good to the communities in need. As the parent of two middle schoolers I shudder to think that providers conducting shared decision making with their patients about these really complex decisions don't have a full set of information to work from. We can do better as a medical community.

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From: Holly Jo Hodges <hollyjo.hodges@modahealth.com>
Sent: Tuesday, October 29, 2024 12:09:00 PM
To: Jason Gingerich <JASON.D.GINGERICH@oha.oregon.gov>; Smits Ariel <ARIEL.SMITS@oha.oregon.gov>; Valerie King <kingv@ohsu.edu>; Marcus Bachhuber <bachhmar@ohsu.edu>; Walker Liz <Liz.Walker@oha.oregon.gov>; drlynnea@yahoo.com <drlynnea@yahoo.com>
Cc: Devan Kansagara <kansagar@ohsu.edu>; Irwin Adriane <Adriane.irwin@oregonstate.edu>; Miriam.mcdonell@pacificsource.com <Miriam.mcdonell@pacificsource.com>; Brian Duty <dutyb@ohsu.edu>
Subject: [EXTERNAL] FW: Pediatric Gender Medicine: Dispatches From a Deceptive Medical Field

This is on the national scene.
Sharing for information only.
HJH

From: Sensible Medicine <sensiblemed@substack.com>
Sent: Saturday, October 26, 2024 4:24:54 AM
Subject: Pediatric Gender Medicine: Dispatches From a Deceptive Medical Field

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Pediatric Gender Medicine: Dispatches From a Deceptive Medical Field

BENJAMIN RYAN

It is my pleasure to introduce this article by the intrepid reporter Benjamin Ryan. I learned of Mr. Ryan during the monkeypox outbreak, our empirical research found that he was the single most accurate source of information on Twitter/X.

Now, he turns his attention to the third rail of American medicine— gender dysphoria and its treatment. This article is worth your time, and he is worth reading & following.

Vinay Prasad, MD MPH

On Wednesday, The New York Times reported that one of the leading figures in the field of pediatric gender medicine, Dr. Johanna Olson-Kennedy, was deliberately shielding from the public research findings indicating that prescribing puberty blockers to gender-distressed children had no apparent psychological benefit. She cited political motivations for withholding from the public vital scientific information that we all paid for, given her investigation was sponsored by the National Institutes of Health.

Many members of the wider public were shocked by Dr. Olson-Kennedy's apparent subterfuge.

They shouldn't have been.

I have spent the past two years immersed the controversial and combustible field of pediatric gender medicine, first as a devoted student of its byzantine and contradictory literature and eventually as a dogged reporter. In my over two decades of science reporting, I have never encountered a medical field in which activist and advocacy goals are so consistently prioritized over dispassionate, honest and transparent science.

I'm talking about everyone from researchers and doctors at prestigious intuitions such as Harvard, Brown and UCSF. I'm talking about the leadership in the American Academy of Pediatrics and other major medical societies (with the notable exception of the American

Society of Plastic Surgeons) and a major Biden administration health official. And perhaps the most shadowy and deceptive of all is the U.S.-based activist-medical organization World Transgender Association for Transgender Health, or WPATH.

As I wrote on Substack yesterday, this medical field is brimming with egregious examples of researchers hiding inconvenient research findings, refusing to share data that might lead to such findings, and discouraging researchers from conducting or publishing research that might prove inconvenient to the mission of providing open access to gender-transition treatment and surgeries for minors. All this goes on within the larger context of the fact that a half-dozen systematic literature reviews—the gold standard of scientific evidence—have found the evidence backing such interventions is largely weak and inconclusive.

Constructing a fearsome buffer zone around this medical and scientific field is an activist cabal that stands in waiting to attack, silence and cancel any researcher, journalist or other public figure who dares step out of line—anyone who questions the wisdom of, or evidence base behind, prescribing puberty blockers and cross-sex hormones to gender-distressed minors.

This includes the major LGBTQ organizations, such as the Human Rights Campaign and GLAAD; as well as prominent and highly aggressive activists, including Alejandra Caraballo, who is a clinical instructor at Harvard Law School and who is particularly fond of defaming people; the popular Substacker Erin Reed, who has proven herself incapable of publishing reliably accurate science reporting; and the pugilistic Northwestern Journalism professor Steven Thrasher.

These activists and nonprofits utter streams of falsehoods as they seek to bully anyone who betrays a perspective on the subject of pediatric gender medicine that is misaligned with their advocacy goals.

Behind them is a liberal media that for the most part does GLAAD's biddings and publishes advocacy talking points instead of conducting incisive, circumspect journalism. (There are notable exceptions, mind you.)

I spent much of last year crafting pitches about articles I wanted to write about the many questionable aspects of pediatric gender medicine. I took my ideas to major left-leaning media outlets, hoping they would publish my reporting. They all refused. All of them. They were too

scared of the blowback and of GLAAD in particular. One told me they feared for their job if they ever stuck their neck out the way I have. Another was clearly fearful of his junior staffers.

They are right to be afraid. There is profound risk in publicly questioning the dogma in this medical field.

Since I began investigating this subject as a reporter and ultimately publishing my work with conservative outlets, I have had friends and colleagues denounce me as evil for defending the small group of fine journalists who also work in this space, such as Jesse Singal. I had the child of a family friend seek to eject me from her mother's book party (I refused to comply). And I've received streams of harassing calls, texts, emails and DMs and even received a threat of harm to my person. All for doing what I have done my entire career: report the truth about science and medicine without fear or favor.

I have heard from countless parents who report, without any trace of bigotry or animus, that their adolescent children have begun identifying as transgender despite any prior indication of gender nonconformity. These parents are heartbroken, terrified and alone. They love their children, but they sincerely do not believe that a medical gender transition will help them.

