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February 17, 2026

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2451
Baltimore, MD 21244-8016

Submitted electronically

Re: RIN 0938-AV73; CMS-2451-P
Medicaid Program; Prohibition on Federal Medicaid Funding for Sex Trait Modification Procedures Furnished to Children and Youth

The National Women's Law Center (NWLC) comments to express our strong opposition to the U.S. Department of Health and Human Services' (HHS) proposed rule targeting health care for transgender youth.[1] Since 1972, NWLC has fought for gender justice in the courts, in public policy, and in our society, spanning across core areas of people's lives—including health and reproductive rights, income security, employment, and education—with an emphasis on those who face multiple and compounding forms of discrimination. Dignity and equity for transgender people form an inextricable part of that mission, including our efforts to strengthen health equity, access to care, and coverage. Throughout those efforts, we have seen the profound impact that access to care has on transgender people's opportunity to thrive and the critical importance of laws and policies protecting this care.

HHS' Centers for Medicare and Medicaid (CMS), however, is now seeking to discard and undermine these laws and policies and replace them with a regulation threatening the health of transgender young people and their access to care. The proposed regulation would bar the use of federal funding for Medicaid and Children's Health Insurance Program (CHIP) coverage of essential care for transgender youth. This proposal is dangerous, unmoored from medical evidence, and contrary to legal requirements. It suffers from numerous substantive deficiencies that we outline throughout this comment, including its failure to account for the impacts of the rule on Medicaid and CHIP enrollees and their families; its apparent reliance on pretextual rationales for an animus-based restriction; its misrepresentation of the scientific and clinical research supporting

[1] 90 Fed. Reg. 59441 (proposed Dec. 19, 2025) (to be codified at 42 C.F.R. pts. 441 and 457) (hereinafter "Proposed Rule").

access to care; and its conflict with legal requirements applying to Medicaid and CHIP. Given these incurable deficiencies, HHS must withdraw the proposed rule in its entirety.

I. Health care for transgender youth is safe, evidence-based, and essential.

Health care for transgender youth, often referred to as transition-related health care (TRH), is best practice care that is medically necessary for many young people. A robust body of research demonstrates the safety, effectiveness, and benefits of this care. The TRH standards of care, which provide for individualized and age-appropriate care, have garnered widespread endorsement from the medical and scientific community, both in the United States and around the world. Major medical associations have repeatedly affirmed their support for these evidence-based standards of care and their opposition to political interference with its provision. Among many others, these include the American Academy of Child and Adolescent Psychiatry,[2] American Academy of Family Physicians,[3] American Academy of Nursing,[4] American Academy of Pediatrics,[5] American Medical Association,[6] American Psychological Association,[7] Endocrine Society[8] and Pediatric Endocrine Society.[9]

Extensive evidence shows that when transgender young people can access the care they need, their health, wellbeing, and quality of life improves significantly. In one of the most comprehensive reviews of the literature to date, researchers commissioned by the Utah state legislature assessed data from more than 28,000 youth with gender dysphoria (GD). Their conclusion was unambiguous. The researchers explained that "after having spent many months searching for, reading, and evaluating the available literature, it was impossible for [them] to avoid drawing some high-level conclusions. Namely, **the consensus of the evidence supports that the treatments**

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[2] American Academy of Child & Adolescent Psychiatry, *AACAP Statement Responding to Efforts to Ban Evidence-Based Care for Transgender and Gender Diverse Youth* (Nov. 8, 2019), https://www.aacap.org/AACAP/Latest_News/AACAP_Statement_Responding_to_Efforts-to_ban_Evidence-Based_Care_for_Transgender_and_Gender_Diverse.aspx.

[3] Press Release, American Academy of Family Physicians et al., Frontline Physicians Oppose Legislation that Interferes in or Penalizes Patient Care (Apr. 2, 2021), https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/equality/ST-G6-FrontlinePhysiciansOpposeLegislationThatInterferesInOrPenalizesPatientCare-040221.pdf.

[4] Carol A. Sedlak & Carol J. Boyd, *Health Care Services for Transgender Individuals: Position Statement*, 64 NURSING OUTLOOK 510 (Aug. 1, 2016), https://doi.org/10.1016/j.outlook.2016.07.002.

[5] *See, e.g.,* Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS e20182162 (Oct. 1, 2018), https://doi.org/10.1542/peds.2018-2162.

[6] *See, e.g.,* American Medical Association, Policy H-185.927, Clarification of Evidence-Based Gender-Affirming Care (adopted and reaffirmed 2024), https://policysearch.ama-assn.org/policyfinder/detail/%22Clarification%20of%20Evidence-Based%20Gender-Affirming%20Care%22?uri=%2FAMADoc%2FHOD-185.927.xml; American Medical Association, *Health Insurance Coverage for Gender-Affirming Care of Transgender Patients* (2019), https://www.ama-assn.org/system/files/transgender-coverage-issue-brief.pdf.

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

[8] Endocrine Society & Pediatric Endocrine Society, *Transgender Health: Position Statement* (Dec. 2020), https://www.endocrine.org/-/media/endocrine/files/advocacy/position-statement/position_statement_transgender_health_pes.pdf.

[9] *Id*.

are effective in terms of mental health, psychological outcomes, and the induction of body changes consistent with the affirmed gender in pediatric GD patients."[10]

Examples of recent studies further illustrate the effectiveness and benefits of TRH:

- **TRH is associated with significant improvements in mental health outcomes among youth:** In a study that included nearly 12,000 transgender youth, those who were able to access hormone therapy were substantially less likely to experience depression and suicidality compared to youth who wanted but did not receive hormone therapy.[11] Another study similarly found that access to puberty-pausing medications and hormone therapy was associated with 60% lower odds of moderate or severe depression and 73% lower odds of suicidality in a 12-month follow-up.[12] Similarly, a retrospective study of 3,500 transgender youth found a reduction of over 40% in hospital admissions or emergency department visits for suicidality among those who received hormone therapy, compared to those who had not.[13]
- **Access to TRH can improve young people's overall wellness:** Transgender youth assessed two years after initiating hormone therapy experienced higher levels of life satisfaction and positive affect (experiences such as joy, gratitude, and contentment), as well as lower levels of depression and anxiety.[14] Young people accessing puberty-pausing medication and hormone therapy also expressed high rates of satisfaction with TRH 3–5 years after beginning care, with many participants reporting that their only regret was not beginning treatment earlier.[15]
- **Access to TRH in adolescence can impact transgender people's wellbeing throughout their lives:** In a study that compared transgender adults who began hormone therapy as youth with those who first accessed the care at 18 or older, the former had better mental health outcomes in the period immediately prior to taking the survey.[16]

Like its effectiveness and benefits, the safety of TRH for youth is well established. The medications prescribed as part of TRH have been safely used for decades to treat conditions such as precocious puberty,[17] and research has further demonstrated their safety when used to treat

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[10] Joanne LaFleur, *Gender-Affirming Medical Treatments for Pediatric Patients with Gender Dysphoria* 90 (Aug. 6, 2024), https://le.utah.gov/AgencyRP/downloadFile.jsp?submissionId=287 (emphasis in original).
[11] Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 JOURNAL OF ADOLESCENT HEALTH 643 (Apr. 2022), https://doi.org/10.1016/j.jadohealth.2021.10.036.
[12] Diana M. Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youth Receiving Gender-Affirming Care*, 5 JAMA NETWORK OPEN e220978 (Feb. 2022), http://doi.org/10.1001/jamanetworkopen.2022.0978.
[13] Marissa Nunes-Moreno, *Mental Health Diagnosis and Suicidality Among Transgender Youth in Hospital Settings*, 12 LGBT HEALTH 20 (Jul. 17, 2024), https://doi.org/10.1089/lgbt.2023.0394.
[14] Diane Chen et al., *Psychosocial Functioning in Transgender Youth After 2 Years of Hormones*, 388 NEW ENGLAND JOURNAL OF MEDICINE 240 (Jan. 2023), http://doi.org/10.1056/NEJMoa2206297.
[15] Kirstina R. Olson et al., *Levels of Satisfaction and Regret with Gender-Affirming Medical Care in Adolescence*, 178 JAMA PEDIATRICS 1354 (Oct. 21, 2024), http://doi.org/10.1001/jamapediatrics.2024.4527.
[16] Jack L. Turban et al., *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, 17 PLOS ONE e0261039 (Jan. 12, 2022), https://doi.org/10.1371/journal.pone.0261039.
[17] *See, e.g.,* Erika L Zevin & Erica A. Eugster, *Central Precocious Puberty: A Review of Diagnosis, Treatment, and Outcomes*, 7 LANCET 886 (Dec. 2023), https://doi.org/10.1016/S2352-4642(23)00237-7.

gender dysphoria. The study commissioned by the Utah state legislature reached the following conclusion:

> **The evidence also supports that treatments are safe in terms of changes to bone density, cardiovascular risk factors, metabolic changes, and cancer.** With regards to these safety outcomes, reviewed studies show that any patient-level changes are minimal, and that despite any small improvements or decrements in individual disease risk factors, the average patient's values remain within the bounds of normal, non-pathological ranges for human population.[18]

This body of evidence leads to a clear conclusion: TRH for youth is safe, effective, and even lifesaving. It demonstrates the need to preserve and strengthen young people's access to this medically necessary care and the dangers of policies that restrict such access.

