DEPARTMENT OF HEALTH

Gender Affirming Care

PURSUANT TO EXECUTIVE ORDER 23-03

12/22/2023

Pursuant to Executive Order 23-03

A report to the Governor, Lieutenant Governor, and Legislature summarizing the safety, effectiveness, and importance of gender affirming care for people in Minnesota.

Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
www.health.state.mn.us

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Introduction

On March 8, 2023, Governor Tim Walz signed Executive Order 23-03 (https://mn.gov/governor/assets/EO%2023-03%20Signed%20and%20filed_tcm1055-568332.pdf) to protect the rights of Minnesota's LGBTQIA+[a] community to seek and receive gender affirming care. This follows a recent increase in legislation restricting gender affirming care in 19 states across the country, 16 of which enacted bans on gender affirming care in 2023.

Gender affirming care (GAC) is a multidisciplinary process with the end goal of reducing gender dysphoria in transgender and gender diverse (TGD) individuals through a variety of treatments. Gender dysphoria is an official diagnosis in the DSM-5 defined as psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.[1] Most of the treatments have to do with changing secondary sexual characteristics like voice pitch, absence/presence of breast tissue, body hair, and body fat distribution, or delaying these changes from occurring using puberty blockers. Undergoing these treatments help to alleviate gender dysphoria and improve mental well-being by aligning a person's physical characteristics with their gender identity.

Gender affirming treatments are supported by scientific evidence and, when performed with proper clinical oversight, are proven to be safe. The safety, efficacy, and importance of GAC have been recognized by many medical and psychological associations, including the American Medical Association,[2] the American Psychiatric Association,[3] the American Academy of Pediatrics,[4] and the U.S. Department of Health and Human Services.[5]

The aim of this report is to describe the importance of gender affirming care, the current state of scientific evidence about the safety and effectiveness of gender affirming care, as well as its public health impacts. This report does not aim to recommend public policies or regulatory or health services decisions.

Literature Review

This report will use the term "transgender and gender-diverse" (TGD) to refer to the focus demographic. The report will use the word "cisgender" to refer to individuals whose gender identity matches their sex assigned at birth. TGD describes those whose gender identity does not align with their sex assigned at birth. Some TGD people transition from one gender binary to the other (male to female or female to male) while others have identities that fall outside of the socially constructed binary (e.g., agender, genderfluid, nonbinary). TGD individuals may have varying culturally specific understandings of gender and may use terminology to describe themselves that do not fit neatly within these categories. Most TGD people socially transition, but not all medically transition, for many different reasons.

Results from a 2015 national survey of adults found that an estimated 1.4% of adults in Minnesota identified as TGD.[6] In the 2022 Minnesota Student Survey (MSS), about 9% of Minnesota students in grades 8, 9, and 11 who reported their gender identity said that they were either agender, a transgender boy, a transgender girl,

[a] LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual +

genderfluid, gender non-conforming, genderqueer, nonbinary, Two-Spirit, or a gender identity not listed. An additional 2% of students reported that they were questioning or unsure about their gender identity. There was not a difference in prevalence of TGD students by grade or geography (9.0% of students living in the seven-county metropolitan area compared to 8.6% in Greater Minnesota). The percent of students who said they were TGD was highest among American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and multiracial students. Students who were assigned female at birth were more likely than students assigned male at birth to be TGD (12.3% vs. 5.0%) or otherwise report that they were questioning or unsure about their gender identity (2.7% vs 1.0%).[7] These differences in prevalence among youth vs adult, and males vs females may be due to changing levels of visibility and feelings of safety between generations and sub-populations.

