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of the Freedom of Information Act

From: Kumar, Vatsala (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC510606A9034939AC2EB2C237DD8CF3-KUMAR, VATS <Vatsala.Kumar@hhs.gov>
To: (b)(6) (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care
Date: 2022/07/22 14:58:49
Priority: Normal
Type: Note

Hi (b)(6)

Please find attached a memo about the Florida proposed rule. While the document is pretty long, note that the memo itself is only the first six pages, and the rest is a rundown of the public hearing that was held.

This focuses primarily on public and written comments I was able to find and some of the major issues that have come up therein, but I'm keeping an eye on the news to see if there are any other developments.
Please let me know if I can do any follow-up on this today or next week!

Have a great weekend!

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, July 20, 2022 11:15 AM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Yup!

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Sent: Wednesday, July 20, 2022 11:14 AM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Yes! Can do. Is Friday an okay timeline for this?

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, July 20, 2022 11:12 AM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: FW: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi Vatsala,

We are meeting with CMS to discuss the below FL proposed rule next week; are you able to do some research to find out the latest? Maybe there is a transcript or recording of the public hearing as well?

If you can draft up the information as a briefing memo for the Director, that would be great. I have attached a sample for format of the header, and for the body you can include the headers of Background, Current Status, and maybe next steps? Also if there is any information about organizations working in FL on the issue that would be good to know.

Once we have a time, I'll send you the invite.

Thank you!
(b)(6)

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Tuesday, June 21, 2022 9:32 AM
To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; Katch, Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>
Cc: Barron, Pamela (HHS/OCR) <Pamela.Barron@hhs.gov>
Subject: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Good morning all,

I am sure you have all seen the news, but I am flagging the State of Florida's proposed rule 59G-1.050, published in the Florida Administrative Record on Friday (6/17/2022), to prohibit Florida Medicaid coverage of the below services "for treatment of gender dysphoria": 1. Puberty blockers; 2. Hormones and hormone antagonists; 3. Sex reassignment surgeries; and 4. Any other procedures that alter primary or secondary sexual characteristics. Proposed 59G-1.050(7)(a). The proposed rule futher states that for the "purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C. Proposed 59G-1.050(7)(b). I have attached the notice here for ease of reference.

There is a public hearing scheduled for July 8, 2022 from 3:00 – 5:00 p.m. in Tallahassee, FL.

I'm not sure if calls are already happening on this, but since they implicate both CMS and OCR equities it seems like coordination would be beneficial.

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her) | Section Chief
Office for Civil Rights
U.S. Department of Health &Human Services
200 Independence Ave. S.W., Room 532E
Washington, D.C. 20201
Phone: (b)(6) (b)(6)
Email: (b)(6)

Please note I will be out of the office with no email access July 4 – 18, 2022.

Sender:	Kumar, Vatsala (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC510606A9034939AC2EB2C237DD8CF3-KUMAR, VATS <Vatsala.Kumar@hhs.gov>
Recipient:	(b) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6)
Sent Date:	2022/07/22 14:58:17
Delivered Date:	2022/07/22 14:58:49

DELIBERATIVE

DATE: July 22, 2022

TO: Melanie Fontes Rainer, Director, Office for Civil Rights

CC: (b)(6) (b) (b)(6) Section Chief

FROM: Vatsala Kumar, Intern

SUBJECT: INFORMATION MEMO – Florida Proposed Rule 59G-1.050

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1. Background

In June 2022, the Florida Agency for Health Care Administration proposed amendments to Florida Administrative Code Rule 59G-1.050, the General Medicaid Policy. 48 Fla. Admin. Reg. 2461–62 (June 17, 2022). The proposed rule states that certain gender-affirming procedures are not covered under Florida Medicare. *Id.*

This memorandum will first detail the content and timeline of the proposed rule, as well as the report used to justify promulgation. It will then explore the current status of the proposed rule and developments since its original publication. It will also note the work of Florida organizations on this rule, before turning to next steps on the proposed rule.

a. Timeline and Contents

The Florida Agency for Health Care Administration proposed an amendment to the Florida General Medicaid Policy in June 2022. The proposed amendment adds the following text:

> (7) Gender Dysphoria
> (a) Florida Medicaid does not cover the following services for the treatment of gender dysphoria:
> 1. Puberty blockers;
> 2. Hormones and hormone antagonists;
> 3. Sex reassignment surgeries; and
> 4. Any other procedures that alter primary or secondary sexual characteristics.
> (b) For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

48 Fla. Admin. Reg. 2461–62 (June 17, 2022). As rulemaking authority for promulgating this amendment, the agency cites Florida Statute § 409.919 and § 409.961, which some commenters have challenged as being insufficient for this proposal. *See infra* Appendix. Sections 409.919 and 409.961 both include the same language surrounding agency rulemaking. Both state that the agency "shall adopt any rules necessary to comply with or administer" Medicaid "and all rules necessary to comply with federal requirements." Fla. Stat. § 409.919 (2021); Fla. Stat. § 409.961

(2021).