II. CMS fails to account for the harm that would result from its proposed rule.

Disregarding the evidence supporting TRH, CMS seeks to undermine access to this care by denying federal funding for its coverage under Medicaid and CHIP. This coverage restriction would threaten the wellbeing of transgender youth enrolled in these programs, estimated to include 270,000 young people,[19] as well as harming their families and providers, intersex people, and the transgender community broadly.

CMS offers only a cursory recognition of the harm its rule would cause. It dismisses some of the proposed rule's most dangerous consequences as negligible or refuses to acknowledge them entirely. CMS' failure to address the harm of its proposed rule, as well as its attempts to minimize or explain away that harm, strongly suggest it has disregarded crucially important evidence that it is obligated to consider.

a. TRH coverage restrictions would hinder or prevent Medicaid and CHIP enrollees' access to necessary care.

The denial of federal funding for TRH coverage under Medicaid and CHIP would leave enrollees and their families with an untenable decision: Unless they are able to secure coverage from other sources—an option that, as explained in section II(c) of this comment, is largely illusory—they are forced to either forgo medically necessary care or pay for it themselves. For most, paying out-of-pocket is far from a realistic option. Medicaid and CHIP are, at their core, anti-poverty programs that primarily serve families with low incomes, including many who are experiencing poverty. As with many forms of ongoing care, the costs of TRH are often prohibitive for an individual patient and their family, and even more for those with low incomes. For most Medicaid and CHIP enrollees, therefore, the proposed rule would severely restrict their access to TRH. In some cases, it would make access virtually impossible. As demonstrated in Section I, the ramifications for those who are unable to access care or whose ongoing treatments are disrupted could be severe, including negative health outcomes such as higher rates of depression, anxiety, and suicidality.

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[18] LaFleur, *supra* note 10 at 90 (emphasis in original).

[19] Lindsey Dawnson & Scott Hulver, *New Trump Administration Proposals Would Further Limit Gender Affirming Care for Young People by Restricting Providers and Reducing Coverage* (Dec. 22, 2025), https://www.kff.org/lgbtq/new-trump-administration-proposals-would-further-limit-gender-affirming-care-for-young-people-by-restricting-providers-and-reducing-coverage.

The consequences of this rule would fall heaviest on the young people most likely to be enrolled in Medicaid or CHIP. These young people include those from low-income families, with Medicaid and CHIP covering approximately 8 in 10 youth living in poverty.[20] As youth of color are more likely to experience poverty, they also make up a disproportionate share of Medicaid and CHIP enrollees. In fact, two thirds (67%) of children enrolled in Medicaid and CHIP are Black, Latine, Asian American, Indigenous, or multiracial.[21] Data on enrollment rates within racial and ethnic communities helps underscore the importance of these programs for many youth of color: Public insurance programs like Medicaid and CHIP cover the majority of Black (62%), Indigenous (61%), Latine (55%), and Native Hawaiian or Pacific Islander (53%) youth age 18 and younger, while covering 29% of white youth.[22] Medicaid and CHIP also cover an outsized share of young people with disabilities, both because they are more likely to experience poverty and because they may qualify for disability-specific eligibility pathways.[23] These programs also cover a higher rate of children living in rural areas.[24] For these enrollee communities, the proposed rule would impose twofold harms: by disproportionately targeting their care and worsening the barriers to TRH that they are already more likely to experience than their peers.

The proposed rule would exacerbate the cost burdens that transgender youth and their families experience when seeking care. Unaffordability is among the most significant barriers to TRH for transgender youth,[25] especially those who are disproportionately represented among Medicaid and CHIP enrollees.[26] A primary factor contributing to this barrier is inadequate coverage of TRH due to restrictions or exclusions in insurance plans and programs.[27] Such restrictions are especially prevalent in Medicaid programs. For example, when comparing different insurance types, a 2022 study with 92,329 transgender respondents found that Medicaid enrollees had the highest likelihood of being denied coverage for hormone therapy.[28] These coverage limitations are often policy-driven: They commonly stem from state laws and regulations targeting TRH, such as

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[20] KFF, *Health Insurance Coverage of Children 0-18 Living in Poverty (Under 100% FPL): 2024* (last accessed Feb. 7, 2026), https://www.kff.org/state-health-policy-data/state-indicator/health-insurance-coverage-children-under-100-fpl.

[21] Medicaid and CHIP Payment and Access Commission, *Access for Special Populations Enrolled in Medicaid and CHIP* (Feb. 13, 2024), https://www.macpac.gov/subtopic/access-for-special-populations-enrolled-in-medicaid-and-chip.

[22] Akash Pillai, *Medicaid Efforts to Address Racial Health Disparities* (Jul. 1, 2024), https://www.kff.org/medicaid/medicaid-efforts-to-address-racial-health-disparities.

[23] *See* Elizabeth Williams, *5 Key Facts About Children with Special Health Care Needs and Medicaid* (Apr. 18, 2025), https://www.kff.org/medicaid/5-key-facts-about-children-with-special-health-care-needs-and-medicaid.

[24] Joan Alker et al., *Medicaid's Role in Small Towns and Rural Areas* (Jan. 15, 2025), https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas.

[25] *See* Ellesse-Roselee L. Akré et al., *Structural Barriers to Accessing Gender-Affirming Care for Transgender and Gender Diverse (TGD) Individuals in the United States*, INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH 1, https://doi.org/10.1080/26895269.2024.2431826. *See also* Kedryn Berrian et al., *Barriers to Quality Healthcare Among Transgender and Gender Nonconforming Adults,* 60 HEALTH SERVICES RESEARCH e14362 (Jul. 10, 2024), https://doi.org/10.1111/1475-6773.14362.

[26] *See* Ankit Rastogi et al., *Health and Wellbeing: A Report of the 2022 U.S. Transgender Survey* 28 (Jun. 2025), https://transequality.org/sites/default/files/2025-06/USTS_2022Health%26WellbeingReport_WEB.pdf (finding that multiracial, Indigenous, and Latine respondents were more likely to avoid care due to cost).

[27] *See* Akré et al., *supra* note 25; Berrian et al., *supra* note 25; Jamie L. Feldman et al., *Health and Health Care Access in the US Transgender Population Health (TransPop) Survey*, 9 ANDROLOGY 1707 (May 25, 2021), https://doi.org/10.1111/andr.13052.

[28] Rastogi et al., *supra* note 26 at 34.

Medicaid coverage exclusions.[29] CMS now proposes a policy that, for many families, would amount to a blanket exclusion of TRH from Medicaid and CHIP coverage, extending the harm of existing restrictions to a national level.

By making TRH unaffordable for more transgender youth and their families, the proposed rule would have cascading impacts throughout their lives. Families who are unable to bear the costs might need to delay this often time-sensitive care or forgo it entirely. Families that do pay out-of-pocket may exhaust financial resources that are already limited for most Medicaid and CHIP enrollees, compromising their ability to pay for other necessities. Other families may incur significant debt, which itself has wide-ranging consequences: In one study, 63% of people with health care debt had to cut back spending on food, clothing, or basic household items; 35% reported that the debt hurt their credit score, sometimes at a cost to their housing stability; and 79% skipped or delayed care or medications due to cost.[30]

b. The proposed rule would likely reduce access to TRH providers.

Although the proposed rule is specific to coverage, it could severely limit the range of providers Medicaid and CHIP enrollees can access, as well as potentially reducing the availability of TRH providers overall. Many transgender youth already struggle to access TRH providers. Many have few or no options for care in their immediate area, particularly in states with laws criminalizing or otherwise targeting TRH providers.[31] This problem has rapidly spread across the country, as hostile federal actions over the past year—including baseless investigations, threats of criminal penalties, denial of funding, and harassment—have deterred or prevented providers from maintaining TRH care for youth.[32] Thus, even prior to the potential implementation of this rule, TRH providers are limited in supply. Many transgender people can only access care if they travel long distances, sometimes out of state, a particularly challenging requirement when TRH entails frequent, ongoing medical visits.[33] For some, the cost and logistical barriers of travel are prohibitive, turning the geographic isolation into an effective bar to care.[34] These barriers can be especially prohibitive for youth more likely to be enrolled in Medicaid: For example, disabled youth and those from low-income families may face pronounced cost burdens and other barriers to travel. And since

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[29] *See* Movement Advancement Project, *Medicaid Coverage of Transgender-Related Health Care* (last accessed Feb. 7, 2026), https://www.lgbtmap.org/equality-maps/medicaid.