Importance of Gender Affirming Care

Gender affirming care is intended to align a person's outward, physical traits with their gender identity, and is associated with improved physical and mental health outcomes.[8,9] This is important because TGD adults and youth experience a wide range of health disparities. For example, one Minnesota study found that compared to cisgender students, TGD students were significantly more likely to report past 30-day cigarette smoking (15.2% vs 5.9%), lifetime suicide attempts (31.0% vs. 7.1%), past year self-harm (54.8% vs 14.4%), and physical bullying victimization (25.1% vs. 12.7%).[10] A study of U.S. adults found that between 2014 and 2017 TGD adults were more likely to report severe mental distress and were less likely to report having health insurance coverage than cisgender respondents.[11]

TGD people are two to six times more likely to be diagnosed with a psychiatric disorder and nine times more likely to attempt suicide over their lifetimes than cisgender people.[6] Anxiety and depression are the most common diagnoses among TGD people, but this health disparity can be found in personality disorders, obsessive-compulsive disorder, and eating disorders, among others. These poor mental health outcomes can be explained by the Minority Stress Model, which suggests that continued experiences of stress resulting from barriers, stigma, and discrimination in a variety of settings (e.g., personal, professional, medical) compound and negatively impact physical and mental health.[12,13]

TGD Minnesotans are also more likely to experience social and economic difficulties than their cisgender counterparts. According to the 2015 U.S. Transgender Survey (USTS), about one-third of TGD Minnesotans were living in poverty, and 11% were unemployed.[6] More than one-quarter (26%) reported that they had been fired, denied a promotion, or not hired during the past year because of their gender identity or expression. Of TGD individuals who were employed, 23% reported experiences of harassment or other kinds of mistreatment based on gender identity. About 30% of TGD individuals reported being mistreated (including verbal harassment, physical attacks, and denial of equal treatment or services) because of being transgender. Almost one in five (18%) TGD individuals reported experiences of housing discrimination during the past year due to being transgender.[6] More recently, the Minnesota-based 2022 Voices of Health survey found that 34% of trans women, 43% of trans men, and 53% of non-binary respondents had ever been homeless in their lifetime.[14] TGD respondents to this survey also reported elevated rates of food insecurity, with 33% of trans women, 31% of trans men, and 48% of non-binary individuals reporting that they had run out of food before getting money to buy more at some point in their life.[14]

The 2022 Voices for Health survey found that TGD Minnesotans are disproportionately without health insurance coverage, with 38% of trans women, 39% of trans men, and 23% of non-binary respondents uninsured.[14]

Further, the USTS found that more than one-fourth (27%) of TGD individuals with insurance coverage reported experiencing a problem with their health insurance related to being transgender, including being denied coverage for routine health care and transition-related care.[6] About 24% of TGD individuals reported deciding not to see a doctor when they needed to in the past year due to fear of being mistreated, and 20% said they did not see a doctor when they needed to because they could not afford it.[6] Another study found that TGD adults were more likely to report cost barriers to care, a disparity which was even more pronounced among Hispanic/Latinx TGD respondents.[15] Even when TGD individuals do access care despite these barriers, it is not uncommon for them to report unfair treatment by providers. For example, between one third and one half of TGD respondents to the 2022 Voices of Health Survey reported that they had been asked unnecessary or invasive questions about their identity by a provider, had providers be physically rough or abusive while treating them, or had to educate a health care provider about LGBTQIA+ people in order to get appropriate care.[14]

Disparities in health outcomes among TGD Minnesotans, especially mental health and substance use outcomes, must be understood in the context of these inequities. Because of their marginalized status, TGD Minnesotans face unique barriers to achieving optimal health that their cisgender counterparts do not. TGD Minnesotans who hold another marginalized identity – for example, TGD Minnesotans who are people of color, disabled, or have limited English proficiency – may face even more severe barriers to health caused by the compounding effects of transphobia and other forms of structural oppression. A health equity approach necessitates careful attention to and attenuation of these barriers to promote an equal opportunity for health and well-being among all Minnesotans.