The Florida Agency for Health Care Administration held a hearing on this proposed rule on July 8, 2022. Written comments were due to the agency on July 11, 2022, and they reportedly received approximately 1,200 total public comments. Forrest Saunders, *Agency for Health Care Administration Set to Decide on Medicaid Coverage of Gender Dysphoria Therapies*, WPTV (July 11, 2022), https://www.wptv.com/news/lgbtq/lgbtq-advocates-decry-possible-end-of-medicaid-coverage-for-gender-dysphoria-treatments. No further developments have yet ensued on the rule.

b. Florida Medicaid Report

In order for services to be covered under Florida Medicaid, they must be "medically necessary." Agency for Health Care Admin., *Florida Medicaid: Definitions Policy* 7 (2017), https://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf. Part of this definition includes being "consistent with generally accepted professional medical standards" and not being "experimental or investigational." *Id.*

Shortly before the proposed rule was published, the Division of Florida Medicaid issued a report ("Florida Medicaid Report") concluding that gender-affirming care is not medically necessary because it is not "consistent with generally accepted professional medical standards" and it is "experimental or investigational." *See* Div. of Fla. Medicaid, *Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria* (June 2022), https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf. In making this conclusion, the report opened the door for the Medicaid exclusion. The Florida Medicaid Report incorporates literature reviews on the etiology of gender dysphoria, desistance of gender dysphoria and puberty suppression, cross-sex hormones as a treatment for gender dysphoria, sex reassignment surgery, and the quality of available evidence and bioethical questions. *Id.* at 1. It also explores coverage policies domestically and in western Europe, and includes several attachments, including articles in support. *Id.* at 1–2.

The Florida Medicaid Report claims that "[a]vailable medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria" and that studies focusing on the benefits "are either low or very low quality and rely on unreliable methods." *Id.* at 2. It claims that current evidence around gender-affirming care shows that it "cause[s] irreversible physical changes and side effects that can affect long-term health." *Id.* From the literature reviews conducted, the report states that "Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety." *Id.* at 3.

Numerous critiques have been levied against the Florida Medicaid Report, both in public comments as described *infra* Part 2 and in external documents. Most comprehensively, faculty members from Yale and other universities[1] drafted a report reviewing the Florida Medicaid

[1] Faculty members were from Yale Law School, Yale School of Medicine Child Study Center, Yale School of Medicine Department of Psychiatry, Yale School of Medicine Department of Pediatrics, University of Texas

Report ("Critical Review"). *See* Meredithe McNamara et al., *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20final%20july%208%202022%20accessible_443048_284_55174_v3.pdf. The Critical Review states that the Florida Medicaid Report "purports to be a review of the scientific and medical evidence but is, in fact, fundamentally unscientific" as it "makes false statements and contains glaring errors regarding science, statistical methods, and medicine." *Id.* at 2. The Critical Review is structured in five parts. It argues that "medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational"; that the Florida Medicaid Report is "a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science" including experts who have been disqualified in court; that the Florida Medicaid Report "makes unfounded criticisms of robust and well-regarded clinical research and . . . cites sources with little or no scientific merit"; that the Florida Medicaid Report's "linchpin" is an analysis which is "extremely narrow in scope, inexpert, and so flawed it merits no scientific weight at all"; and that the Florida Medicaid Report "erroneously dismisses solid studies as 'low quality,'" which if followed regularly would mean that widely-used medications and common medical procedures would also have to be denied coverage. *Id.* at 3.

The Agency for Health Care Administration responded to the Critical Review, stating that it is "another example of the left-wing academia propaganda machine arrogantly demanding you follow their words and not the clear evidence-based science sitting right in front of you" and that it is a "hodgepodge of baseless claims" without authority or credibility. Dara Kam, *Expert Report Condemns Florida's Plan to Ban Medicaid Coverage for Transgender Care*, Palm Coast Observer (July 17, 2022), https://www.palmcoastobserver.com/article/expert-report-condemns-floridas-plan-to-ban-medicaid-coverage-for-transgender-care.

2. Current Status

a. July 8, 2022 Hearing

The Florida Agency for Health Care Administration held a lively public hearing on July 8, 2022 on the proposed rule. The hearing consisted mostly of public comments, a comprehensive summary of which is attached in the Appendix. The full hearing can be viewed online. 7/8/22 Agency for Health Care Administration Hearing on General Medicaid Policy Rule, Fla. Channel (July 8, 2022), https://thefloridachannel.org/videos/7-8-22-agency-for-health-care-administration-hearing-on-general-medicaid-policy-rule/.

The hearing included a "panel of experts" consisting of Dr. Andre Van Mol, Dr. Quentin Van Meter, and Dr. Miriam Grossman. Dr. Van Meter has been found by a court unqualified to be an expert on the subject of gender-affirming care. *See* Stephen Caruso, *A Texas Judge Ruled This Doctor was Not an Expert. A Pennsylvania Republican Invited Him to Testify on Trans Health*

Southwestern, and University of Alabama at Birmingham. *See* Meredithe McNamara et al., *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida%20report%20final%20july%208%202022%20accessible_443048_284_55174_v3.pdf.

Care, Penn. Capital-Star (Sept. 15, 2020), https://www.penncapital-star.com/government-politics/a-texas-judge-ruled-this-doctor-was-not-an-expert-a-pennsylvania-republican-invited-him-to-testify-on-trans-health-care/. He is also the president of the American College of Pediatricians, an advocacy group whose primary focus is to advocate for conservative policies in medicine, which has been categorized by the Southern Poverty Law Center as a hate group. *See American College of Pediatricians*, Southern Poverty L. Ctr., https://www.splcenter.org/fighting-hate/extremist-files/group/american-college-pediatricians (last visited July 22, 2022). Dr. Van Mol is also a member. *Andre Van Mol*, Pub. Discourse, https://www.thepublicdiscourse.com/author/andre-van-mol/ (last visited July 22, 2022). The panelists spoke at several times during the hearing, primarily to point the audience towards the Florida Medicaid Report. *See* Appendix.