[30] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/health-costs/kff-health-care-debt-survey/#c7f7c77b-dec4-4baf-bed1-78e3522b4f46--the-consequences-of-health-care-debt.

[31] Tara Weixel & Beth Wildman, *Geographic Distribution of Clinical Care for Transgender and Gender-Diverse Youth*, 150 PEDIATRICS e2022057054 (Nov. 2022), https://doi.org/10.1542/peds.2022-057054.

[32] Theresa Gaffney, *Amid Federal Pressure, More Hospitals Stop Gender-Affirming Care for Minors*, STAT NEWS (Feb. 5, 2026), https://www.statnews.com/2026/02/05/hospitals-stop-gender-care-minors-trump-administration-pressure. Among other examples, Children's Hospital Los Angeles cited the "increasingly severe impacts of federal administrative actions and proposed policies" when announcing it had "no viable alternative" to ending their provision of TRH care for youth. Sonja Sharp, *Children's Hospital Los Angeles Halts Transgender Care Under Pressure from Trump*, LA TIMES (Jun. 12, 2025), https://www.latimes.com/california/story/2025-06-12/childrens-hospital-of-los-angeles-transgender-care. Children's National Hospital similarly pointed to "escalating legal and regulatory risks to Children's National, our providers, and the families we serve." Andrea Swalec, *Children's National Hospital to Stop Prescribing Gender-Affimring Medication*, NBC WASHINGTON (Jul. 21, 2025), https://www.nbcwashington.com/news/local/childrens-national-hospital-to-stop-prescribing-gender-affirming-medication/3961133.

[33] Akré et al., *supra* note 25.

[34] *Id*.

Medicaid coverage is typically limited to in-state services with only few exceptions, their options are even more confined, especially if they live in a state where the TRH for youth is banned or subject to a Medicaid exclusion. The decreasing availability of TRH providers has had a domino effect on access to care for all transgender people, as the remaining providers have become overwhelmed with more patients than they have capacity to accept.[35]

This rule would worsen this barrier even further for Medicaid and CHIP enrollees. If CMS restricts federal funding for TRH coverage, enrollees and their families who do not have alternative funding sources will be far less likely to find a provider. CMS claims that the rule would not impact health professionals' ability to provide this care to Medicaid and CHIP enrollees,[36] but that assertion disregards the obvious downstream effect of restricting funding: Providers are unlikely to accept Medicaid and CHIP patients if they cannot be reimbursed or if they experience significant uncertainty regarding payment. CMS has itself acknowledged this probable outcome elsewhere, but instead of treating it as a harmful consequence of the proposed rule, CMS has wielded it as a justification. Administrator Mehmet Oz, for example, has argued that denying reimbursement for TRH providers exposes what he claims are their true motive of profit rather than patient welfare. He argued that if providers were genuinely "so die-hard desirous of helping children," it should not matter to them if they are not paid for their services.[37] This claim strains credulity. It is self-evident that for the vast majority of providers, compensation is necessary for maintaining their operations, and it is plainly foreseeable that without reimbursement, most providers would not have a viable option for treating Medicaid and CHIP enrollees. In turn, enrollees would have far fewer available providers, and in some cases, none at all.

Loss of Medicaid and CHIP reimbursement can also affect providers' ability to offer TRH more broadly, potentially making it harder for patients with other forms of insurance to access care. CMS claims that providers who lose Medicaid and CHIP compensation can offset that loss by relying more heavily on patients with other forms of insurance.[38] Pediatric providers, however, rely heavily on Medicaid funding. Medicaid is the primary payer for nearly half (48%) of all pediatric hospital discharges, a proportion especially high in rural areas (54%) and predominantly low-income areas (67.5%).[39] Outpatient pediatric providers also heavily depend on Medicaid reimbursement, with Medicaid being the primary expected source of payment for 39% of pediatric office-based physicians' visits.[40] This data strongly suggests that pediatric TRH providers would face significant financial fallouts if they are denied Medicaid funding, potentially making it harder for them to maintain their services. In that case, the Medicaid and CHIP funding restriction could make it harder for transgender youth to find available providers regardless of their source of

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[35] *See, e.g.,* Abbie E. Goldberg & Elana Redfield, *The Experiences of Gender-Affirming Care Providers in States Without Law Restricting Access to Care* (Apr. 2025), https://williamsinstitute.law.ucla.edu/publications/experiences-gac-providers (finding that state restrictions have led to an influx of patients and related pressures for TRH providers in other states).

[36] Proposed Rule, 90 Fed. Reg. at 59449.

[37] Department of Health and Human Services, *Protecting Children*, at 17:00 (YouTube, Dec. 18, 2025), https://www.youtube.com/live/aY1XfN6Tt0Q?si=S9rRPs4tKv28IACL&t=3993.

[38] Proposed Rule, 90 Fed. Reg. at 59449.

[39] Jay G. Berry et al., *US Pediatric Hospitalizations Among Children Enrolled in Medicaid*, 180 JAMA PEDIATRICS 101 (Nov. 17, 2025), http://doi.org/10.1001/jamapediatrics.2025.4537.

[40] In contrast, Medicaid was the primary expected source of payment for less than 12% of adults aged 18-64 and 2% of adults aged 65 and older. Jill J. Ashman et al., *Characteristics of Office-Based Physician Visits by Age, 2019*, 184 NATIONAL HEALTH STATISTICS REPORTS 1, 3 (Apr. 19, 2023), https://stacks.cdc.gov/view/cdc/125462.

insurance, especially youth who live in low-income or rural areas where providers may draw a larger portion of funding from Medicaid.

c. Potential alternative sources of funding would not mitigate these harms.

CMS tries to minimize the impacts of its proposed rule by claiming that families seeking to maintain access to care can simply "look to obtain other health insurance or privately pay for these services."[41] However, this alternative is not feasible for the vast majority of enrollees and their families.

As explained above, paying out-of-pocket for TRH is impossible for many families, particularly those with low incomes. Meanwhile, the option of using other sources of coverage, such as private insurance or TRICARE, is only available to a small minority of youth enrolled in Medicaid.[42] Dual coverage is most commonly among children enrolled through non-income-based eligibility pathways, typically children with complex health needs or disabilities. But even among this population, Medicaid is the only source of coverage for the vast majority of enrollees.[43]

Moreover, those who are dually covered may not be able to rely on their primary insurer for TRH coverage, particularly as the federal government's attempts to undermine coverage of TRH in private insurance or programs like TRICARE continue to escalate. For example, the federal government has recently sought to restrict TRH coverage for dependents under TRICARE using a range of levers: The National Defense Authorization Act for Fiscal Year 2025 prohibited coverage of many forms of TRH[44]; President Trump signed an executive order during his first week in office demanding the exclusion of TRH from TRICARE coverage for youth[45]; the Department of Defense (DOD) issued a memorandum banning TRH coverage for individuals under the age of 19[46]; and DOD promulgated a rule excluding hormone therapy and puberty-pausing medications from coverage.[47] The federal government has also attempted to weaken private insurance coverage of TRH for people of all ages, including through the executive order on TRH[48]; a rule prohibiting issuers subject to Essential Health Benefits (EHB) requirements from providing coverage for TRH as an EHB[49]; and a letter to Federal Employee Health Benefits carriers requiring them to exclude TRH from coverage for employees and dependents.[50] These actions have compromised coverage even while they are subject to ongoing litigation, and the federal government has continued to pursue additional policies targeting TRH coverage. As a result, even Medicaid and CHIP enrollees who do have alternative insurance may not be able to depend on it to get the care they need.

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[41] Proposed Rule, 90 Fed. Reg. at 59449.
[42] *See* Williams, *supra* note 23.
[43] *Id*.
[44] *Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025*, Pub. L. No. 118-159, § 708, 138 Stat. 1773 (Dec. 23, 2024).
[45] Exec. Order No. 14187, § 6, 90 Fed. Reg. 8771, 8771–73 (Feb. 3, 2025).
[46] *See Doe v. Department of Defense*, No. 8:25-cv-02947, Complaint at 13 (D. Md. Sept. 8, 2025).
[47] TRICARE; Notice of TRICARE Plan Program Changes for Calendar Year (CY) 2026), 90 Fed. Reg. 48728, 48729 (Oct. 28, 2025).
[48] Exec. Order No. 14187, § 7.
[49] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27074, 27152 (Jun. 25, 2025).
[50] Office of Personnel Management, FEHB Program Carrier Letter 2025-01b; Chemical and Surgical Sex-Trait Modification Services for Plan Year 2026 Proposals (Aug. 15, 2025), https://www.opm.gov/healthcare-insurance/carriers/fehb/2025/2025-01b.pdf.