This week, I had a Zoom call with one parent whose former spouse had transitioned genders and whose very young children then followed suit. This was a lifelong liberal whose sociopolitical principles left them with searing cognitive dissonance as they pushed back on potentially medicalizing one child's trans identity. The parent believed that the child's self-conception was surely the product of the former spouse's influence.

I wish I could show you the restrained agony on this parent's face as they spoke with resigned sadness about their effort to protect their child from doctors who might, with the best of intentions, harm the kid and to maintain their relationship.

Because I want you all to remember that at the center of this debate is the well-being of a population of profoundly vulnerable children.

The best way to ensure these kids get the best care is to advocate for better science. Doing so takes bravery these days.

But it must be done.

I am an independent journalist, specializing in science and health care coverage. I contribute to *The New York Times*, *The Guardian*, *NBC News* and *The New York Sun*. I have also written for *the Washington Post*, *The Atlantic* and *The Nation*.

Follow my Substack: https://benryan.substack.com

Follow me on Twitter: @benryanwriter.

Visit my website: benryan.net

A guest post by

Benjamin Ryan

I am a health and science journalist and often cover pediatric gender medicine. I contribute to The New York Times, the Washington Post, NBC News and The New York Sun. www.benryan.net
www.twitter.com/benryanwriter

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Attachment 5: OHA report on Gender-affirming Treatment for OHP Members, 2015-2014, prepared for the Oversight Project, August 7, 2025

Public Records Request Response
Requester: Oversight Project
Request No.: 2025-0712

Gender-affirming treatment for OHP members, 2015–2024

This document provides calendar year 2015-2024 data on Oregon Health Plan (OHP) members who received services associated with gender-affirming treatment (i.e., surgical procedures, hair removal, speech therapy, hormone therapy medications, and/or puberty suppression medications).

Population

These tables include OHP members who had one or more OHP claims for services associated with gender-affirming treatment during 2015-2024.

Please note, OHA's primary source for Medicaid member data is the administrative claims and encounter data used for billing/payment for health care services and does not represent a clinical record. Thus, these data do not represent the prevalence of gender dysphoria across all OHP members, only those OHP members for whom a gender dysphoria or related diagnoses was present on any medical services claim in the time frame reported. Also, not all people who are transgender, non-binary, or those questioning their gender identity seek medical intervention.

Services

Gender-affirming procedures

The analysis of gender-affirming procedures includes:

- Surgical procedures, which include chest and genital masculinization/ feminization, face feminization, gonad removal, hysterectomy, phalloplasty, tissue transfer, and vulvoplasty/vaginoplasty.
- Hair removal, with no co-occurring diagnosis of warts (the same procedure codes can be used for both hair and wart removal)
- Speech therapy
- Same day facility and anesthesia costs

OHA consulted with clinical experts to develop an initial list of procedures to include in analysis and expanded the list to include additional gender-affirming services based on guidance from other insurers (Medicare, commercial plans). Procedures were included if a primary diagnosis of gender dysphoria was present on the service claim and if OHP paid for the service.

Gender-affirming medications

The analysis of gender-affirming medications includes:

- Hormone therapy medication, which is typically used by transgender and nonbinary people to produce physical changes in the body that are caused by female or male hormones during puberty. Hormone therapy helps better align the body with a person's gender identity.
- Puberty suppression medication, which can be used to delay the changes of puberty in youth who are transgender, non-binary, or those questioning their gender identity and who have started puberty. In some cases, individuals 18 and over may receive GnRH analogs which have other gender-affirming effects aside from puberty suppression.

OHA consulted with clinical and pharmacy experts to identify the appropriate hormone therapy and puberty suppression drugs to include while also excluding conflicting diagnoses. The analysis of gender-affirming medication includes retail pharmacy claims and physician-administered drugs.

For physician-administered drugs, puberty suppression medications were the only medication type present in our dataset (not hormone therapy). Claims were included if a primary diagnosis of gender dysphoria was on the procedure claim with no diagnosis of a puberty disorder on the same claim.

Retail pharmacy claims includes both puberty suppression medication and hormone therapy. Pharmacy claims cannot be tied to specific diagnoses, so we included claims if the member had a primary diagnosis related to gender dysphoria at any time during 2015-2024. Claims were then excluded if the member had ever been diagnosed during 2015-2024 with a puberty disorder. For members receiving hormone therapy, members were excluded if they had ever been diagnosed during 2015-2024 with conditions related to menstruation, endometriosis, uterine fibroids, other endocrine disorders, or menopause, as these medications can also be used to treat those conditions. Progestins were also excluded due to their use for birth control and conditions related to menstruation. Progestins are often used in addition to other gender affirming hormone therapy captured in this analysis but are not used on their own as gender affirming care.

Data in Table

Costs

The table includes the fees specific to the listed gender-affirming procedures, as well as an estimate of same-day facility/anesthesia charges. Medicaid rates are generally lower than self-pay or commercial rates for surgical services.

The table also includes the fees paid for medications, including physician-administered drugs. Claims for physician-administered drugs include the cost of the medication as well as the cost of administration.

Please note, these costs do not represent entire episodes of care which would include pre-operative and post-operative care specifically associated with the procedure. While episodes of care reporting is common, OHA's procedure and episode grouper tools are limited to certain situations, and do not include an episodes of care grouper for gender-affirming treatment. OHA is not aware of any grouper available that groups episodes of care related to gender-affirming treatment, and developing this framework would involve extensive external clinical consultation, time, and cost.