Over the two-hour hearing period, fifty public commenters spoke. Forty-two of those commenters supported the proposed rule and eight opposed it. Of the forty-two in support, two formerly identified as transgender but have since detransitioned, eight were representatives of the Christian Family Coalition, and at least ten mentioned God or the Bible as part of their rationale. Many supporters also raised concerns that children and teenagers are not mature or knowledgeable enough to choose these procedures, or that they are being unduly influenced by their peers and may later regret transitioning. Notably, the proposed rule would apply to gender-affirming care for individuals of all ages, not only youth. 48 Fla. Admin. Reg. 2461–62 (June 17, 2022). Several supporters also cited the Florida Medicaid Report as being well-researched and providing a strong basis for the rule; some opponents of the rule noted criticisms of the report including those raised by the Critical Review.

b. Florida Organizations and Individuals

The university faculty who wrote the Critical Review also wrote a significant public comment on the proposed rule. *See* Letter from Anne L. Alstott et al. to Simone Marstiller & Tom Wallace re Rule No. 59G-1.050: General Medicaid Policy (July 8, 2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/alstott%20et%20al%20full%20comment%20proposed%20rule%20re%20gender%20dysphoria_443049_284_55174_v3.pdf. The letter highlights similar concerns, noting that the "complete absence of scientific foundation for the Proposed Rule renders it an arbitrary and capricious use of rulemaking power" and that it "cannot [be] characterize[d] . . . as a valid interpretation of the existing Florida regulations on generally accepted professional medical standards, because the [Florida Medicaid] Report fails to satisfy Florida's own regulatory requirements for scientific review." *Id.* at 2. It reiterates concerns about the Florida Medicaid Report, including the cited experts' bias and lack of expertise, errors about scientific research and medical regulation, and lack of scientific weight. *Id.* passim, 20.

Disability Rights Florida submitted a comment also opposing the proposed rule. *See* Letter from Peter P. Sleasman to Simone Marstiller re Proposed Amendments to Rule 59G-1.050, https://disabilityrightsflorida.org/images/uploads/DRF_Gender_Affirming_Care_Comment_-_Final_Signed.pdf. The letter focuses primarily on how this proposed rule "will cause unnecessary and disproportionate harm to individuals with disabilities living in Florida," especially those who are low-income. *Id.* at 1. It notes that transgender individuals "are more

than twice as likely as the general population to live in poverty," and transgender individuals with disabilities are four times as likely. *Id.* at 2. Disability Rights Florida goes on to raise concerns about the agency's "apparent failure to take even minimal steps to ensure that the rulemaking workshop . . . is accessible to the very people with disabilities it will directly impact," citing to the lack of accommodations, contact information for seeking accommodations, and response regarding livestreaming. *Id.* at 3.

As did the Endocrine Society. *See* Letter from Ursula Kaiser to Agency for Health Care Administration re 59G-1.050: General Medicaid Policy (July 8, 2022), https://www.endocrine.org/-/media/endocrine/files/advocacy/society-letters/2022/july-2022/response-to-fl-medicaid-nprm.pdf. They note that their guidelines, "while not standards of care that clinicians are legally bound to follow, . . . provide a framework for best practices, and deviations must be justified." *Id.* at 1–2. They expound on how their guidelines were developed—using a "robust and rigorous process that adheres to the highest standards of trustworthiness and transparency" and with a "systematic review of the evidence that supports [clinical] questions"—in contrast to the Florida Medicaid Report, which "did not include endocrinologists with expertise in transgender medicine," "makes sweeping statements against gender affirming medical care that are not supported by evidence or references provided," and "does not acknowledge the data showing harm reduction and improvements in behavioral health issues" that result from gender affirming care. *Id.* at 2–3. The letter goes on to state that this proposed rule would cause irreparable harm to transgender youth, including putting their lives at risk. *Id.* at 6.

Equality Florida advocated against the rule as well. Equality Florida, Press Release, Equality Florida Decries Proposed Rule to Eliminate Medicaid Coverage for Gender Affirming Care (June 17, 2022), https://www.eqfl.org/proposed-ahca-rule-2022. They note that this will affect approximately 9,000 transgender Floridians insured with Medicaid, and that "major medical and mental health associations recognize the critical importance of gender affirming care." *Id.*

The Florida Coalition for Trans Liberation has also put together a short policy brief around the proposed rule. *See* Fla. Coal. for Trans Liberation, *Stop Rule 59G-1.050* (2022), https://drive.google.com/file/d/11CHjVMOOli_8a1tdaE_jKacf-xOK5akA/view. They note that this proposed rule contravenes all major medical advice, pushes a political agenda, and can be life-threatening. *Id.*

Florida Policy Institute also submitted a comment. *See* Letter from Anne Swerlick to Thomas Wallace re Proposed Rule 59G-1.050, Florida Administrative Code (July 7, 2022), https://www.dropbox.com/s/ld9f8yzo61xrxac/FPI_gender-affirming-care_comments_July72022.pdf?dl=0&mc_cid=08420fb607&mc_eid=6cb16947ac. They note that the proposed rule would "bar transgender patients from accessing essential care and reverse current Medicaid policies which have been in effect for years. *Id.* at 1. They also point out that this is counter to established standards of care, inconsistent with antidiscrimination laws, and exacerbates the challenges that transgender individuals already face. *Id.* It closes by noting that this rule seems to be "weaponiz[ing] [the Medicare program] as a tool for promoting a particular political agenda." *Id.*

While the majority of public comments during the July 8 hearing were in support of the rule, few comments posted online seem to be, and Florida Medicaid has not made all of the comments publicly available. Christian Family Coalition, who was also heavily represented at the July 8 hearing, did make a public statement, stating that this rule was "important and necessary" to protect Floridians, "especially minors, from harmful transgender surgeries, hormone blockers, and other unnatural therapies." *CFC Florida to Testify in Support of DeSantis Administration Rule Banning Medicaid Funding for Transgender Surgeries and Puberty Blockers*, Best Things Fla. (July 8, 2022), https://bestthingsfl.com/news/cfc-florida-to-testify-in-support-of-desantis-administration-rule-banning-medicaid-funding-for-transgender-surgeries-and-puberty-blockers-31403227-tallahassee-fl.html.