Gender Affirming Care Services

GAC describes a multi-step and multidisciplinary process with the goal of reducing or eliminating gender dysphoria for TGD people. An approach that centers and affirms the identities, needs, and goals of patients and families, GAC includes a variety of medical and non-medical interventions and varies for each person. Many medical procedures require a diagnosis of gender dysphoria, as determined by the World Professional Association for Transgender Health; this diagnosis can be given by a primary care provider or a specialist. Depending on the scope of the primary care provider's practice and the desired intervention(s) of the TGD individual, subsequent treatment may come from them or from a specialized provider, such as an endocrinologist, plastic surgeon, or an electrologist.

Medical interventions can change either primary or secondary sex characteristics. Primary sex characteristics include reproductive organs such as the penis, ovaries, and uterus. Secondary sex characteristics include features like presence or absence of breast tissue, muscle mass, and facial or body hair; fat distribution; and voice pitch and can also be altered by non-medical interventions such as hair removal or voice training.

Some TGD people undergo surgeries to alter certain primary and secondary sex characteristics. In people assigned female at birth, breast reductions are the most common, followed by hysterectomies and genital reconstruction. In people assigned male at birth, genital reconstructions are the most common, followed by facial feminization, breast augmentation, tracheal shave, and voice surgery. Some secondary sex characteristics can be altered with hormone therapy – testosterone for transmasculine individuals; spironolactone and estrogen for transfeminine individuals; and puberty blockers for questioning youth. Some of these changes are permanent, while others are reversible if hormones are stopped. GAC can also include social support, voice training, particularly for those assigned male at birth people since feminizing hormones have no effect on voice

pitch, removal of facial and body hair through electrolysis, ongoing sexual and reproductive health services, and individual, family, or group therapy with a gender affirming provider.[16]

GAC looks different not only for every patient, but also at every stage of the lifespan. For instance, TGD children who are prepubescent transition socially only, meaning that they do not undergo any medical interventions but do make changes to how they present themselves in their everyday life, like using a different name, pronoun, hairstyle, or style of dress.[42] GAC services appropriate for this age group may include open discussions with the child and their family and connection with support systems as necessary.[43] TGD adolescents, on the other hand, might wish to use puberty blockers (also referred to as GnRH inhibitors or puberty-suppressing medication) to delay the development of unwanted secondary sex characteristics.[17] These medications prevent the onset of pubertal changes that might greatly increase a TGD or questioning child's feelings of distress and dysphoria and would otherwise be irreversible or difficult to reverse later. Puberty blockers give TGD adolescents and their families time to further explore each child's identity, needs, goals, and options for further intervention.[17] Puberty blockers are considered fully reversible, meaning that if a patient stops taking them, pubertal changes will resume.[17] Because the effect of puberty blockers are so easily reversed, whereas the effects of unwanted pubertal changes and related gender dysphoria can be serious and long-lasting, many experts recommend the use of a flexible, gender affirming approach towards TGD or questioning children, rather than a potentially harmful "delayed transition" or "watchful waiting" approach.[17]

Efficacy and Safety

GAC can have a positive effect on the mental health outcomes of TGD people.[18] In adolescents, puberty blocking hormones have been associated with lower odds of lifetime suicidal ideation,[19] and GAC services have been shown to reduce gender dysphoria and improve psychological functioning.[20] A large national survey of TGD individuals found that those who underwent any kind of gender affirming surgery had lower odds of past-month psychological distress, past-year tobacco use, or past-year suicidal ideation than those who did not.[6] A study of 325 TGD adults and adolescents pursuing GAC determined that those who underwent hormonal and/or surgical treatments showed improvements in global psychological functions and decreases in gender dysphoria.[8,21]

In June 2023, the American Medical Association passed a resolution[22] to protect access to evidence-based GAC for TGD youth. This resolution was co-sponsored by eight additional medical societies, including the American College of Physicians and the American College of Obstetricians and Gynecologists. GAC has also been approved by the American Academy of Pediatrics,[4] the American Psychiatric Association,[3] the American Medical Association,[2] and the Health Resources and Services Administration.[23]