Nor can enrollees rely on the possibility that states will use their own funding to cover this care, an alternative that CMS repeatedly cites in order to dismiss the harm of its rule. Some states may opt not to use sequestered funds to cover this care; others may offer only inadequate coverage that does not make up for the loss of federal funding. States also have reason to be concerned that they may face groundless investigations and threats to their federal funding if their Medicaid programs cover TRH for youth, particularly since HHS has signaled its willingness to target states for such policies on multiple occasions. For example, in a April 2025 to state Medicaid directors, CMS indicated that it views coverage of TRH as a potential violation of a range of federal laws.[51] The proposed rule itself goes out of its way to suggest that TRH coverage runs afoul of the statutory requirements states must follow when administrating Medicaid and CHIP.[52] This claim is entirely unfounded, but states may nevertheless feel pressured to comply with CMS' implicit demand. States have also taken notice of the Trump administration's aggressive investigations into other state programs, often based on baseless claims and misconstructions of the law.[53] Agencies under the current administration have repeatedly taken the previously-rare step of withdrawing significant federal funds from a range of state programs, sometimes without prior investigation, forcing states into costly litigation.[54] In the face of these threats, states may be reluctant to cover TRH even when they recognize its medical necessity, depriving enrollees of coverage entirely.

d. The proposed rule's promotion of prejudice and disinformation harms transgender people broadly.

The harm of this proposed rule goes beyond its immediate impact on coverage and access to care: The prejudice and disinformation it relies on threatens the health and safety of transgender people, regardless of whether it would directly affect their access to TRH. The proposed rule wields the power of the federal government to further an aggressive, concerted effort to target the rights and dignity of transgender people. It stigmatizes transgender youth, dismisses the legitimacy of their experiences and needs, spreads myths about their care, and erodes public trust in the providers and families who support them.

These tactics are dangerous in and of themselves. Research on the impact of other anti-transgender and anti-LGBTQ+ policies and rhetoric illustrates numerous potential consequences:

- **Impacts on wellbeing and mental health:** A study of LGBTQ+ youth overall found that the overwhelming majority (90%) said their wellbeing was negatively impacted due to recent politics,[55] an experience also reported by 88% of transgender adults in second

[51] Centers for Medicare & Medicaid Services, Letter to State Medicaid Directors: Puberty blockers, cross-sex hormones, and surgery related to gender dysphoria (Apr. 11, 2025), https://www.cms.gov/files/document/letter-stm.pdf.

[52] Proposed Rule, 90 Fed. Reg. at 59450.

[53] *See, e.g., California v. Department of Education et al.*, 26-cv-01259-WHO (N.D. Cal. Feb. 11, 2026); Laura Meckler & Lauren Lumpkin, *Trump Administration Opens 18 New Probes Over Trans Athletes*, WASHINGTON POST (Jan. 14, 2026), https://www.washingtonpost.com/education/2026/01/14/trump-administration-trans-athletes-investigations.

[54] *See, e.g.,* Chris Cameron, *Federal Judge Blocks Trump Plan to Cut $600 Million in Health Funds*, N.Y. TIMES (Feb, 12, 2026), https://www.nytimes.com/2026/02/12/us/politics/trump-health-funding-cuts-ruling.html; Nick Gwyn, *Trump Administration's Five-State Funding Freeze Is Unlawful, Harmful, and a Major Threat to People in Every State* (Jan. 23, 2026), https://www.cbpp.org/research/federal-budget/trump-administrations-five-state-funding-freeze-is-unlawful-harmful-and-a.

[55] Ronita Nath et al., *2024 U.S. National Survey on the Mental Health of LGBTQ+ Young People* 11 (2024), https://www.thetrevorproject.org/survey-2024/assets/static/TTP_2024_National_Survey.pdf.

study.[56] The spread of anti-transgender policies has also been repeatedly linked to higher rates of depression, anxiety, and suicidality among transgender people.[57] The mental health impacts of policies like state TRH bans have also reached families[58] and providers,[59] who have reported higher levels of anxiety, fear, stress, and burnout.

- **Harassment and violence:** Government officials and politicians who spread anti-transgender disinformation often implicitly legitimize and even encourage interpersonal abuse. As the political attacks on transgender people have escalated, so have threats, harassment, and violence against them and their providers. Transgender youth reported high rates of such experiences within the year prior to a survey: As a result of anti-LGBTQ+ policies and debates, 45% experienced cyberbullying and online harassment, 24% faced bullying at school, and one in ten experienced physical assault.[60] Analyses of Federal Bureau of Investigations also revealed a sharp rise in crimes targeting LGBTQ+ youth in K–12, correlating with the proliferation and distribution of anti-LGBTQ+ laws.[61] TRH providers have also faced a dramatic rise in violent threats and harassment, jeopardizing their personal safety and their medical practice.[62]

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[56] Movement Advancement Project, *New Study Reveals Dramatic Changes for LGBTQ Adults Since November 2024* (Oct. 2025), https://www.mapresearch.org/2025-norc-survey-report.

[57] Lindsay Y. Dhanani & Rebecca R. Totton, *Have You Heard the News? The Effects of Exposure to News About Recent Transgender Legislation on Transgender Youth and Young Adults*, 20 SEXUALITY RESEARCH AND SOCIAL POLICY 1345 (Apr. 2023), https://doi.org/10.1007/s13178-023-00810-6; George B. Cunningham et al., *Anti-Transgender Rights Legislation and Internet Searches Pertaining to Depression and Suicide*, 17 PLOS ONE e0279420 (Dec. 22, 2022), https://doi.org/10.1371/journal.pone.0279420; Sharon G. Horne et al., *The Stench of Bathroom Bills and Anti-Transgender Legislation: Anxiety and Depression Among Transgender, Nonbinary, and Cisgender LGBQ People During a State Referendum*, 69 JOURNAL OF COUNSELING PSYCHOLOGY 1 (Jan. 2022), https://doi.org/10.1037/cou0000558; Amy Novotney, *'The Young People Feel It': A Look at the Mental Health Impact of Transgender Legislation* (Jun. 29, 2023), https://www.apa.org/topics/lgbtq/mental-health-anti-transgender-legislation.

[58] Roberto L. Abreu et al., *"I Am Afrida for Those Kids Who Might Find Death Preferable": Parental Figures' Reactions and Coping Strategies to Bans on Gender Affirming Care for Transgender and Gender Diverse Youth*, 9 PSYCHOLOGY OF SEXUAL ORIENTATION AND GENDER DIVERSITY 500 (2022), https://psycnet.apa.org/doi/10.1037/sgd0000495; Richard A. Brandon-Friedman et al., *The Perspective of Gender-Diverse Youth and Caregivers Coping with Legislation Banning Gender-Affirming Medical Interventions*, 75 JOURNAL OF ADOLESCENT HEALTH S8 (2024), https://doi.org/10.1016/j.jadohealth.2023.11.033.

[59] Pranav Gupta et al., *Exploring the Impact of Legislation Aiming to Ban Gender-Affirming Care on Pediatric Endocrine Providers: A Mixed-Methods Analysis*, 7 JOURNAL OF THE ENDOCRINE SOCIETY bvad111 (Oct. 2023), https://doi.org/10.1210/jendso/bvad111; Landon D. Hughes et al., *"These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents*, 69 JOURNAL OF ADOLESCENT HEALTH 976 (Oct. 2021), https://doi.org/10.1016/j.jadohealth.2021.08.020.

[60] Morning Consult & Trevor Project, *Issues Impacting LGBTQ Youth* 7 (Jan. 2023), https://www.thetrevorproject.org/wp-content/uploads/2023/01/Issues-Impacting-LGBTQ-Youth-MC-Poll_Public-2.pdf. *See also* Kirby Phares et al., *Anti-LGBTQ+ Policies and Rhetoric Are Harming LGBTQ+ Lives* 7 (Mar. 2024), https://www.filesforprogress.org/memos/Anti-LGBTQ-Policies-and-Rhetoric-Are-Harming-LGBTQ-Lives.pdf.

[61] The analysis found that an increase in hate crimes targeting LGBTQ+ people in K–12 schools correlated with the rise in anti-LGBTQ+ laws, with hate crimes more than quadrupling in states that enacted laws restricting LGBTQ+ students' rights. Laura Meckler et al., *In States With Laws Targeting LGBTQ Issues, School Hate Crimes Quadrupled*, WASHINGTON POST (Mar. 12, 2024), https://www.washingtonpost.com/education/2024/03/12/school-lgbtq-hate-crimes-incidents/?utm_campaign=news.