Table 1. Gender-affirming treatment services for OHP Members, 2024-2015

	Gender-affirming procedures			**Gender-affirming medications**	Total Procedure, Same Day, & Medication Costs
Year	Procedure Costs	Same Day Costs †	Total Procedure & Same Day Costs	Medication Costs	
2024	$4,922,637	$3,138,876	$8,061,513	$4,282,556	$12,344,069
2023	$3,382,472	$2,176,785	$5,559,257	$4,182,029	$9,741,286
2022	$3,535,887	$1,863,597	$5,399,484	$3,934,554	$9,334,038
2021	$2,834,740	$1,456,679	$4,291,419	$2,920,969	$7,212,388
2020	$2,162,095	$1,031,343	$3,193,438	$2,032,907	$5,226,345
2019	$1,621,193	$1,223,902	$2,845,095	$1,525,825	$4,370,920
2018	$1,446,201	$1,107,936	$2,554,137	$1,208,599	$3,762,736
2017	$1,283,247	$878,727	$2,161,974	$879,732	$3,041,706
2016	$775,257	$584,893	$1,360,150	$687,775	$2,047,925
2015	$190,624	$183,870	$374,494	$346,860	$721,354

Data source: MMIS/DSSURS via HAL_REPORTING, 04/17/2025

† Same day costs are additional (facility and anesthesia) costs from the day that an OHP member received a gender-affirming procedure.

Attachment 6: OHA report Gender Affirming Care for OHP Members with Gender Dysphoria Diagnosis – Response to request; June 16, 2023

Gender Affirming Care for OHP Members with Gender Dysphoria Diagnosis – Response to request; June 16, 2023

This brief provides Calendar Year 2015-2022 data on Oregon Health Plan (OHP) members with a primary gender dysphoria diagnosis who received Gender Affirming Care services; and includes information on Gender Affirming Care services (i.e., surgical procedures, hair removal, and speech therapy) costs and number of members receiving services, segmented by age groups.

Oregon's Medicaid program, the Oregon Health Plan, began covering Gender Affirming Care services for members with gender dysphoria diagnoses in 2015, thus the data presented here are from 2015-2022. (For more information about OHP coverage, see: https://www.oregon.gov/oha/HPA/DSI-HERC/FactSheets/Gender-dysphoria.pdf)

Population: These tables include OHP members who had one or more OHP medical services claims for Gender Affirming Care services, with a primary diagnosis of gender dysphoria on that claim, during 2015-2022. The tables provide unique individuals, not number of services.

Please note, OHA's primary source for Medicaid member data is the administrative claims and encounter data used for billing/payment for health care services and does not represent a clinical record. Thus, these data do not represent the prevalence of gender dysphoria across all OHP members, only those OHP members for whom a gender dysphoria or related diagnoses was present on any medical services claim in the time frame reported. Also, not all people who are transgender or gender diverse seek medical intervention.

Small numbers in the following tables have been suppressed as OHA has responsibility to protect the confidentiality of people in Oregon while reporting reliable data. We do not report breakouts where the underlying population is less than 50, and we do not report (non-zero) numbers less than 5. We report numbers between 5 and 12 but they may be statistically unreliable and should be interpreted with caution. In some cases, additional values must be suppressed to prevent backward calculation of a suppressed number. All other values are reported.

Services: The tables below show the following Gender Affirming Care services provided for OHP members with a primary diagnosis of gender dysphoria on the service claim:

- Surgical procedures, which include chest and genital masculinization/feminization, face feminization, gonad removal, hysterectomy, phalloplasty, tissue transfer, and vulvoplasty/vaginoplasty.
- Hair removal, where a subsequent surgical procedure is performed (hair removal is only covered as part of pre-surgical preparation for other Gender Affirming care surgical procedures) and no co-occurring diagnosis of warts (as the same procedure code is used for both hair and wart removal).
- Speech therapy
- Same day facility and anesthesia costs

Please note, procedure and billing codes for Gender Affirming Care surgical procedures involve multiple procedures as steps in the larger surgery, many of which are nonspecific to body parts and fall under multiple surgery types.

Costs: The tables include the professional fees specific to the listed procedures with and without same-day facility charges. We also added anesthesia costs to the procedure costs. Please note, Medicaid rates are generally considerably lower than self-pay or commercial rates for surgical services.

Please note, these costs do not represent entire episodes of care which would include pre-operative and post-operative care specifically associated with the procedure. While episodes of care reporting is common, OHA's procedure and episode grouper tools are limited to certain situations, and do not include an episodes of care grouper for Gender Affirming Care. OHA is not aware of any grouper available that groups episodes of care related to Gender Affirming Care. Creating one that contained these episodes of care would be complex. It would require extensive external clinical consultation and substantial time and cost.

2022-2015 Summary: Gender Affirming Care Services for OHP Members with Primary Diagnosis of Gender Dysphoria

	Individuals						
	Surgical Procedures	Hair Removal	Speech Therapy	Total Unique Individuals	Total Medicaid Population	% Medicaid Population	Total Costs
2022	569	74	44	**655**	1,444,999	0.05%	$6,087,383
2021	438	87	22	**517**	1,344,804	0.04%	$4,896,467
2020	362	51	16	**417**	1,222,715	0.03%	$3,324,116
2019	333	69	< 5	**371**	1,059,445	0.04%	$2,990,167
2018	291	83	< 5	**340**	1,035,115	0.03%	$2,672,208
2017	268	91	< 5	**324**	1,032,325	0.03%	$2,240,916
2016	188	39	0	**213**	1,037,766	0.02%	$1,400,336
2015	75	< 5	0	**77**	1,111,672	0.01%	$412,317

Data Source: MMIS/DSSURS

6/16/2023

2022-2015: Gender Affirming Care Services for OHP Members with Primary Diagnosis of Gender Dysphoria