The consensus among these professional organizations is that GAC is generally safe when supervised by a medical professional. In one 2021 statement, the American College of Obstetricians and Gynecologists stated, "The majority of medications used for gender transition are common and can be safely prescribed by a wide variety of health care professionals with appropriate training and education, including, but not limited to, obstetrician–gynecologists, family or internal medicine physicians, endocrinologists, advanced practice clinicians, and psychiatrists".[24] Complications are rare if care is overseen by a licensed medical professional. However, there are some risks that come with GAC that must be detailed by providers via an informed consent model before patients can decide about their treatment. For example, hormone therapy, including gender affirming hormone therapy, has been associated with cardiovascular diseases such as venous thromboembolism.[25] The Endocrine Society has developed guidelines on how health care providers can provide

individualized management of gender affirming hormone therapy to reduce the risks based on the individual's comorbidities.[26] However, the potential adverse events such as suicidal ideation of not receiving GAC likely outweigh the potential risks of gender affirming hormone therapy if evidence-based care is implemented.

Barriers to Care

TGD individuals may face barriers to care that cisgender individuals do not, whether due to their gender identity or to the nature of the care they need. TGD adults are less likely to be insured, more likely to report cost-related barriers to access to care, and more likely to have a disability that impacts their access to care than cisgender adults.[6] Even for those who are insured, some insurance plans do not include coverage of GAC or only include certain aspects. Authorization of coverage can be dependent on requirements such as a medical diagnosis of gender dysphoria, referral letters, or undergoing hormone therapy for certain periods of time, which may be difficult to fulfill based on access to gender affirming providers or personal gender expression. This creates gaps in necessary treatments for gender dysphoria. A national study shows that 25% of respondents seeking hormone therapy, and 55% of those seeking gender affirming surgery, were denied coverage. Overall, 25% of respondents had issues with their insurance related to their gender identity, such as refusal to change a name and/or gender or denial of coverage for gender-related services.[6]

In November 2023, a Joint Administrative Bulletin[27] was issued by the Minnesota Departments of Health, Human Rights, Human Services, and Commerce to advise health plan companies "delivering or issuing individual and group health insurance policies in Minnesota that discriminating against an individual because of the individual's gender identity or gender expression is prohibited." The Bulletin details the legal protections for GAC in Minnesota.

Arguments Against Gender Affirming Care

Legislation banning GAC has increased in the past few years, as have the arguments against it. One of these arguments is the existence of detransitioners, people who identified as TGD for some part of their life before returning to identifying with their gender assigned at birth. Opponents to GAC use detransitioners to argue that TGD identities are temporary and require no affirmative treatment. However, a study of 17,151 TGD individuals who received GAC showed that of the 13.1% that detransitioned, only 15.9 % cited at least one internal reason for detransitioning, such as regret or uncertainty regarding their gender identity.[6] Another meta-analysis of 27 different studies of TGD that underwent gender affirming surgery (n = 7,928) found that <1% of respondents expressed clear regret for their surgery.[28]

Another argument against GAC is the hypothesized Rapid-Onset Gender Dysphoria (ROGD), which proposes that a rise in adolescents identifying as TGD is due to "social contagion" rather than legitimate gender identities. Evidence for this hypothesis is suggested to be the disproportionate number of TGD adolescents assigned female at birth. A study of 7,290 adolescents found that the proportion of transgender individuals assigned female at birth increased from 2017 to 2019. However, the authors clarified that change in proportion assigned female at birth was due to a decrease in the number of transgender respondents assigned male at birth rather than an increase in transgender respondents who were assigned female at birth, which contradicts the ROGD hypothesis. The study also asserted that the ROGD hypothesis's assumption that adolescents transition to

garner social capital is unlikely, as TGD adolescents are more likely to be bullied, both online and in person, than their cisgender peers.[29,30]

Strategies to Promote Health and Well-being among Transgender and Gender Diverse Individuals by Improving Access to Gender Affirming Care

TGD individuals in Minnesota experience significant social, mental, and physical health inequities and disparities. Protecting the rights and abilities to access GAC can help reduce gender dysphoria and improve the health and well-being of TGD individuals. Several key strategies can improve access to GAC for all TGD Minnesotans.