3. Next Steps

Several nonprofit groups in Florida are prepared to push back against the proposed rule. Lambda Legal, the National Health Law Program, the Florida Health Justice Project, and Southern Legal Counsel issued a statement criticizing the Florida Medicaid Report and stating that they "stand ready to defend the rights of transgender people in Florida." *LGBTQ Groups to Fight Florida Over Medicaid Ban for Trans Treatments*, CBS Miami (June 6, 2022), https://www.cbsnews.com/miami/news/lgbtq-groups-fight-florida-medicaid-ban-transgender-treatments/.

One potential avenue for doing so may be seeking an administrative determination. Florida law says that any person "substantially affected by a . . . proposed rule may seek an administrative determination of the invalidity of the rule on the ground that the rule is an invalid exercise of delegated legislative authority. Fla. Stat. § 120.56 (2022). If a complaint is properly filed, the state must assign an administrative law judge (ALJ) to conduct a hearing within thirty days. *Id.* at (1)(c). The ALJ may declare the proposed rule wholly or partially invalid, and the rule then may not be adopted unless the judgment is reversed on appeal. *Id.* at (2)(b).

Appendix: Summary from July 8, 2022 Hearing

This appendix will detail the public comments made at the July 8 hearing regarding the proposed changes to 59G-1.050. There is no readily available transcript of the proceedings, so please note that names below may be missing or misspelled. Each speaker was met with audience applause at the end of their remarks, but any audience reactions during remarks are noted below.

The meeting opened with introductions of the panelists and representatives and a brief summary of the rule before opening the floor for public comments. Public commenters were asked to state their name and organization and to limit comments to two minutes, focusing only on the proposed rule language. The agency also noted that comments could be submitted via email.

The first speaker was Chloe Cole, a 17-year-old detransitioner from California. Cole began medical transition at the age of 13. In retrospect, she states that she was not becoming a man, but was just "fleeing from the uncomfortable feeling of being [a] wom[a]n." Chloe states that she "really didn't understand all of the ramifications of any of the medical decisions that [she] was making" when she chose to undergo a double mastectomy at the age of 15. She lamented that she will never be able to breastfeed, has blood clots in her urine, cannot fully empty her bladder, and does not know if she can ever give birth.[2]

The next speaker was Sophia Galvin, also a detransitioner. She states that she had a history of mental illness, including self-harm and suicidal ideation, and that her desire to transition was "all in an effort to escape the fear of being a woman in this society." Galvin stated that she had no support when she chose to detransition; her doctor told her to stop taking hormones but she did not see a mental health counselor. She said that "this is not good for children" and she "was harmed by this, and it should not be covered under Medicaid."

Next, the mother of a transgender boy spoke. She said that a physician gave her son testosterone at the age of 16 without her consent or knowledge, and that Medicaid covered her son's double mastectomy, hysterectomy, and vaginoplasty. She states that her son had private insurance but it was bypassed. She said that it is "impossible to change one's biological sex" and that doctors should not be affirming the "lie that biological sex is changeable." She characterized these lies as "child abuse," at which point the crowd began to applaud, and said that "amputating the healthy body parts of a child whose brain has not reached full decision-making maturity is simply criminal." This lead to more applause. She further characterized gender-affirming care as a "medical experiment."

The next speaker, Jeanette Cooper, spoke on behalf of Partners for Ethical Care. Cooper stated that "we need to make space in the public sphere for ethical therapists by removing the medical treatment option" and characterized gender identity affirmation as a "poisoned bandage on the

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[2] Several news sources also reported on Chloe and her testimony. *See, e.g.*, Tyler O'Neil, *California Ex-Trans Teen Backs Florida Ban on Medicaid Funds for Transgender Medical Interventions*, Fox News (July 10, 2022), https://www.foxnews.com/health/california-ex-trans-teen-backs-florida-ban-medicaid-funds-transgender-medical-interventions. In one article, she urged individuals to "wait until you are a fully developed adult" prior to transitioning. *Id.* Notably, the Florida proposed rule is not only a prohibition on gender-affirming procedures for minors, but prohibits Medicaid funding for any gender-affirming procedures regardless of age.

skin of children causing permanent psychological and physical harm." The audience applauded when Cooper said "everyone knows what a woman is, but some people are afraid to say it." Cooper went on to state that "the state has no business using taxpayer funding to turn children into permanent medical patients" and "assisting doctors in selling disabilities to vulnerable suffering children." She further said that gender-affirming care is "not real healthcare" and that the state should instead fund "legitimate care" that addresses trans children's "actual needs." She likened the satisfaction children get from gender-affirming care to "a street drug that needs to be injected every day." Cooper closed by stating that the medical is "failing these families" and that her organization supports the proposed rule.

Donna Lambert, on behalf of Concerned Parents, also supported the rule. She said that "the healthcare professionals are presenting many [parents] with a false and painful choice: accept what we know will permanently harm our children, or lose them to suicide." She stated that "there is no data to prove that medically transitioning minors prevents suicide" and that parents lose their children down this "dangerous medical path permanently harming their healthy bodies with off-label drugs and experimental surgeries." Lambert said that transgender children "become angry and hostile and resentful; they begin lashing out at anyone who will not agree with their newfound identity." She described this as a "destructive social phenomenon" which "cuts parents out of the equation."

A Christian pastor spoke next, stating that the Bible teaches that "God makes people made and female" and to try and transition people "is a sin" and "should be a criminal abuse of children, especially when they're not at the age when they can properly process what they're doing to themselves." He said that the "one goal" of doctors who provide gender-affirming care is to "cut[ ] back on the birth rate." He supported the proposed rule and said Florida should "go further" and classify aiding in this case as "extreme child abuse."