		Individuals				Total Costs					Average Costs			
Year	Service	Total unique individuals†	Age (12-14)‡	Age (15-17)	Age (18+)	Service Costs (OHP Paid)	Same Day Facility & Anesthesia Costs^ (OHP Paid)	Third Party Paid	Medicare Paid	Total Costs	Average Service Costs (OHP Paid)	Average Third Party Paid	Average Medicare Paid	Average Total Costs
	Surgical Procedures*	569	< 5	^^	550	$3,174,833		$155,324	$112,899	$3,443,056	$5,580	$273	$198	$6,051
	Hair Removal	74	0	0	74	$192,838		$0	$12,242	$205,080	$2,606	$0	$165	$2,771
	Speech Therapy	44	**	**	**	$12,028		$160	$143	$12,331	$273	$4	$3	$280
2022	**TOTAL**	**655**				**$3,379,699**	**$2,426,916**	**$155,485**	**$125,283**	**$6,087,383**				
	Surgical Procedures*	438	< 5	^^	408	$2,414,027		$212,675	$74,351	$2,701,053	$5,511	$486	$170	$6,167
	Hair Removal	87	0	< 5	^^	$283,050		$0	$14,285	$297,335	$3,253	$0	$164	$3,418
	Speech Therapy	22	**	**	**	$6,788		$0	$1,097	$7,885	$309	$0	$50	$358
2021	**TOTAL**	**517**				**$2,703,864**	**$1,890,195**	**$212,675**	**$89,733**	**$4,896,467**				
	Surgical Procedures*	362	0	21	342	$1,924,731		$46,179	$77,834	$2,048,744	$5,317	$128	$215	$5,660
	Hair Removal	51	0	0	51	$189,692		$75	$16,101	$205,868	$3,719	$1	$316	$4,037
	Speech Therapy	16	**	**	**	$9,474		$0	$867	$10,341	$592	$0	$54	$646
2020	**TOTAL**	**417**				**$2,123,897**	**$1,059,163**	**$46,254**	**$94,802**	**$3,324,116**				
	Surgical Procedures*	333	0	10§	323	$1,340,433		$55,281	$98,460	$1,494,174	$4,025	$166	$296	$4,487
	Hair Removal	69	0	0	69	$221,506		$926	$21,970	$244,402	$3,210	$13	$318	$3,542
	Speech Therapy	< 5	**	**	**	$896		$0	$0	$896	^^	$0	$0	^^
2019	**TOTAL**	**371**				**$1,562,835**	**$1,250,695**	**$56,207**	**$120,430**	**$2,990,167**				
	Surgical Procedures*	291	0	5§	286	$1,117,452		$36,608	$74,607	$1,228,667	$3,840	$126	$256	$4,222
	Hair Removal	83	0	0	83	$270,635		$3,892	$33,841	$308,368	$3,261	$47	$408	$3,715
	Speech Therapy	< 5	**	**	**	$0		$0	$187	$187	$0	$0	^^	^^
2018	**TOTAL**	**340**				**$1,388,087**	**$1,134,985**	**$40,501**	**$108,635**	**$2,672,208**				
	Surgical Procedures*	268	0	15	253	$1,049,476		$8,876	$66,564	$1,124,916	$3,916	$33	$248	$4,197
	Hair Removal	91	0	0	91	$196,979		$1,337	$23,716	$222,032	$2,165	$15	$261	$2,440
	Speech Therapy	< 5	**	**	**	$227		$0	$0	$227	^^	$0	$0	^^
2017	**TOTAL**	**324**				**$1,246,682**	**$893,740**	**$10,213**	**$90,281**	**$2,240,916**				
	Surgical Procedures*	188	0	< 5	^^	$727,312		$3,016	$47,092	$777,420	$3,869	$16	$250	$4,135
	Hair Removal	39	**	**	**	$33,587		$98	$323	$34,008	$861	$3	$8	$872
	Speech Therapy	0	0	0	0	$0		$0	$0	$0	$0	$0	$0	$0
2016	**TOTAL**	**213**				**$760,899**	**$588,909**	**$3,114**	**$47,414**	**$1,400,336**				
	Surgical Procedures*	75	0	< 5	^^	$189,772		$0	$38,919	$228,691	$2,530	$0	$519	$3,049
	Hair Removal	< 5	**	**	**	$849		$0	$0	$849	^^	$0	$0	^^
	Speech Therapy	0	0	0	0	$0		$0	$0	$0	$0	$0	$0	$0
2015	**TOTAL**	**77**				**$190,620**	**$182,778**	**$0**	**$38,919**	**$412,317**				

* Surgical procedures include chest and genital masculinization/feminization, face feminization, gonad removal, hysterectomy, phalloplasty, tissue transfer, and vulvoplasty/vaginoplasty. These involve multiple procedures as steps in the larger surgery, many of which are nonspecific to body parts and fall under multiple surgery types and cannot be reliably assigned to one surgery type without complex episode of care grouping.

† Because individuals can receive more than one type of service, the number of unique individuals in each service category do not add up to the total unique individuals for that year

‡ No services were provided for individuals under 12 years of age in the timeframe specified.

^ Facility and anesthesia costs cannot be attributed to specific services when more than one service was provided on the same day. Only totals are reported for these costs.

< 5 Estimate suppressed due to small numbers; statistically unreliable.

** Value suppressed to protect confidentiality. Denominator less than 50.

^^Value suppressed to prevent backward calculation of other suppressed value(s).

§ May be statistically unreliable due to small numbers; interpret with caution.

Data Source: MMIS/DSSURS, 6/16/23

Attachment 7: OHA memorandum on Gender Affirming Care Utilization and Cost to Commercial Insurers in Oregon for Rep. Yunker, December 16, 2024

Memorandum

To: Oregon State Representative Dwayne Yunker

From: Oregon Health Authority, Office of Health Analytics, All Payer All Claims Program

Date: December 16, 2024

Subject: Gender Affirming Care Utilization and Cost to Commercial Insurers in Oregon

Gender Affirming Care in Oregon

Utilization Trends and Costs to Commercial Insurers

Response to Request from Oregon State Representative Dwayne Yunker, December 2024

Overview

This report presents cost and utilization data for gender affirming care in Oregon from 2015-2023. It includes utilization data on individuals with commercial, Medicaid and/or Medicare insurance and a primary diagnosis of gender dysphoria who received gender affirming care procedures (surgery, hair removal and speech therapy), hormone therapy and/or puberty suppression, in summary and segmented by age, race/ethnicity, insurance type and year. The cost of this care is calculated for people with commercial insurance. The costs to Medicare and Medicaid are not calculated for this report.