Implement an Informed Consent Model for Gender Affirming Care

The World Professional Association for Transgender Health's (WPATH) 8th edition standards of care promote an informed consent model that acknowledges that there are many valid forms of assessment for adults (and, to a lesser extent, adolescents) seeking medical transition, not all of which must involve obtaining one or more letters of referral.[16] These standards of care "seeks to better acknowledge and support patients' right of, and their capability for, personal autonomy in choosing care options without the requirement of external evaluations or therapy by mental health professionals",[31] and is becoming more widespread among providers in the U.S. This framework emphasizes the importance of patients' knowledge of their own experience and autonomy over their health decisions over that of formal diagnosis and pathologizing of TGD identity. The informed consent model conceptualizes GAC as part of ongoing primary care, where a trusted provider with whom the patient has a relationship can discuss transition-related goals and concerns and monitor the GAC as they would any other long-term treatment regimen.[32] The primary care provider would seek consultation from specialists when necessary and refer out if a patient decides they are interested in a surgical procedure.[33] In this model of care, initiation of transition and continuous provision of GAC are not conditioned upon referral from a mental health care provider, but allow patients to seek mental health treatment for gender dysphoria and other concerns, like depression.[31] Some TGD patients have reported increased trust in their mental health provider and enhanced ability to fully explore the benefits of mental health treatment when the role of the provider is not primarily to assess the patient's readiness for GAC.[31,34]

However, while WPATH standards of care guidelines recommend the informed consent model, many insurance plans still put conditions on access to GAC that patients may view as burdensome or stigmatizing. These include requirements that a patient undergo a "real life experience test," obtain a formal clinical diagnosis of gender dysphoria, present a letter of referral from a mental health provider, or receive continuous mental health services for the duration of GAC treatment. Requirements that patients receive GAC services in a specific order may also be burdensome, difficult to navigate, or not relevant to individual patient needs. For example, conditioning coverage of hair removal on hormone therapy might prevent a TGD patient who is experiencing significant dysphoria around facial hair but is postponing hormone therapy for fertility preservation reasons from getting the care that they need. There is not one right path for every TGD person to take through transition. Not every TGD person will want every form of gender affirming care for which they qualify.

Ensure Health Insurance Coverage for Gender Affirming Care

Given that TGD individuals in Minnesota are less likely to have adequate health insurance coverage, improving coverage for GAC is important to reduce disparities among this population. In addition, a 2016 cost-effectiveness analysis conducted by the Massachusetts Group Insurance Commission found that covering medically necessary transition procedures was a cost-effective intervention for reducing the costs of suicidality, depression, and other negative health outcomes, providing positive outcomes for both insurers and plan members.[35]

In December 2022, Minnesota became one of 25 U.S. states to affirm that their Medicaid program covers GAC services. An estimated 5,000 TGD adults in Minnesota were Medicaid recipients in 2022.[36] While this guarantee currently only applies to those TGD Minnesotans who qualify for Medicaid according to eligibility criteria related to income and disability status, this coverage could be expanded to all TGD residents of Minnesota seeking GAC, and families moving to Minnesota for the purpose of receiving GAC. However, because many providers do not accept Medicaid, it is important that more insurance providers include coverage for GAC services. In Colorado, the state applied to the federal Center for Medicare and Medicaid Services to include coverage for GAC in the state's Essential Health Benefit (EHB) Benchmark Plan. The cost to consumers was negligible and the policy requires insurance plans offered in the state's individual and small group markets to offer GAC coverage that is equal to coverage on the Benchmark Plan.[37]