Brandy Hendricks stated that gender-affirming procedures "have been shown to be extremely harmful, especially to minors." She lamented that children are being allowed to "change their genders before they've even reached puberty or shortly after." She said that pharmaceutical companies are advertising puberty blockers to children and unethically enriching themselves. She too characterized gender-affirming care as "child abuse" and as "experimental."

Sabrina Hartsfield, an alumna of Florida State University and a born-again Christian, spoke against the rule. Hartsfield said that "without gender-affirming healthcare, transgender and gender nonconforming individuals will die." She said that, "according to every major legitimate medical organization, gender-affirming care is the treatment for gender dysphoria." She said gender affirming care is "medically necessary and lifesaving treatment" that should not be decided by big government overreach. An audience member shouted something indiscernible at this point in Hartsfield's comment. Hartsfield went on to state that the proposed rule violates the Affordable Care Act and Medicaid Act's nondiscrimination provisions. She noted that denying gender-affirming care can be life-threatening.

Simone Chris, an attorney and the director of the Transgender Rights Initiative at Southern Legal Council, "vehemently oppose[d]" the proposed rule. She stated that her organization's experience working with hundreds of transgender individuals has evinced "the tremendous

benefits that access to [gender-affirming] care provides." Chris went on to state that "the insidiousness of this rule is exacerbated by the fact that it places in its crosshairs the individuals in our state who are already disproportionately likely" to face poverty, homelessness, poor health outcomes, and limited access to healthcare. She noted that every major medical association supports gender-affirming care, and that the proposed changes would "cause significant harm" by depriving individuals of "critical, lifesaving medical care." Chris went on to state that the changes to the rule substitute the state's judgment for that of the patient and their doctor, and that it is a "shameful waste of state resources." She cited to nationwide litigation which has struck down similar laws as inconsistent with the guarantees provided by the Medicaid Act, the Equal Protection Clause of the Fourteenth Amendment, and the Affordable Care Act, and noted that Florida will undoubtedly face similar challenges, wasting taxpayer money.

The next speaker, Matthew Benson, a pediatrician and pediatric endocrinologist, agreed with the proposed changes, stating that the data used to support gender-affirming care "is not scientific." He cited to a Swedish study from 2016 which found that the mortality rates of transgender individuals who received gender-affirming care were three times that of the general population, and that they attempted suicide five times more often than the general population. He also cited a similar study from Denmark wherein 10 percent of the study population died over the 20-year study period. Benson said we need better data and longer-term trials "to justify these kinds of very aggressive therapies."

Karen Schoen, a former teacher, spoke on behalf of Florida Citizens Alliance. She opened by stating that she would like to know "why 0.03 percent of the population is dictating to 99.97 percent of the population" that their elective surgeries should be paid for. This was met with audience applause. Schoen said that "kids change their minds" and that they become fearful of maturing. She lamented that thirteen-year-olds cannot drive a car, have a drink, or shoot a gun, but are "in charge" when it comes to changing their gender. This was met with audience laughter and applause.

The next speaker was Bill Snyder. Snyder first told a story about "reality disease," stating that "the further we move from reality, the further we move from morality" and that "the further we move from virtue, the more secular we become." Secularity leads to less freedom, he said, and then urged Florida to approve the changes to the rule.

Avery Fork with Christian Family Coalition, a college counselor, also spoke in support of the proposed rule. She characterized gender-affirming procedures as "unnatural therapies being promoted by radical gender ideals and with no basis in science." She said the proposed rule would prevent taxpayers from having to pay for "highly unethical and dangerous procedures."

Richard Carlins also spoke in support of the rule. He said that our Constitution was founded on "biblical principles." Carlins said children are being indoctrinated through commercials, Disney World, Coca-Cola commercials, and restaurants, and that gender-affirming procedures are a "horrendous evil." He said that "God raises up nations and he brings down nations," which was met with audience vocal support, and that this is a recent phenomenon. He said we've been "living in Judeo Christian principles" for 1500 years, and "it's just recently that we're throwing any mention of God [or] the Bible under the bus."

Amber Hand with the Body of Christ grew up with two queer parents. She said she had been considering gender transition for most of her life, but that "we have to teach these kids right from wrong" and that it is wrong to teach children they can make these decisions. Hand said that she is glad she never transitioned because she recently realized she wanted children. She went on to quote the Bible and that it's "not okay to change your identity."

The next speaker, Ms. Hazen, also supported the rule. She said that children are being pressured at a young age to identify as transgender, and that much of the pressure comes from the internet. She cited a follow-up study of individuals who transitioned, which found that the suicide rate in those individuals was twenty times the general population. She said that this evinces the "deep regret" they face after "mutilating" their bodies. She said that children "don't understand that they will never be able to procreate ever again" when we "mutilate these children's bodies at an early age."

Leonard Lord also spoke in favor of the proposed changes. He said that he was also uncomfortable in his body as a child but was able to get comfortable by becoming closer with God. The audience murmured in approval. He said that "either we're playing games, or we really believe there's a God and the Bible is true," and that this "problem" happens because we don't believe in God. Lord said that, with regard to mental health issues, "God's spirit is the answer to what's missing in their lives," again leading to audience applause and cheers. He said that by taking God, the Bible, and prayer out of schools, we are removing ourselves of power, love, and a sound mind. The audience again applauded. He said the "devil is the author of confusion" (the audience cheered) and that "if you spend your life trying to figure out if you're a man or a woman you'll never know why you're here" (again, audience applause).