This report is in response to a request from Oregon State Representative Dwayne Yunker and responds to the following questions:

1. How many patients in Oregon have been diagnosed with/are receiving treatment for gender dysphoria?
    a. By race/ethnicity and age group
2. How have these numbers changed over time?
    b. By age group
3. What is the cost to commercial carriers?
    c. Both aggregated cost and typical cost for individual procedures
    d. How have these costs changed over time?

Population

This report includes data from individuals in Oregon who have commercial, Medicaid, and/or Medicare insurance. Utilization data is presented for all three types of insurance. Cost is presented only for commercial insurance. **Tables present unique individuals within a given category, not the number of claims.** There are three sections of the report corresponding to three different subpopulations:

Section 1: Individuals with a primary diagnosis of gender dysphoria

Section 2: Individuals with a primary diagnosis of gender dysphoria who had one or more medical claims related to gender affirming care (surgery, hair removal, and/or speech therapy)

Section 3: Individuals with a primary diagnosis of gender dysphoria who had one or more pharmacy claims related to gender affirming care (hormone therapy and/or puberty suppression)

Data

This report uses administrative claims data from the All Payer All Claims (APAC) data warehouse. APAC contains information about health care claims including diagnoses, procedures, services, medications and payments for the majority of people in Oregon.

APAC is an administrative claims database used for billing and payment for health care services and does not represent a clinical record. These data do not represent the prevalence of gender dysphoria among individuals in Oregon, only those who had a primary gender dysphoria diagnosis within an insurance claim within a given year. Not all people who are transgender, non-binary, or those questioning their gender identity seek medical intervention.

Methods

OHA consulted with clinical and pharmacy experts to identify diagnosis, procedure, and pharmacy codes related to gender affirming care. The methods used to extract and summarize APAC data adhere closely to the methods in a similar 2023 report using Medicaid data. The programming code from the 2023 report was directly translated into equivalent code for use in APAC's secure analytic environment.

Gender Dysphoria

This report identifies gender dysphoria through a list of seven diagnosis codes (International Classification of Diseases, Tenth Revision, Clinical Modification[1]) and includes only the primary diagnosis. Persons with age missing in the APAC data were excluded. APAC's Unique Person Identifier was used to de-duplicate persons.

Gender affirming care

This report uses the following definition of gender affirming care:

- A person with gender dysphoria
    - Who receives a gender affirming procedure AND/OR
    - Who receives a gender affirming medication

Medical Treatment

The list of gender affirming procedure codes in this report is based on the original list from the 2023 report. This report also incorporated billing guidance from Medicare and several large commercial insurers to augment the list of gender affirming procedure codes to more closely align with the requirements of coverage for gender affirming care in House Bill 2002 (2023). To be considered a gender affirming procedure, a claim must have included a primary diagnosis of gender dysphoria. The medical treatment categories include:

- Hair removal, either as an adjunct to a surgical procedure or for other purposes.
- Speech therapy, to help individuals modify their voice characteristics, such as pitch, resonance, and intonation.
- Surgery, which may include chest and genital masculinization or feminization, face feminization, gonad removal, hysterectomy, phalloplasty, tissue transfer, and vulvoplasty or vaginoplasty.

[1] The International Classification of Diseases (ICD) is revised periodically by the World Health Organization (WHO). While WHO updates the ICD annually, a complete revision of the ICD reflects advances in science and medicine in reporting diseases and health conditions. In May 2019, WHO members, including the United States, approved the adoption of the eleventh revision (ICD-11) to be effective January 2022. In this revision, the term 'gender incongruence' is used in diagnoses to retain access to care while acknowledging that gender diverse identities are not conditions of mental illness. This is a change from the tenth revision (1993) where 'gender dysphoria' is included as a mental disorder. ICD-11 has three conditions related to 'gender incongruence' based on the age of the patient (adolescence/adulthood, childhood or unspecified).

Pharmacy Treatment

The list of hormone therapy and puberty suppression medications in this report is based on the original list from the 2023 report and includes hormone therapy received in a clinic setting. The pharmacy treatment categories include:

- Hormone therapy, which is typically used by people to produce physical changes in the body that are caused by female or male hormones during puberty. This hormone therapy helps better align the body with a person's gender identity.
- Puberty suppression, which is used to delay the changes of puberty in young people who have started puberty. In some cases, people 18 and over may receive puberty suppression medications such as gonadotropin-releasing hormone (GnRH) analogs. In these cases, the medications have other gender affirming effects aside from puberty suppression.

Note: Pharmacy claims do not include primary diagnoses, so a person was categorized as having gender affirming pharmacy treatments if they had at least one relevant pharmacy treatment and a medical claim with a primary diagnosis of gender dysphoria within the study period (2015-2023). This may result in inflated counts, since there are reasons other than gender affirming care that individual may use the listed medications. Some hormone therapies and puberty suppressants are physician-administered, in which case the claim will include a diagnosis.

Data Tables

The data tables presented here use the following definitions:

- Persons: count of unique persons within a given category. For tables that include years, a unique person is counted once for each year. For tables that include age group, a unique person was assigned the age at the end of the calendar year to avoid double-counting.
- Diagnosis: primary diagnosis of gender dysphoria from a medical claim.
- Cost: the amount that the commercial insurer paid for the service. This does not include any payments made by the person receiving care, such as deductibles or copays. Please note: these costs do not represent entire episodes of care, which would include, among other things, pre-operative and post-operative care specifically associated with the procedure. While episodes of care reporting is common, APAC does not currently license an episodes of care grouper for gender affirming care.