[62] *See, e.g.,* Casey Parks, *Doctors Who Treat Trans Patients Say Threats Worsened After Trump's Orders*, WASHINGTON POST (Mar. 9, 2025), https://www.washingtonpost.com/nation/2025/03/09/doctors-transgender-safety-threats-trump. *See also* Landon D. Hughes et al., *Adolescent Providers' Experiences of Harassment Related to Delivering Gender-Affirming Care*, 73 JOURNAL OF ADOLESCENT MEDICINE 672 (Aug. 15, 2023),

- **Avoidance of medical care:** Concerns about safety, privacy, and mistreatment have led transgender youth and their families to avoid or postpone health care, including both TRH and other forms of care.[63] For example, 29% of surveyed transgender youth said they did not feel safe seeking medical care when sick or injured as a result of anti-LGBTQ+ policies.[64] The resulting loss of care can further threaten their health—especially as the spike in harassment, violence, and negative mental health outcomes has made their access to medical services more important than ever.
- **Displacement:** Political attacks have forced many transgender people and their families to move or consider moving to another state, even when uprooting their lives jeopardizes their personal and financial stability. Nearly half (45%) of transgender youth report that they or their family have considered moving to a different state due to anti-LGBTQ+ politics and laws.[65] A survey conducted in June 2025 found that just in the months since November 2024, nearly one in ten transgender people had in fact moved to a different state as a response to the hostile climate.[66]

The proposed rule and the incendiary claims HHS made to justify it have already compounded these impacts. Finalizing the rule would magnify the harm even further.

e. The proposed rule risks intersex people's health and rights.

The proposed rule would also harm intersex people, including those who do not identify as transgender. The proposed rule allows for an exception when the young person has "a medically verifiable disorder of sexual development."[67] This carveout fails to shield intersex people from the barriers to care imposed by the rule, and in fact invites violations of their rights.

The core function of the exception is not to protect intersex youth and their access to medically necessary care: It is to permit and endorse the procedures frequently performed on intersex infants and young children without their consent. As HHS previously recognized, these procedures are almost never carried out to address a present medical need. Rather they are intended to conform an intersex child's physical traits to a specific sex category based on stereotypical ideas of how bodies should appear and function.[68] Most often performed before a child turns two years old,

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https://doi.org/10.1016/j.jadohealth.2023.06.024; Human Rights Campaign, *Online Harassment, Offline Violence: Unchecked Harassment of Gender-Affirming Care Providers and Children's Hospitals on Social Media and its Offline Violent Consequences* (Dec. 8, 2022), https://hrc-prod-requests.s3-us-west-2.amazonaws.com/HRCF-OnlineHarassmentOfflineViolence.pdf; Goldberg & Redfield, *supra* note 35. https://williamsinstitute.law.ucla.edu/publications/experiences-gac-providers.

[63] Jessie Melina Garcia Gutiérrez et al., *A Narrative Synthesis Review of Legislation Banning Gender-Affirming Care*, 12 CURRENT PEDIATRICS REPORTS 44 (Jun. 2024), https://doi.org/10.1007/s40124-024-00320-y; Hughes et al., *supra* note 59; Novotney, *supra* note 57; Human Rights Watch, *"They're Ruining People's Lives": Bans on Gender-Affirming Care for Transgender Youth in the US* (Jun. 2025), https://www.hrw.org/report/2025/06/03/theyre-ruining-peoples-lives/bans-on-gender-affirming-care-for-transgender-youth.

[64] Morning Consult & Trevor Project, *supra* note 60.

[65] Nath et al., *supra* note 55 at 11.

[66] Movement Advancement Project, *supra* note 56.

[67] Proposed Rule, 90 Fed. Reg. at 59463.

[68] Department of Health and Human Services, *Advancing Health Equity for Intersex Individuals* 5 (Jan. 2025), https://interactadvocates.org/wp-content/uploads/2025/01/intersex-health-equity-report.pdf (hereinafter HHS Intersex Health Equity Report). *See also* Human Rights Watch & InterACT, *"I Want to Be Like Nature Made Me": Medically Unnecessary Surgeries on Intersex Children in the US* (Jul. 25, 2017),

these procedures preemptively deprive intersex youth of the ability to participate in medical decision-making and often result in lasting and irreversible medical complications.[69] International bodies such as the United Nations and the World Health Organization have repeatedly described nonconsensual surgeries on intersex children as human rights violations,[70] and a growing number of medical associations and experts have called for the end of this practice.[71] The proposed rule, however, explicitly permits coverage of these nonconsensual procedures, disregarding the evidence of their harm and departing without explanation from the position HHS adopted as recently as January 2025.[72] This rule would constitute a tacit endorsement of such procedures, undermining progress made towards their eradication and perpetuating their negative impacts on intersex people.

The endorsement of these procedures stands in stark contrast with the proposed rule's attitude towards TRH coverage for transgender people. Care for transgender adolescents is medically necessary, evidence-based, and effective. Per the well-established standards of care for TRH, its course of treatment is determined through shared medical decision-making that ensures that all parties, including the patient who initiated the care, are fully informed and consenting.[73] By contrast, the procedures endorsed in proposed rule's exception are conducted long before the intersex individual can participate in decision-making, they are not guided by medical necessity or recognized standards of care, and significant evidence demonstrates their harms and marginal benefits. This contrast underscores the true thrust of this proposed rule: not to protect children or follow scientific evidence, but to target health care based on ideological preconceptions and sex stereotypes.

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https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us.

[69] HHS Intersex Health Equity Report, *supra* note 68 at 5.

[70] United Nations Human Rights Council, Re. 55/14, Combatting Discrimination, Violence and Harmful Practices Against Intersex Persons, U.N. Doc. A/HRC/RES/55/14 (Apr. 4, 2024), https://digitallibrary.un.org/record/4045699?ln=en&v=pdf; United Nations Office of the High Commissioner for Human Rights, *Background Note on Human Rights Violations Against Intersex People* (2019), https://www.ohchr.org/sites/default/files/BackgroundNoteHumanRightsViolationsagainstIntersexPeople.pdf; Human Rights Council Juan E. Méndez (Special Rapporteur), *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* 18–19, UN Doc. A/HRC/22/53 (2013), https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf; World Health Organization, *Eliminating Forced, Coercive and Otherwise Involuntary Sterilization: An Interagency Statement (OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF, and WHO)* 13 (2014), https://iris.who.int/server/api/core/bitstreams/f32e6f52-8cd4-45a5-8b19-6aecd9c71575/content;

[71] The Brussels Collaboration on Bodily Integrity, *Genital Modifications in Prepubescent Minors: When May Clinicians Ethically Proceed?*, 25 AMERICAN JOURNAL OF BIOETHICS 53 (Jul. 17, 2024), https://doi.org/10.1080/15265161.2024.2353823; Luke Muschialli et al., *Perspectives on Conducting "Sex-Normalising" Intersex Surgeries Conducted in Infancy: A Systematic Review*, 4 PLOS GLOBAL PUBLIC HEALTH e0003568 (Aug. 28, 2024), https://doi.org/10.1371/journal.pgph.0003568.

[72] HHS previously recognized the harms of nonconsensual procedures on intersex children in *Advancing Health Equity for Intersex Individuals*, a landmark report published January 17, 2025. While HHS later removed the report from its website without explanation, the report is archived at https://interactadvocates.org/wp-content/uploads/2025/01/intersex-health-equity-report.pdf.

[73] *See* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH S1 (Sep. 15, 2022), https://doi.org/10.1080/26895269.2022.2100644; Wylie C. Hebree et al., *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 JOURNAL OF CLINICAL ENDOCRINOLOGY AND METABOLISM 3869 (Sep. 13, 2017), https://doi.org/10.1210/jc.2017-01658.

Meanwhile, the exception fails to adequately protect intersex adolescents who seek consensual, patient-initiated care that may otherwise by affected by the proposed rule. For example, Medicaid and CHIP administrators may be unaware of the exception, putting the onus on intersex enrollees and their families to provide the often-inaccessible legal evidence to dispute a coverage denial. Program administrators who are aware of the exception may require documentation of the enrollees' intersex traits out of fear of noncompliance with the rule. As a result, intersex youth and their families may be forced to submit supporting letters from providers or medical history records. Such documentation is deeply invasive and, in some cases, may create a significant barrier, particularly for enrollees whose intersex traits are not explicitly reflected in their medical history. Further compounding these barriers, many Medicaid programs have routine and systematic deficiencies in their communication with enrollees, and many neglect to account for barriers that enrollees may experience to submitting documentation, such as barriers related to income, language or literacy barriers, limited internet access, and disability.[74] Yet another complication may result from the requirement that intersex traits be "medically verifiable." This ambiguous term has no medical, scientific, or legal basis. As a result, Medicaid and CHIP program administrators may not understand this phrase or impose an overly restrictive interpretation, while intersex enrollees and their providers may have difficulty determining what evidence must be provided to show they qualify for the exemption.