The next speaker, Pam, also supported "stopping Medicaid from paying for children and teenagers to have such changes." She said that children are "confused" and likened gender-affirming procedures to "paying for [children] to have furry animal body parts," to which the audience cheered. She said she is thankful that Florida will "stop the madness" for "the sake of the children."

Jon Harris Maurer, the public policy director for Equality Florida, spoke next against the proposed rule. Maurer said that the proposed changes are without scientific or legal basis and are "clearly discriminatory." He cited to numerous experts and organizations who endorse gender-affirming care. Maurer also said that the agency "lacks the specific delegated rule-making authority to adopt the proposed rule" and that the statute cited "grants no authority" for the agency to usurp the role of healthcare providers. He said the rule is discriminatory and targets the transgender community, and that it would harm the 9,000 transgender Floridians on Medicaid. An audience member began to shout, and the audience began to speak over Maurer. He said that the proposed rule is politically calculated and urged them to reject the rule.

Anthony Verdugo spoke on behalf of the Christian Family Coalition as the Executive Director. Verdugo supported the rule. He said that "they call it gender-affirming care" but "they don't care, and it's not affirming." He called Chloe Cole and Sophia Galvin "heroes," and said that this is a "war on children and this is a crime against humanity." Verdugo said that "groomers" are pressuring children to undergo gender-affirming procedures. He cites to the warning label on a

package of hormones which states that emotional instability is a side effect. He said that the organizations Maurer listed "have been discredited" and cited to "more renowned" organizations who believe that "the suppression of normal puberty, the use of disease-causing cross sex hormones, and the surgical mutilation and sterilization of children" are "atrocities" and "not health care."

The next speaker, a veteran and police officer, said that doctors, parents, teachers, and scientists have been wrong before, but that detransitioners are the "evidence" we need. He said we need to "stop being ignorant" and that churches are bigger than any organization and in support of the proposed change. The audience met this with cheers and applause throughout.

Michael Haller, a doctor and professor of medicine at the University of Florida, spoke on his own behalf. After establishing himself as an expert, he said that this proposed rule makes "numerous false claims, uses biased reviews of the literature, and relies on more so-called experts who actually lack actual expertise" in caring for transgender youth. He said that the state's assertion that gender-affirming care is not safe or effective is "patently false" and that nearly every major medical organization supports this care. He says the state is "either unwilling or willfully chooses to ignore the totality of evidence for gender-affirming care." He said that the state's experts are unqualified. Haller noted that the proposal is "poorly-conceived," likely to cause harm, and should be rejected.

At this point, a member of the panel, Dr. Van Meter, made a comment. He said that the Endocrine Society guidelines are not standards of care, but merely guidelines, drafted by "ideologues" from the World Professional Association for Transgender Health. He said that this group excluded "world renowned experts in the field" and did not include their input "on purpose." He said that we "have to stop using the term 'standards of care' when there are absolutely no standards of care in this instance that have been addressed."

Robert Youelis spoke next, lamenting that gender-affirming care was not on anyone's radar even five years ago. He said that this is man "proclaim[ing] himself as God" and that there is only one truth. Youelis said we are "philosophically and morally" going down a slippery slope when we start considering gender-affirming care. He said that brains are not fully developed until the age of twenty-five, and children cannot make other decisions in life, so we should not be educating anyone about gender identities until they are in twelfth grade.

The next speaker, Keith Claw of Florida Citizens Alliance, spoke next. He said that children in public schools are "purposefully confused, desensitized, and even pressured into abnormal sexual behavior" and that "gender idealogues are coaching kids to be into this dysphoria." He said that there is ongoing debate as to whether gender dysphoria is biological or psychological. He said that taxpayers should not have to pay for gender-affirming care.

Robert Roper spoke next, also in support of the rule. He said that it "serves to protect the children." He said "gender confusion is the only disorder that comes with a false assertion that a child can be born in the wrong body" and that it is "impossible" to become the opposite gender. He went on to say that gender dysphoria is the only "disorder [where] the body is mangled to conform to the thoughts of the mind" and where "the child actually dictates his or her medical

care . . . instead of the other way around." He called this a "social media epidemic manufactured by social media influencers making a lot of money off the very vulnerable element of our society." He likened gender-affirming procedures to giving drugs to a drug addict or alcohol to an alcoholic and cited to a Reddit post where 35,000 individuals expressed regret of transitioning.

Karl Charles of Lambda Legal spoke against the proposed rule. He said that this care is "essential and in some cases lifesaving," "clinically effective," "evidence based," and "widely accepted." Charles said that exclusions such as this one cause "serious immediate and irreparable harm" to those who already experience "well-documented and pervasive stigma" and barriers to healthcare. He said that he is particularly concerned by the agency's characterization of this care as "experimental and ineffective," and that this is contrary to available medical evidence and misrepresents studies. He notes that the so-called experts relied on have been discredited and do not treat transgender patients. He noted that no one on the panel was a transgender Medicaid recipient in Florida, and that singling out transgender Medicaid participants violates Equal Protection and ACA § 1557.

A panelist at this point referred everyone to the appendices to the Florida Medicaid Report, including Dr. Cantor's reports cited to on page thirty-nine, which discusses each organization that has supported gender-affirming care.

Ed Wilson spoke in support of the proposed rule, saying that it would "protect children who are not mature enough to be comfortable in their own bodies" from "making mistakes that will destroy their lives." He said that taxpayer money should "never be used to destroy innocent lives" and that gender-affirming care "never actually succeed[s]" but does cause harm. He characterized it as "mutilation" and an "atrocit[y]" to be banned, "not healthcare."