In alignment with OHA policy, small numbers in the following tables have been suppressed to protect the confidentiality of people in Oregon. Counts of persons less than 50 are shown as < 50. In some cases, the total and mean costs are suppressed and shown as “#” to prevent backward calculation of the count of persons. Data from 2023 are preliminary because the

final 2023 Q4 data collection is pending and 2023 Medicare fee-for-service data is not yet available.

Key Findings

Gender affirming care comprises a small portion of overall healthcare utilization. The percentage of persons with a primary diagnosis of gender dysphoria ranged from 0.03 percent of the overall population in APAC in 2015 to 0.35 percent in 2023. The cost of providing gender affirming care is also a small portion of overall medical and pharmacy costs to commercial insurers. The cost to commercial insurers for gender affirming care ranged from 0.02 percent in 2015 to 0.18 percent in 2023 of total commercial health care costs. The costs to Medicare and Medicaid were not calculated for this report.

The number of people diagnosed with gender dysphoria is similarly small compared with the number of people diagnosed with chronic diseases. For instance, in 2023, there were 204,740 persons with a primary diagnosis of diabetes, accounting for $522,552,383, or 4.8 percent of total commercial spending, compared with 14,153 individuals with a gender dysphoria diagnosis, accounting for $19,706,415 or 0.18 percent of total commercial spending.

Section 1: Gender Dysphoria Diagnosis

Tables 1-4 present data on the population of individuals with commercial, Medicaid, and/or Medicare insurance in Oregon who have a medical claim that includes a primary diagnosis of gender dysphoria. This does not represent the total prevalence of gender dysphoria in Oregon, only the count of individuals with an insurance claim that includes this diagnosis.

Table 1: Gender Dysphoria Primary Diagnosis for People with Commercial, Medicaid, and Medicare in Oregon and Cost to Commercial Insurers from 2015-2023

	Individuals with Commercial, Medicaid, and/or Medicare Insurance			Cost to Commercial Insurers Only		
	Persons with Gender Dysphoria Diagnosis	All Persons in APAC	% of All Persons	Medical + Pharmacy Cost for Gender Affirming Care	All Medical + Pharmacy Costs for Commercial Insurers	% of All Medical + Pharmacy Costs
2015	1,964	3,897,226	0.05%	$1,034,527	$6,287,779,877	0.02%
2016	2,929	3,667,125	0.08%	$2,006,886	$5,311,632,725	0.04%
2017	4,003	3,708,162	0.11%	$3,639,412	$5,710,611,491	0.06%
2018	5,030	3,814,428	0.13%	$4,616,457	$5,964,447,185	0.08%
2019	6,337	3,885,317	0.16%	$5,764,751	$6,671,721,557	0.09%
2020	7,498	3,982,844	0.19%	$7,215,425	$6,554,411,877	0.11%
2021	9,813	4,065,956	0.24%	$9,684,754	$7,265,268,291	0.13%
2022	12,322	4,129,071	0.30%	$12,646,183	$7,653,507,482	0.17%
2023*	14,149	3,919,868	0.36%	$14,100,581	$7,991,332,740	0.18%

Data Source: APAC Release 21
* 2023 data are preliminary.

Table 2: Gender Dysphoria Primary Diagnosis by Race/Ethnicity for People with Commercial, Medicaid, and Medicare in Oregon from 2015-2023*

	Persons with Gender Dysphoria Diagnosis, 2015-2023	All Persons in APAC, 2015-2023	% of All Persons
Asian	303	96,327	0.31%
Black or African American	625	151,391	0.41%
Hispanic or Latino	1,081	332,816	0.32%
American Indian or Alaska Native	381	55,291	0.69%
Native Hawaiian or Pacific Islander	61	19,079	0.32%
Other	931	251,416	0.37%
White	11,688	2,328,857	0.50%
Missing**	12,133	3,659,286	0.33%

Data source: APAC Release 21
APAC data is not yet aligned with REALD SOGI data collection standards.
Race/ethnicity was calculated using the rarest race methodology.
* 2023 data are preliminary.
**A high percentage people in APAC have missing values for race/ethnicity. Missingness varies by insurance type – in 2022, race/ethnicity was missing for three percent of people with Medicare, 18 percent of people with Medicaid, and 50 percent of people with commercial insurance. Use caution when interpreting this data.

Table 3: Gender Dysphoria Primary Diagnosis by Age Group and Year for People with Commercial, Medicaid, and Medicare in Oregon from 2015-2023

	Age Group^	Persons with Gender Dysphoria Diagnosis	All Persons in APAC	% of All Persons
2015	Age 9 to 14	76	282,754	0.03%
	Age 15 to 17	144	142,315	0.10%
	Age 18 +	1,744	3,052,679	0.06%
2016	Age 9 to 14	101	259,212	0.04%
	Age 15 to 17	218	128,824	0.17%
	Age 18 +	2,610	2,897,123	0.09%
2017	Age 9 to 14	152	264,166	0.06%
	Age 15 to 17	325	128,596	0.25%
	Age 18 +	3,526	2,934,845	0.12%
2018	Age 9 to 14	235	277,659	0.08%
	Age 15 to 17	409	135,246	0.30%
	Age 18 +	4,386	3,013,466	0.15%
2019	Age 9 to 14	332	280,685	0.12%
	Age 15 to 17	546	136,192	0.40%
	Age 18 +	5,459	3,084,206	0.18%
2020	Age 9 to 14	354	282,045	0.13%
	Age 15 to 17	569	137,468	0.41%
	Age 18 +	6,575	3,187,609	0.21%
2021	Age 9 to 14	603	281,188	0.21%
	Age 15 to 17	882	140,708	0.63%
	Age 18 +	8,328	3,273,400	0.25%
2022	Age 9 to 14	694	278,384	0.25%
	Age 15 to 17	1,157	144,232	0.80%
	Age 18 +	10,471	3,341,803	0.31%
2023*	Age 9 to 14	611	273,419	0.22%
	Age 15 to 17	1,226	145,951	0.84%
	Age 18 +	12,312	3,148,362	0.39%

Data source: APAC Release 21
* 2023 data are preliminary.