III. The rationale proffered in the proposed rule appears to be a pretext for anti-transgender animus.

The primary rationale that CMS provides for the proposed rule is its belief that TRH is unsafe and unproven. As detailed in Section IV of this comment, this belief is incompatible with the evidence and grounded in distortions and disinformation. The incongruity between this rationale and the factual basis is so extensive that it is difficult to explain it away as a mere misunderstanding of the scientific evidence. Rather, it raises serious questions about whether CMS has reverse-engineered its claims about the safety and effectiveness of TRH in service of a different motive. The proposed rule's development and language strongly suggest such a motive: an ideological opposition to transgender people and the care they may need. Taken together, the evidence of animus and the patent flaws in CMS' purported rationale strongly suggest that this rationale is pretextual. When a rule suffers from this type of disconnect between the actual impetus for agency action and the reasons provided in the preamble, it cannot survive review under the Administrative Procedure Act (APA).[75]

a. Evidence strongly suggests the rule is motivated by animus.

Numerous sources indicate that the proposed rule is based in anti-transgender ideology, including the executive order that mandated the proposed rule, the regulatory language, and the justifications that HHS officials have relied on. Cumulatively, this evidence strongly points to animus as being the primary and potentially only true motive for this rule.

The proposed rule emerged out of the president's week-one executive order on TRH, which called on HHS to take regulatory and subregulatory action "to end the chemical and surgical mutilation

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[74] *See, e.g.,* Suzanne Wikle et al., *States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity* (Jul. 19, 2022), https://www.cbpp.org/research/health/states-can-reduce-medicaids-administrative-burdens-to-advance-health-and-racial.

[75] *See Department of Commerce v. New York*, 588 U.S. 752, 785 (2019).

of children," including by changing Medicaid coverage requirements to fit that objective.[76] The executive order makes no effort to hide its bias. It claims, for example, that TRH represents "a stain on our Nation's history"; that "the so-called 'transition' of a child" is "destructive" and a "tragedy"; and that it driven by health providers who "are maiming and sterilizing a growing number of impressionable children under the radical and false claim that adults can change a child's sex."[77] On its own, the development of a proposed rule out of a presidential directive or an administration's political priorities is not evidence of impropriety. But the executive order's anti-transgender prejudice is so strident, baseless, and overt that it casts doubt on the motives of policies it generates. HHS does not try to dispel those doubts in the context of this proposed rule: In fact, it explicitly credited the executive order as both the source of authority and a guiding principle for the rule and offered a full-throated endorsement of its contents.[78] HHS' reliance on the executive order thus offers an initial sign that the proposed rule is motivated by animus.

The proposed rule itself provides further indications of animus. For example, HHS has chosen to refer to TRH as "sex-rejecting procedures," an ideologically laden term that has no medical or legal basis. This phrase appears to have been developed by an extremist think tank with the explicit intent of persuading a broader audience to adopt its anti-transgender positions, maximizing restrictions on care, and precluding nondiscrimination arguments.[79] A recent report by the think tank urged HHS to discard the term "sex-trait modification," the language HHS had been using in previous regulations and policies targeting TRH.[80] The report argued that the term "sex-rejecting procedures" better rebuts the suggestion that TRH is legitimate care and "more effectively communicates the unnatural and disruptive nature of the targeted procedures."[81] While HHS itself does not provide an explanation for its decision to change its terminology, the clearly hostile connotations of the phrase "sex-rejecting procedures," as well as the rationale expressed by its developers, further show the role that animus has likely played this proposed rule.

A third source of evidence of animus is in the justifications HHS officials have given for this proposed rule. The press event where HHS announced the rule featured a lengthy string of inflammatory falsehoods and accusations about transgender people, their care, and their providers, including the following examples:

- HHS Secretary Robert F. Kennedy Jr. asserted that "the American Medical Association and the American Academy of Pediatrics peddled a lie…that sex can be changed."[82] He alleged that they maliciously conspired to spread this lie in the service of "big money

[76] Exec. Order No. 14187, § 5.
[77] Exec. Order No. 14187, § 1.
[78] *See, e.g.,* Department of Health and Human Services, *Protecting Children*, at 10:23 (YouTube, Dec. 18, 2025), https://www.youtube.com/live/aY1XfN6Tt0Q?si=S9rRPs4tKv28IACL&t=3993.
[79] Eric Kniffin et al., *Terminology and Definition: Replacing "Gender-Affirming Care" with "Sex-Rejecting Procedures"* (May 9, 2025), https://eppc.org/publication/terminology-and-definition-replacing-gender-affirming-care-with-sex-rejecting-procedures; Walker Bragman, *HHS Has Been Using Anti-Trans Language From a Christian Right Think Tank*, IMPORTANT CONTEXT (Feb. 9, 2026), https://www.importantcontext.news/p/hhs-is-using-anti-trans-language.
[80] *See, e.g.,* Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27074, 27152 (Jun. 25, 2025).
[81] Kniffin et al., *supra* note 79.
[82] Department of Health and Human Services, *Protecting Children*, at 2:23 (YouTube, Dec. 18, 2025), https://www.youtube.com/live/aY1XfN6Tt0Q?si=S9rRPs4tKv28IACL&t=3993.

interests,"[83] like hospitals who "rake in millions of dollars by convincing boys and girls" that access to TRH is "the only way to achieve true happiness and belonging in life."[84]

- Administrator Oz similarly referred to TRH providers as "charlatans"[85] who have engaged in "predatory actions"[86] and "shameful[ly]…profiteered" off of "a pathology that has afflicted the medical profession."[87]
- Demonstrating disdain for both transgender youth and providers who support them, Administrator Oz added that a medical professional supporting a transgender young person has turned them into "an opportunity" and "a victim"[88] by exploiting a "decision they might have wandered into mistakenly in a whimsical moment."[89]
- In reference to other actions announced at the press event, HHS officials variously referred to the provision of TRH as "barbaric,"[90] an attempt to "blackmail" parents,[91] and a "sorry episode that will go down in medical history of how the power of enthrallment to a false science can damage and harm lives."[92] One official maligned transgender people generally, claiming that recognizing their existence represents "a denial of fundamental truths" that "can destroy natures from within," that is it "at the root of the evils we face," and that it demonstrates "a hatred for nature as God designed it and for life as it was meant to be lived."[93]

These statements, coming from the highest ranks of the agency, were explicitly offered as justifications for the anti-transgender actions announced in the press event, including this proposed rule. As such, they provide direct insight into the motives behind the rule. Together, those statements, the language of the proposed rule, and the executive order that spawned it all strongly indicate that the rule is based in anti-transgender animus.

b. A rule whose rationales are pretextual cannot survive under the APA.

The APA does not permit rulemaking where the justifications offered in the proposed rule are pretextual. A recent case before the Supreme Court involved rulemaking with facts similar to this proposed rule: Several indications suggested that an agency predetermined the desired outcome of its rule before it reviewed the evidence and that the rationale its proposed rule relied on was merely a cover for an unstated motive. The Supreme Court rejected the rule as arbitrary and capricious under the APA, pointing to "a significant mismatch between the decision the Secretary made and the rationale he provided."[94] The justification in the rule appeared "contrived"[95] and "more of a distraction" than a reasoned explanation for agency action.[96]

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[83] *Id*. at 7:44.
[84] *Id*. at 8:17.
[85] *Id*. at 11:37.
[86] *Id*. at 11:13.
[87] *Id*. at 16:50.
[88] *Id*. at 13:20.
[89] *Id*. at 14:21.
[90] *Id*. at 18:39.
[91] *Id*. at 33:01.
[92] *Id*. at 36:15.
[93] *Id*. at 37:06.
[94] *Department of Commerce v. New York*, 588 U.S. 752, 783 (2019).
[95] *Id*. at 784.
[96] *Id*. at 785.

This proposed rule seems to demonstrate a similar "disconnect between the decision made and the explanation given."[97] The rationales offered in the proposed rule all stem from CMS' assertion that TRH is neither safe nor effective. But this groundless assertion does not appear to be based on CMS' genuine assessment of the data, but rather on an attempt to distort the evidence to fit a forgone conclusion. As detailed in Section IV of this comment, the proposed rule's counterfactual claims about TRH seem to be driven not by evidence but by anti-transgender ideology, undercutting CMS' assertion that the proposed rule emerged out of its scientific analysis. Together with the indications of prejudice presented above, the evidence strongly suggests that the reasons outlined in the preamble are *post hoc* rationalizations for an animus-based restriction—a flaw that would render the rule arbitrary and capricious.

IV. CMS relies on a gross misrepresentation of the evidence supporting TRH.

The central justification that CMS provides for the proposed rule is its belief that TRH is dangerous and unsupported by medical evidence. This belief is not grounded in data: As demonstrated in Section I of this comment, the widely accepted evidence demonstrates that TRH is safe, effective, and necessary for the health and wellbeing of many transgender youth. Rather, CMS' rationale is based on skewed data, disinformation, and ideologically driven preconceptions.