Waiving the requirement for a gender dysphoria diagnosis for insurance coverage is one strategy for reducing barriers to GAC for TGD individuals. Even when an insurance plan includes coverage for GAC services, it is common for plans to deny coverage on an individual basis. These denials of coverage are often due to payers' claims that a particular gender affirming treatment is not medically necessary.[38] Insurance denials for routine preventative care, like prostate exams and cervical screenings, have also been known to occur because coverage for those services is associated with a particular gender marker. There are current programs to assist TGD individuals in navigating these insurance issues, for example the Gender Care Access Project at Rainbow Health offers services like this to TGD Minnesotans as resources allow.[39] Sustainable funding for projects like this could play an important role in ensuring that TGD patients get the care that they need. Further work could be done to reduce these insurance barriers by educating professionals who work with insurance claims and medical billing on the basics of GAC, including the wide scientific consensus that GAC services are medically necessary.[40] Coverage should include not only medications and surgeries but other costs associated with them, like syringes for injections. It is also important to ensure that coverage extends to different options for delivery of care. For example, if a TGD patient finds weekly in-person testosterone injections to be burdensome or prohibitive, but accessing testosterone pills would be significantly more expensive, then they are experiencing a coverage barrier to care.

Training and Network Building Among Health Care Providers

There are not enough knowledgeable health care providers able to provide high-quality GAC services in Minnesota, particularly in certain areas of the state. Many TGD patients report difficulty finding a knowledgeable provider in their area, or long wait times before being able to see the identified provider. Well-prepared primary care providers can be an excellent source of GAC for TGD patients, and providing more providers with training and the tools necessary to provide GAC would make these services more available and accessible to Minnesotans. Training for providers could include how to discuss treatment goals with their

patient, manage what parts of the treatment plan they can, and make appropriate referrals to more knowledgeable providers or specialists for what parts of the treatment plan that they cannot.[41] Referral networks can be developed to help primary care providers and their patients find TGD-positive specialists to which they can refer and community-based resources in their area that might benefit TGD patients. Due to the documented inequities in mental health outcomes that TGD face, it is especially important for providers to be knowledgeable about safe and affirming mental health services and resources for survivors of interpersonal violence. Providing these trainings for providers at Federally Qualified Health Centers, which offer sliding scale costs, might be critical for TGD patients dealing with economic disadvantage.

In addition to training providers on the basic health needs specific to TGD patients, it is critical that all providers and health care facility staff are adequately trained to conduct their everyday interactions with TGD patients in a respectful, non-judgmental, and affirming manner. This includes, at a minimum, using the correct names and pronouns for patients, not using stigmatizing or outdated language to describe the patient's experience, and not asking unnecessary or intrusive questions about the patient's body that one would not ask a cisgender patient.[38] Positive and respectful treatment of TGD patients can help prevent TGD patients from experiencing unintentional harms or prevent them from seeking needed care in the future due to fear of mistreatment by health care personnel.

Medical Association's Guidelines

WPATH Standards of Care:[16]: WPATH Standards of Care for the Health of Transgender and Gender Diverse People (Version 8) (https://www.wpath.org/publications/soc)

Endocrine Society:[26] Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (https://academic.oup.com/jcem/article/102/11/3869/4157558)

Center for Excellence in Transgender Health:[32] Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People | Gender Affirming Health Program (https://transcare.ucsf.edu/guidelines)

American College of Obstetricians and Gynecologists:[24] Health Care for Transgender and Gender Diverse Individuals | ACOG (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals)

Other States' Approaches

Enacted Policies

Colorado was the first state in the country to explicitly include gender affirming care services in its benchmark health insurance plan for essential health benefits: Colorado Gender-Affirming Care Coverage Guide (https://doi.colorado.gov/for-consumers/consumer-resources/special-insurance-topics/lgbtq-health-care-rights/gender-affirming)