Table 4: Gender Dysphoria Primary Diagnosis by Insurance Type (Medicare, Medicaid, and Commercial) in Oregon from 2015-2023

	Year	Persons with Gender Dysphoria Diagnosis	All Persons in APAC**	% of All Persons
Medicare	2015	158	819,813	0.02%
	2016	235	845,471	0.03%
	2017	296	879,751	0.03%
	2018	355	912,941	0.04%
	2019	414	941,076	0.04%
	2020	453	961,553	0.05%
	2021	510	968,020	0.05%
	2022	532	988,122	0.05%
	2023*	323	734,676	0.04%
Medicaid	2015	1,173	1,369,364	0.09%
	2016	1,825	1,397,534	0.13%
	2017	2,380	1,340,189	0.18%
	2018	2,936	1,283,179	0.23%
	2019	3,647	1,289,544	0.28%
	2020	4,493	1,320,226	0.34%
	2021	5,783	1,439,777	0.40%
	2022	7,257	1,545,886	0.47%
	2023*	8,436	1,646,657	0.51%
Commercial	2015	740	2,306,717	0.03%
	2016	1,036	1,870,918	0.06%
	2017	1,552	1,910,082	0.08%
	2018	2,014	2,088,543	0.10%
	2019	2,601	2,251,240	0.12%
	2020	2,970	2,728,299	0.11%
	2021	3,997	2,767,729	0.14%
	2022	5,176	2,747,052	0.19%
	2023*	6,048	2,649,815	0.23%

Data Source: APAC Release 21

* 2023 data are preliminary.

** People can have more than one insurance type per year and some people cycle in and out of coverage within a given year. The total number of unique persons per year is not equal to the sum of the persons in Medicare, Medicaid and Commercial.

Section 2: Medical Treatment

Tables 5 and 6 present data on the population of individuals with commercial, Medicaid, and/or Medicare insurance in Oregon who have a medical claim with a primary diagnosis of gender dysphoria and at least one procedure related to gender affirming care. The cost of medical treatment is calculated for people with commercial insurance. The costs to Medicare and Medicaid are not calculated for this report.

Table 5: Gender Affirming Medical Treatment and Cost to Commercial Insurers in Oregon from 2015-2023

	Treatment Category^^	Persons with treatment	Persons in Commercial with treatment	Total Cost to Commercial Insurers	Mean Cost to Commercial Insurers
2015	Hair removal	<50	<50	#	#
	Speech therapy	<50	<50	#	#
	Surgery	123	<50	#	#
2016	Hair removal	<50	<50	#	#
	Speech therapy	<50	<50	#	#
	Surgery	311	112	$1,613,526	$14,406
2017	Hair removal	108	<50	#	#
	Speech therapy	<50	<50	#	#
	Surgery	464	175	$2,845,043	$16,257
2018	Hair removal	112	<50	#	#
	Speech therapy	<50	<50	#	#
	Surgery	567	248	$3,564,811	$14,374
2019	Hair removal	111	<50	#	#
	Speech therapy	<50	<50	#	#
	Surgery	676	311	$4,061,367	$13,059
2020	Hair removal	123	55	$96,983	$1,763
	Speech therapy	<50	<50	#	#
	Surgery	738	355	$4,827,697	$13,599
2021	Hair removal	205	85	$218,363	$2,569
	Speech therapy	<50	<50	#	#
	Surgery	952	482	$6,523,801	$13,535
2022	Hair removal	196	88	$205,321	$2,333
	Speech therapy	93	<50	#	#
	Surgery	1,197	595	$8,591,544	$14,440
2023*	Hair removal	208	108	$236,137	$2,186
	Speech therapy	117	66	$30,831	$467
	Surgery	1,324	671	$9,498,162	$14,155

Data Source: APAC Release 21
Number was suppressed to prevent backward calculation of value < 50.

* 2023 data are preliminary.

^^ A person can receive more than one type of treatment (such as hair removal and surgery) per year, so the treatment categories are not mutually exclusive and the number of unique persons per year is not equal to the sum of persons in each category.

Table 6: Gender Affirming Medical Treatment by Age Group^, and Cost to Commercial Insurers in Oregon from 2015-2023

	Treatment Category^^	Persons in Commercial with Treatment			Total Cost to Commercial Insurers			Mean Cost to Commercial Insurers		
		Age 9 to 14^	Age 15 to 17	Age 18 and up	Age 9 to 14	Age 15 to 17	Age 18 and up	Age 9 to 14	Age 15 to 17	Age 18 and up
2015	Hair removal	<50	<50	<50	#	#	#	#	#	#
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	<50	#	#	#	#	#	#
2016	Hair removal	<50	<50	<50	#	#	#	#	#	#
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	108	#	#	$1,587,938	#	#	$14,703
2017	Hair removal	<50	<50	<50	#	#	#	#	#	#
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	171	#	#	$2,804,740	#	#	$16,402
2018	Hair removal	<50	<50	<50	#	#	#	#	#	#
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	238	#	#	$3,478,159	#	#	$14,614
2019	Hair removal	<50	<50	<50	#	#	#	#	#	#
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	287	#	#	$3,886,134	#	#	$13,541
2020	Hair removal	<50	<50	53	#	#	$96,259	#	#	$1,816
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	321	#	#	$4,586,233	#	#	$14,287
2021	Hair removal	<50	<50	84	#	#	$216,923	#	#	$2,582
	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	442	#	#	$6,348,295	#	#	$14,363
2022	Hair removal	<50	<50	85	#	#	$199,915	#	#	$2,352

	Speech therapy	<50	<50	<50	#	#	#	#	#	#
	Surgery	<50	<50	545	#	#	$8,252,875	#	#	$15,143
2023*	Hair removal	<50	<50	92	#	#	$209,002	#	#	$2,272
	Speech therapy	<50	<50	61	#	#	$29,726	#	#	$487
	Surgery	<50	<50	558	#	#	$9,066,485	#	#	$16,248

Data Source: APAC Release 21

Number was suppressed to prevent backward calculation of value < 50.