In the absence of peer-reviewed data to support its position, CMS relies primarily on HHS' own review of the evidence.[98] Yet medical and scientific experts have widely criticized the HHS report for both its misrepresentation of the evidence and its scientifically unsound process.[99] HHS' report is selective and biased: the review elevates contested, flawed, and discredited studies while dismissing the robust body of research contradicting its claims. Instead of grappling with studies that show the safety and effectiveness of TRH for youth, the review falls back on misleading assertions that the research is low quality and unreliable or even resorts to ad hominem attacks against medical associations and experts. With so few studies supporting its claim, HHS draws heavily on non-scientific and anecdotal sources in its report, with lay press articles, blogs, or social media posts constituting more than 20% of its references.[100] HHS' rushed, shoddy review stands in sharp contrast to the widely accepted World Professional Association for Transgender Health (WPATH) standards of care: Maintained since 1972, the WPATH standards of care, now in their eighth edition, relied on more than 70 systematic reviews, consensus recommendations from more than 100 experts in transgender health, and nearly a decade's worth of development.[101]

HHS' report recommends that these widely endorsed clinical standards be replaced with treatment restricted to psychotherapy alone. This position forms the core of the proposed rule: CMS draws directly on the report's recommendation and attempts to turn it into a coverage policy. The

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[97] *See id*. at 785.
[98] Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (Nov. 19, 2025), https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report.pdf (hereinafter HHS Review).
[99] *See, e.g.,* Nadia Dowshen et al., *A Critical Scientific Appraisal of the Health and Human Services Report on Pediatric Gender Dysphoria*, 77 JOURNAL OF ADOLESCENT HEALTH 342 (Sep. 2025), https://doi.org/10.1016/j.jadohealth.2025.06.002; G. Nic Rider et al., *Scientific Integrity and Pediatric Gender Healthcare: Disputing the HHS Review*, SEXUALITY RESEARCH AND SOCIAL POLICY (Oct. 13, 2025), https://doi.org/10.1007/s13178-025-01221-5.
[100] Dowshen et al., *supra* note 99.
[101] *Id*.

methodological flaws underlying this psychotherapy-only stance are therefore pertinent to assessing the basis of this proposed rule.

HHS asserts that there is no evidence of harm resulting from a psychotherapy-only approach. The few studies it cites for this claim, however, do not provide evidence that this approach is harmless, nor did they attempt to.[102] While HHS recognizes elsewhere in the report that "the absence of evidence of harms in published studies is not equivalent to evidence of absence of harms,"[103] it raises this point solely to discredit systematic reviews of TRH. Even more broadly, HHS itself concedes that there is "no evidence on the effect of psychotherapy" on gender dysphoria when provided in isolation.[104] But instead of shaping its recommendation according to the data, the report redirects to an unsubstantiated claim that this "dearth of evidence"[105] results from widespread bias in the scientific and medical community.[106]

In particular, the report hypothesizes that researchers have refused to study psychotherapy-only approaches because they conflate it with conversion therapy. Decades of research reveals the dangers of conversion therapy, linking it with higher rates of post-traumatic stress disorder, depression, and suicidality, as well as with isolation from community, damaged family relationships, and higher rates of poverty throughout adulthood.[107] HHS disregards the well-documented harm of conversion therapy, and in fact it tries to recharacterize it as a favorable effort to "help children and adolescents come to terms with their bodies"[108] for the purpose of "the resolution of GD."[109] HHS persists in recommending that TRH for youth should be limited to psychotherapy alone, in spite of its own suggestion that this practice overlaps with conversion therapy and its own acknowledgement that no evidence supports its preferred policy. In doing so, HHS further demonstrates that its psychotherapy-only position is based on ideology rather than fact and thus cannot serve as a factual basis for CMS' rulemaking. Indeed, the proposed rule's reliance on the report may indicate that the regulatory carveout for mental health counseling is itself motivated in part by a desire to promote conversion therapy.

The origins of the report further demonstrate that its conclusion was predetermined and politically motivated rather than a result of neutral scientific inquiry. The HHS report was developed in

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[102] HHS relies on a handful of studies on psychosocial interventions (such as social transition and counseling) and claims that "no harms were reported" as a result of psychotherapy. HHS Review, *supra* note 98 at 93. However, none of those studies evaluated the outcomes of restricting TRH to psychotherapy alone. Even disregarding the fact that some examined therapy in combination with social transition (such as name changes, changes to legal gender markers, and access to activities and settings like sports and restrooms), their assessment was related to the impact of psychotherapy access—which is not synonymous with the impact of permitting only psychotherapy and barring access to other care. Therefore, these studies provide no relevant evidence for HHS' recommendation. *See* Alex R. Dopp et al., *Interventions for Gender Dysphoria and Related Health Problems in Transgender and Gender-Expansive Youth* 20 (Nov. 26, 2024), https://www.rand.org/pubs/research_reports/RRA3223-1.html.

[103] HHS Review, *supra* note 98 at 101.

[104] *Id*. at 94.

[105] *Id*. at 260.

[106] *Id*. at 262–263.

[107] *See, e.g.,* Nguyen K. Tran et al., *Conversion Practice Recall and Mental Health Symptoms in Sexual and Gender Minority Adults in the USA: A Cross-Sectional Study*, 11 LANCET 879 (Nov. 2024), https://doi.org/10.1016/S2215-0366(24)00251-7; Amy Przeworski et al., *A Systematic Review of the Efficacy, Harmful Effects, and Ethical Issues Related to Sexual Orientation Change Efforts*, 28 CLINICAL PSYCHOLOGY: SCIENCE AND PRACTICE 81 (2021), https://doi.org/10.1111/cpsp.12377.

[108] HHS Review, *supra* note 98 at 262.

[109] *Id*. at 93.

response to a direct mandate from Executive Order 14187.[110] That executive order was unambiguous about the purpose of the HHS report: to reveal "the blatant harm done to children by chemical and surgical mutilation" and "end[] reliance on junk science," specifically in opposition to the WPATH standards.[111] This report was commissioned in service of executive order's overall objective of ending any federal support for TRH and ultimately eradicating TRH entirely.[112] Indeed, the executive order made clear that the report would discredit the very legitimacy of transgender people's experiences.[113] The HHS report delivered on this mandate, skewing data and relying on discredited theories to fit the conclusion it was trying to reach, disparaging medical experts who disagreed with its claims, and denigrating transgender youth and their loved ones.

CMS' reliance on this fatally flawed review casts serious doubts about the validity of its core justifications for the proposed rule. Indeed, echoing the unsound methods of the HHS report, CMS dismisses the large body of research contradicting the assumptions underlying its proposed rule, relies on irrelevant or methodologically weak studies to support its views, and misrepresents both the nature of TRH and the experiences of the transgender community as a whole.

V. The proposed rule is contrary to statutory and regulatory requirements.

The proposed rule conflicts with the basic purpose of the statute establishing the Medicaid and CHIP programs, the obligations it creates to ensure young people's access to needed care, and statutory and regulatory requirements related to amount, duration, and scope of covered services. As this proposed rule is contrary to the statute it seeks to implement, it exceeds CMS' authority and cannot be justified.

a. The proposed rule disregards the purpose of the statute.

The provisions of the Social Security Act that establish the Medicaid and CHIP programs and the subsequent design of those programs have consistently demonstrated Congress' intent: to expand access to health care, especially for people who may otherwise be unable to afford it. The Medicaid Act[114] and decades of case law uniformly "demonstrate that the primary objective of Medicaid is to provide access to medical care,"[115] a conclusion that the Supreme Court[116] and circuits courts[117] have repeatedly affirmed. Similarly, the purpose of CHIP, as made explicit in the statute, is "to provide funds to States to enable them to initiate and expand the provision of child health assistance

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[110] Exec. Order No. 14187, § 3(ii).
[111] *Id*. at § 3.
[112] *Id*. at § 1.
[113] *Id*. at § 3(ii).
[114] While the Medicaid Act does not include a purpose clause, it specifies that it is designed "to furnish…medical assistance" for those "whose income and resources and insufficient to meet the costs of necessary medical services." *See* 42 U.S.C. § 1396-1.
[115] *Gresham v. Azar*, 950 F.3d 93, 100 (D.C. Cir. 2020), vacated and remanded on unrelated grounds sub nom. *Becerra v. Gresham*, 142 S. Ct. 1665, 212 L. Ed. 2d 576 (2022), and vacated and remanded sub nom. *Arkansas v. Gresham*, 142 S. Ct. 1665, 212 L. Ed. 2d 576 (2022).
[116] *See Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 275 (Medicaid is a program that "provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs"). *See also National Federation of Independent Businesses v. Sebelius*, 567 U.S. 519, 523 (2012); *Schweiker v. Hogan*, 457 U.S. 569, 571 (1982); *Harris v. McRae*, 448 U.S. 297, 301 (1980).
[117] *See, e.g., Pharmaceutical Research and Manufacturers of America v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001), aff'd sub nom. *Pharmaceutical Research and Manufacturers of America v. Walsh*, 538 U.S. 644, 123 S. Ct. 1855 (2003); *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989), aff'd, 499 U.S. 83, 111 S. Ct. 1138 (1991); *University of Washington Medical Center v. Sebelius*, 634 F.3d 1029, 1031 (9th Cir. 2011).

to uninsured, low-income children."[118] The proposed rule is inconsistent with this central objective. Rather than seeking to expand coverage to those who need it, it attempts to impose a restriction that is unnecessary, unjustified, and harmful. CMS has not provided a credible rationale for a rule that undermines the statute's purpose and therefore has not met the burden of demonstrating that it is within its authority.

b. The proposed rule disregards requirements regarding the coverage and provision of care for younger Medicaid enrollees.