Suzanne Zimmerman, a relative of a gender dysphoric youth, spoke next. She "pray[ed]" that the state "not make it easy" for this youth's parents to be persuaded towards gender-affirming care. She pointed to the testimony of detransitioners to state that "God doesn't make mistakes" (the audience said "amen"). She urged them to support the changes.

Jean Halloran also supports the changes. She said that Medicaid should not be supporting or paying for gender-affirming care. She likened gender-affirming care to cosmetic changes to make her look younger, receiving audience applause and laughter.

Ezra Stone, a clinical social worker, pointed to research that medical transition is safe and effective. They pointed to clients who have "expressed tremendous relief" and an increased sense of safety when they are able to access medical care. They said that "understanding and being seen as [one's] true sel[f] creates a sense of belonging, which is a fundamental human need." They pointed to the political climate in Florida as causing harm and anxiety to "transgender, nonbinary, questioning, and gender-diverse Floridians." Their patients "worry about their access to medical care" and experience fear of violence daily, which supports the minority stress model that says that expecting harm and violence has a negative impact on mental health and well-being. They said that this proposed change will create an atmosphere of fear and take away medically necessary care.

Peggy Joseph shared the thoughts of Ryan T. Anderson, author of *When Harry Became Sally*. She cited to the Obama Administration's refusal to mandate coverage of gender-affirming surgeries under Medicaid, which said that there was "not enough evidence" to determine whether it improved health outcomes. She said that studies with positive outcomes were exploratory, without follow-up, which "could be pointing to suicide." She cited to the Swedish study regarding suicide rates, as well. She said the "minimal standard of care should be with a standard of normality" and that gender dysphoric thoughts are "misguided and cause harm."

A panelist again interjected to note that the report on pages 35–36 and 42–45 discusses the international consensus.

Jack Walton with the Christian Family Coalition is a pastor. He said he has counseled queer individuals for thirty-seven years. He believes that "gender dysphoria should be labeled as child abuse" and the doctors who prescribe gender-affirming care are "tear[ing] the child apart and call[ing] it health care." Walton says that gender-affirming care is "not science" and that any such procedures "should be labeled criminal." He said that "nearly 90 percent of those that escape from that life do it by the time they reach the end of puberty because they come back to their senses that they were created male and female by God." Walton expressed that suicide happens when a transgender person transitions but "still do[es]n't find the completion that they thought they felt." He said that many individuals transition because of child abuse they faced as children or because they were not accepted by others. He closed by saying there are "two genders, male and female; women bear children, women breastfeed, women have menstrual cycles, men do not." He said he "would not provide the anorexic with food and [he] would not say give money to do something that would harm a child."

Another member of the Christian Family Coalition, Jose, also supported the changes. He characterized gender-affirming care as "mutilation" and said that transgender individuals need "counseling" and should not be given a "destructive choice." He said that everyone will have to "stand before our living God and give account for where we stand on this and other issues." He thanked Chloe Cole and Sophia Galvin for their testimonies.

The panel then asked that members of the same organization be mindful of their time.

Bob Johnson, an attorney, spoke next. He thanked the agency for putting together the report, noting that it is "thorough," and said the "case is compelling." He strongly supports the rule change, and this is in large part due to the report making the case. He noted that the "FDA does not approve any medication as clinically indicated for gender dysphoria" and lamented the lack of randomized controlled trials and long-term data for puberty suppression medication.

Sandy Westad also spoke on behalf of Christian Family Coalition. She said that her heart is "breaking for what these kids are going through" and that "the parents need to stay in control." She said that kids "play house" and "pretend," but they "don't want to be or understand or even know what it is to change from one sex to another." She said, "children cannot make those kinds of decisions" and "cannot decide who they are."

Gayle Carlins also spoke from Christian Family Coalition. She said her beliefs are based on the

Bible, which is "the only truth that there is," and which says that "God created male and female." She went on to "bring science into it," stating that females have two X chromosomes and males have an X and a Y chromosome, and that "it's an impossibility to change from one to the other" "no matter what kind of mutilation or anything is done to a person."

Dorothy Barron spoke next, also from Christian Family Coalition. She first thanked Florida's "great governor," eliciting audience cheers and applause, and thanked Chloe Cole and Sophia Galvin for not "going along with what you were trying to be brainwashed into" (also eliciting audience cheers and applause). She said "they're definitely targeting our youngest," and lamented that "we can't seem to find baby formula anywhere but yet Medicaid can fund this nonsense." Barron said it "has to be left up to the parents," and that "whatever you choose to practice in the privacy of your own home is your business"; she is "not discriminating against any genders or whatever." She said that it needs to be "taken out of the schools." She said Michael Haller's testimony was "shameful" and is "why we're in this bloody mess right now," to which the audience also cheered and applauded.

The panel reminded the public to be focused on the rule and respectful of other speakers.

Troy Peterson, the president of Warriors of Faith, supported Christian Family Coalition, and came from the Tampa Bay area. He said that he represents "thousands that stand in agreement" with the proposed change. He thanked the doctors for the report and said that "when [he] saw the evidence, [he] could clearly see that we need this rule." He quoted from Genesis and said that God created male and female, and he is opposed to Michael Haller as well. He said that "if [he] had any authority in the medical field, [he] would have [Michael Haller's] license revoked." The audience whistled and verbally approved. He said that the most thorough follow-up of transgender individuals in Sweden said that "the suicide rate is twenty times that of the comparable peers" and that "50 percent of the gender identity confused children have thoughts of suicide."

Janet Rath spoke next. She said that "fifty years ago, as parents, we were smarter than what's going on today," and that parents are being left out of their children's lives. She said some of this is the fault of parents and some is the fault of teachers. She said her granddaughter, a teacher, has told her that "if she has a child that comes in and identifies as a cat, she must have a litterbox there and a bowl of water." Rath said that our country is going "absolutely insane," and the audience murmured in agreement. She said that Dr. Fauci is "nothing but a money-grabbing liar" and "we have been hoodwinked ever since." Rath went on to say that "Chinese children in third grade are learning advanced calculus" but "our third graders are learning which bathroom to use."