* 2023 data are preliminary.

^ A person can belong to more than one age group per year. The number of unique persons per age group per year is different than the sum of the persons in each age group.

^^ A person can receive more than one type of treatment (such as hair removal and surgery) per year, so the treatment categories are not mutually exclusive and the number of unique persons per year is not equal to the sum of persons in each category.

Section 3: Pharmacy Treatment

Tables 7 and 8 present data on the population of individuals with commercial, Medicaid, and/or Medicare insurance in Oregon who have at least one medical claim that includes a primary diagnosis of gender dysphoria within the study period (2015-2023) and have at least one pharmacy claim related to gender affirming care. The cost of pharmacy treatment is calculated for people with commercial insurance. The costs to Medicare and Medicaid are not calculated for this report.

Table 7: Gender Affirming Pharmacy Treatment and Cost to Commercial Insurers in Oregon from 2015-2023

	Treatment Category	Persons with treatment	Persons in Commercial with Treatment	Total Cost to Commercial Insurers	Mean Cost to Commercial Insurers
2015	Hormone therapy	1,237	528	$73,619	$139
	Puberty suppression	<50	<50	#	#
2016	Hormone therapy	1,930	731	$93,256	$128
	Puberty suppression	65	<50	#	#
2017	Hormone therapy	2,658	1,058	$183,954	$174
	Puberty suppression	87	<50	#	#
2018	Hormone therapy	3,583	1,428	$261,547	$183
	Puberty suppression	124	59	$741,576	$12,569
2019	Hormone therapy	4,462	1,887	$342,122	$181
	Puberty suppression	159	82	$1,310,325	$15,980
2020	Hormone therapy	5,580	3,006	$675,850	$225
	Puberty suppression	178	97	$1,611,707	$16,616
2021	Hormone therapy	6,960	3,707	$897,046	$242
	Puberty suppression	242	148	$2,037,445	$13,767
2022	Hormone therapy	8,863	4,931	$1,180,919	$239
	Puberty suppression	325	198	$2,650,368	$13,386
2023*	Hormone therapy	10,857	6,683	$1,463,739	$219
	Puberty suppression	370	243	$2,871,712	$11,818

Data Source: APAC Release 21
Number was suppressed to prevent backward calculation of value < 50.
* 2023 data are preliminary.
^^ A person can receive more than one type of treatment (such as hormone therapy and puberty suppression) per year, so the treatment categories are not mutually exclusive and the number of unique persons per year is not equal to the sum of persons in each category.

Table 8: Gender Affirming Pharmacy Treatment by Age Group^, and Cost to Commercial Insurers in Oregon, 2015-2023

	Treatment Category^^	Persons in Commercial with Treatment			Total Cost to Commercial Insurers			Mean Cost to Commercial Insurers		
		Age 9 to 14^	Age 15 to 17	Age 18 and up	Age 9 to 14	Age 15 to 17	Age 18 and up	Age 9 to 14	Age 15 to 17	Age 18 and up
2015	Hormone therapy	<50	<50	505	#	#	$70,200	#	#	$139
	Puberty suppression	<50	<50	<50	#	#	#	#	#	#
2016	Hormone therapy	<50	<50	694	#	#	$87,912	#	#	$127
	Puberty suppression	<50	<50	<50	#	#	#	#	#	#
2017	Hormone therapy	<50	<50	1,010	#	#	$178,168	#	#	$176
	Puberty suppression	<50	<50	<50	#	#	#	#	#	#
2018	Hormone therapy	<50	67	1,353	#	$5,132	$255,227	#	$77	$189
	Puberty suppression	<50	<50	<50	#	#	#	#	#	#
2019	Hormone therapy	<50	95	1,779	#	$7,341	$332,652	#	$77	$187
	Puberty suppression	<50	<50	<50	#	#	#	#	#	#
2020	Hormone therapy	<50	142	2,832	#	$19,971	$650,761	#	$141	$230
	Puberty suppression	51	<50	<50	$937,608	#	#	$18,384	#	#
2021	Hormone therapy	56	201	3,450	$10,331	$55,683	$831,033	$184	$277	$241
	Puberty suppression	78	<50	<50	$959,098	#	#	$12,296	#	#
2022	Hormone therapy	56	287	4,588	$10,989	$67,466	$1,102,464	$196	$235	$240
	Puberty suppression	93	75	<50	$1,283,124	$979,875	#	$13,797	$13,065	#
2023*	Hormone therapy	78	372	6,233	$10,966	$70,434	$1,382,339	$141	$189	$222
	Puberty suppression	118	90	<50	$1,633,783	$773,592	#	$13,846	$8,595	#

Data Source: APAC Release 21
Number was suppressed to prevent backward calculation of value < 50.

* 2023 data are preliminary.

^ A person can belong to more than one age group per year. The number of unique persons per age group per year is not equal to the sum of the persons in each age group.

^^ A person can receive more than one type of treatment (such as hormone therapy and puberty suppression) per year, so the treatment categories are not mutually exclusive and the number of unique persons per year is not equal to the sum of persons in each category.