Illinois explicitly protects access to reproductive and gender affirming care services (and their providers) in the Patient and Provider Protection Act of 2023 and amends the Illinois Insurance Code to require coverage for hormonal therapy: ACLU Illinois Patient and Provider Protection Act (https://www.aclu-il.org/en/legislation/hb-4664-patient-and-provider-protection-act)

Maryland added GAC coverage to the Maryland Medical Assistance Program, requiring treatment be provided in a nondiscriminatory manner: Maryland General Assembly (https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0283?ys=2023RS)

Massachusetts made GAC a legally and constitutionally protected right for Massachusetts residents and those who travel to the state for care: Massachusetts Act Expanding Protections for Reproductive and Gender-Affirming Care (https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter127)

New Mexico prohibits public entities from denying or discriminating against New Mexico residents seeking gender affirming care: Office of Governor Michelle Lujan Grisham, Governor signs House Bill 7, Reproductive and Gender-Affirming Health Care Act (https://www.governor.state.nm.us/2023/03/16/governor-signs-house-bill-7-reproductive-and-gender-affirming-health-care-act/)

Glossary

Agender: “Without gender”; individuals identifying as having no gender identity.

Cisgender: An individual whose gender identity aligns with their sex assigned at birth.

Gender dysphoria: An official diagnosis in the DSM-5 defined as psychological distress that results from an incongruence between one’s sex assigned at birth and one’s gender identity; not all TGD people experience gender dysphoria.

Gender expression/presentation: The outward manner in which individuals express or display their gender. This may include choices in clothing and hairstyle or speech and mannerisms. Gender identity and gender expression may differ; for example, a woman (transgender or cisgender) may have an androgynous appearance, or a man (transgender or cisgender) may have a feminine form of self-expression.

Genderfluid: Having different gender identities at different times.

Gender identity: A person's internal sense of self and how they fit into the world, from the perspective of gender.

Gender non-conforming: A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person.

Genderqueer: Blurring the lines around gender identity and sexual orientation. Genderqueer individuals typically embrace a fluidity of gender identity and sometimes sexual orientation.

Intersex: A condition in which an individual’s sexual characteristics do not fall into binary classifications of male and female.

Non-Binary: Transgender or gender-nonconforming person who identifies as neither exclusively male nor exclusively female. This term can be used both as a specific gender identity or an umbrella term that includes agender, genderfluid, and any other identity outside the male or female binary.

Primary sex characteristics: Characteristics that are present at birth and are necessary for reproduction, i.e. internal and external genitalia.

Secondary sex characteristics: Characteristics that develop throughout puberty and are not necessary for reproduction, e.g. body hair, fat distribution, voice pitch.

Transfeminine: An individual, typically AMAB, who transitions socially and/or medically to a feminine gender identity/expression; includes but is not limited to transgender women.

Transgender: A person whose gender identity differs from the sex that was assigned at birth. May be abbreviated to trans. A transgender man is someone with a male gender identity and a female birth assigned sex; a transgender woman is someone with a female gender identity and a male birth assigned sex.

Transmasculine: An individual, typically AFAB, who transitions socially and/or medically to a masculine gender identity/expression; includes but is not limited to transgender men.

Two-Spirit/2Spirit/2S: An umbrella term coined in the 1990s that refers to an array of traditional gender identities specific to Indigenous cultures, which do not fit into the male or female binary. Traditionally, American Indian and Alaska Native Two-Spirit people were individuals who combined activities of both men and women with traits, activities, and roles unique to their status as Two-Spirit people. In most tribes, they were considered neither men nor women; they occupied a distinct, alternative gender status. In modern times, Indigenous people from various communities across the Americas, with many unique gender-variant identities, describe themselves as Two-Spirit. Many but not all Two-Spirit people might also use terms like transgender and nonbinary to describe themselves.

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