The proposed rule undermines states' compliance with affirmative obligations for covering and providing health services for younger enrollees. Specifically, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires states to provide access to a range of services for eligible Medicaid enrollees under the age of 21, with the primary goal of identifying and treating conditions at the earliest opportunity in order to prevent them from worsening later in life.[119] States are required to provide Medicaid-coverable services and pay for them in any amount that is medically necessary, regardless of whether those services are specifically included under the state's Medicaid plan.[120] These comprehensive services include "necessary health care, diagnostic services, treatment, and other measures…to correct or ameliorate defects and physical and mental illnesses and conditions" identified through screening services.[121]

A federal district court recently concluded that excluding Medicaid coverage of TRH for transgender youth violated the EPSDT statute.[122] The court found that the plaintiffs, youth enrolled in the Florida Medicaid program, were "entitled to prevail because treatments at issue comport with the standards of care for their medical conditions and there are no alternative, equally effective treatments."[123] The defendants' "laundry list of purported justifications" bear a close similarity to those used in the CMS rule, including allegations of "low-quality" evidence, treatment risk, and bias in the medical profession.[124] The court rejected every proffered justification, concluding that they "are largely pretextual and, in any event, do not call for a different result."[125]

CMS does not claim that gender dysphoria falls outside the scope of the broadly phrased category of "defects and physical and mental illnesses and conditions." Indeed, treatment for gender dysphoria is precisely the sort of care that the EPSDT benefit is meant to apply to: Providing TRH at a younger age can help prevent gender dysphoria from worsening later in life and reduces the risk of other conditions, such as depression or anxiety.[126] CMS' brief discussion of the intersection with EPSDT requirements merely points to the risks it attributes to TRH,[127] an argument that was specifically rejected in the aforementioned case as both baseless and irrelevant[128] and that is

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[118] 42 U.S.C. § 1397aa.
[119] 42. U.S.C. § 1396d(r).
[120] 42. U.S.C. § 1396d(r).
[121] 42. U.S.C. § 1396d(r)(5).
[122] *Dekker v. Weida*, 679 F. Supp. 3d 1271, 1298 (N.D. Fla. 2023).
[123] *Id*.
[124] *Id*. at 1293.
[125] *Id*.
[126] *See, e.g.,* Jack L. Turban et al., *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, 17 PLoS ONE e0261039 (Jan. 12, 2022), https://doi.org/10.1371/journal.pone.0261039.
[127] Proposed Rule, 90 Fed. Reg. at 59452.
[128] *Dekker*, 679 F. Supp. 3d at 1293.

contradicted by the evidence. By denying the use of federal funding to cover TRH, the proposed rule would give rise to a conflict for states that seek to comply with their EPSDT obligations and undermine the benefit guaranteed to enrollees.

c. The proposed rule is inconsistent with requirements related to amount, duration, and scope of covered services.

The proposed rule is contrary to two key provisions related to amount, duration, and scope of covered services. First, the Medicaid statute's comparability clause requires that services be equal in amount, duration, and scope for all beneficiaries within an eligibility group.[129] As the Second Circuit has explained, this provision "prohibits discrimination among individuals with the same medical needs stemming from different medical conditions."[130] Multiple courts have concluded that the comparability clause applies to TRH exclusions in Medicaid programs.[131] One court, for example, found that Wisconsin's TRH exclusion violated the Medicaid Act because it excluded treatments "deemed medically necessary by a beneficiary's medical provider to treat gender dysphoria, even though those same procedures [were] covered when deemed medically necessary to treat other conditions."[132] Another court applied the same reasoning in its ruling in favor of transgender Medicaid beneficiaries in New York.[133] Similarly, a federal district court in Florida concluded that plaintiffs challenging coverage restrictions for transgender youth were entitled to prevail on their comparability provision claim "because cisgender Medicaid beneficiaries are covered for the same puberty blockers and hormones at issue," and the fact that "cisgender patients receive the drugs for a different diagnosis does not make the different treatment permissible."[134] Meanwhile, one court has rejected a comparability provision claim, but it did so without any analysis of that claim itself and focused exclusively on standards for preliminary injunctions.[135]

CMS' rule mimics the very policies courts rejected as violating the comparability clause. It prohibits coverage of services for beneficiaries when used to treat gender dysphoria but explicitly allows coverage of such services for the treatment of other conditions. The proposed rule does not appear to address the conflict with the comparability clause or the prior case law. In other contexts, however, CMS has suggested that the distinct purposes underlying care for transgender and cisgender youth justify differential treatment. Courts have soundly refused to accept such a justification for a comparability clause violation. The Second Circuit, for example, has stated that "allowing a state to deny medical benefits to some categorically needy individuals that it provides to others with the exact same medical needs simply by defining such services…as aimed at treating only some medical conditions would risk swallowing the comparability provision whole."[136] It clarified that "[m]edical services are always, by nature, diagnosis-specific, and rarely are two

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[129] 42 U.S.C. § 1396a(a)(10)(B)(i),
[130] *Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016).
[131] The decision in *United States v. Skrmetti* does not disturb these precedents. The *Skrmetti* Court reached the erroneous conclusion that TRH restrictions discriminate solely based on medical condition and age. *See* 605 U.S. 495, 519 (2025). But the comparability clause specifically prohibits discrimination based on medical condition, as does the regulation discussed later in this section, and they would therefore both continue to apply to TRH exclusions even under the faulty reasoning in *Skrmetti*.
[132] *Flack v. Wisconsin Department of Health Services*, 395 F. Supp. 3d 1001, 1009 (W.D. Wis. 2019).
[133] *Cruz v. Zucker*, 116 F. Supp. 3d 334, 348 (S.D.N.Y. 2015).
[134] *Dekker*, 679 F. Supp. 3d at 1298.
[135] See *Doe v. Snyder*, 28 F.4th 103 (9th Cir. 2022).
[136] *Davis*, 821 F.3d at 257.

diagnoses or medical histories exactly alike."[137] As the court recognized, relying on the diagnosis a treatment is used for would defeat the aim of the comparability clause entirely.

Federal regulations include an additional prohibition on discriminatory coverage limits, providing that Medicaid programs cannot "arbitrarily deny or reduce the amount, duration, or scope of a required service…to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or treatment."[138] CMS' proposal to restrict coverage of care only when it is used to treat gender dysphoria is indisputably a distinction based on diagnosis, type of illness, or treatment, and its failure to justify this distinction on any credible medical or legal grounds renders that distinction arbitrary. Courts have agreed with this assessment in similar contexts: Decisions dating back to 1980 conclude that Medicaid exclusions for TRH are arbitrary denials that violate this prohibition.[139]

CMS tries to justify its violation of this regulation by arguing that the impugned therapies have a different "risk/benefit profile" when used to treat gender dysphoria compared with other conditions. But CMS fails to explain why a distinction in risks and benefits is materially relevant to the language of this prohibition. It is plainly obvious that health services have different impacts depending on the diagnosis they treat. A prohibition on limiting services based on diagnosis necessarily and inherently contemplates those differences. Even if CMS were not relying on misrepresentations about the risks and benefits of care for transgender youth, differences in the impact of the treatments based on diagnosis would not be relevant grounds to deviate from this requirement.

VI. Conclusion

CMS' proposed rule would jeopardize the health of Medicaid and CHIP enrollees and impose unwarranted hardships on their families; it appears to rely on pretextual rationales to disguise anti-transgender animus; it rejects and misrepresents the large body of scientific and medical evidence regarding their care; and it disregards the legal protections enrollees are guaranteed. Rather than a reflection of law, science, or ethics, this rule represents a baseless and dangerous attempt to restrict access to care, in furtherance of an anti-transgender ideology that cannot form a valid basis for rulemaking. The proposed rule must be withdrawn.

We request that the supporting documentation we have made available through direct links in our citations be considered as part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS does not intend to consider these materials part of the record as requested, we ask that you notify us and provide us with an opportunity to submit copies of the studies and articles into the record.

For further information, please contact Ma'ayan Anafi, Senior Counsel for Health Equity and Justice, at manafi@nwlc.org.

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[137] *Id*.
[138] 42 C.F.R. § 440.230.
[139] *See Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980).