Gerald Lomer drove 3.5 hours to attend the hearing. He supported the proposed rule and "the best governor in the United States," to which the audience cheered and applauded. He told "stories" of a girl who wanted to spend more time with her father and thought that being a boy was the best way to do so and a boy who wanted to spend more time with his mother and thought that being a girl was the best way to do so. He said that thirteen-year-olds cannot drive a car, drink a beer, or smoke a cigarette, but are able to take hormones and obtain surgeries for gender-affirming care. He characterized gender-affirming surgeries as "mutilating."

A pastor from Florida spoke next on behalf of Protect Our Children Project, Duval Country Charter House, and Christian Family Coalition. She supported the rule prohibiting funding for "unnatural therapies" and does not want taxpayers to subsidize transgender care. She said that "transgenderism is driven by unethical pharmaceutical companies enriching themselves with puberty blockers" and that this is child abuse. She cited to Swedish psychiatrist Dr. Christopher Gillberg, who has said that "pediatric transition is possibly one of the greatest scandals in medical history."

Paul Aarons, a physician, spoke next. He said he has transgender patients and friends. He said that he opposes the proposed change, because it "conflicts with the preponderance of medical science and practice and would do irreparable harm" to transgender Floridians of all ages. He said that the American Academy of Pediatrics and its Florida chapter have directly refuted the agency's report. Aarons said that, "contrary to an earlier comment, the Endocrine Society has stated, 'medical intervention for transgender youth and adults, including puberty suppression hormone therapy, and medically indicated surgery, has been established as their standard of care. Federal and private insurers should cover such interventions as prescribed by a physician.'" He said gender dysphoria is "very real" and that people should meet and speak to transgender individuals, which will help them realize that denial of care "at any age would be inhumane and a violation of human rights." He said that gender-affirming care is "generally accepted professional medical standards" and that this rule would put the health and lives of transgender people in danger. He said that "it feels like Medicaid is crossing into a political lane by seeking to preempt provider/patient/family decision-making." He said that, if the agency still wants to address this topic, they should "at least convene an appropriate panel of experts including transgender community members to inform yourselves and the public about the overwhelming evidence against denying coverage for gender affirming care."

A doctor on the panel then encouraged everyone to read the report and its attachments. He said that the report focuses on studies which have been brought up, and "specifically the flaws" in those studies. He also encouraged audience members not to interrupt when others are speaking. He went on to say that the Endocrine Society's 2017 guidelines "are guidelines, just that," and they "do not guarantee an outcome" and "do not establish a standard of care." He also referred to international reviews which "all came to the same conclusion" that "this should not be going on in minors at all," to which the audience applauded. He said that children need "strong psychological support" and that four decades of literature point to the "overwhelming probability of mental health problems after these childhood events" and "problems like autism spectrum disorder." He said that in other nations, having "psychological instability . . . blocks you from the transition pathway" and that "those things be taken care of first because transition simply won't fix them." He said that the report is a "very well-researched document" and addresses a lot of the concerns raised in comment letters.

Another panelist then referred everyone to Attachment C of the report and Dr. Hruz's *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*.

January Littlejohn, a mental health counselor, spoke next. Her child expressed that they were experiencing gender dysphoria in 2020, shortly after three of their friends had started identifying as transgender. She said that the middle school had "socially transitioned [her child] without

their knowledge or consent"[3] and that her child's "mental health spiraled." She said that she has worked with a psychologist to help address her child's low self-esteem and anxiety, and has "given [her child] more one-on-one time, in-person activities away from trans influences, limited [her child's] internet use, and declined to affirm [her child's] newly-chosen name and pronouns." She said that they set "appropriate boundaries" and allowed her child to choose hairstyle and clothing but "denied harmful requests such as breast binders, puberty blockers, cross-sex hormones, and surgeries." She said it was "clear from [their] conversations" that her child was uncomfortable with their developing body and had "an intense fear of being sexualized." Littlejohn said that her child was "filled with self-loathing and was in true emotional pain," but "had been led by peers and influencers to believe that gender was the source of [their] pain." She said that her child needed to be "remind[ed] that hormones and surgeries can never change [their] sex or resolve [their] issues." She said that she "shudder[s] to think what could have happened if [they] had affirmed [her child's] false identity and consented to medical treatment" as opposed to "lovingly affirm [her child] as [they are], beautifully unique and irreplaceable and undeniably female." She said that her child has "desisted and is on a path to self-love" but unfortunately gender dysphoric children are "being encouraged to activism peer pressure to disassociate from their bodies and to believe their body parts can be simply removed, modified, or replaced." Littlejohn said that "the irreversible consequences of medically transitioning, including loss of sexual and reproductive function, cannot be fully understood by children or teens who lack the necessary maturity or experience."

Kendra Barris, a mental health attorney, spoke next. She first addressed the comment about the lack of peer-reviewed standards of care, saying that this lack means that "a lot of people who are harmed or experience bad outcomes from these surgeries or other interventions have no ability to sue." She said that "they have had decades to create peer-reviewed standards of care and they have not," and she suspects that some people do not want to standards because it would open them up to lawsuits, which is not currently happening. She went on to say that "when you put a female on testosterone, within about five years [they are] going to have to have a hysterectomy," which for teens could mean a potential hysterectomy before the age of twenty. She said that "hysterectomy is correlated with negative mental health outcomes and cognitive decline" and that this is worse the earlier a hysterectomy is performed. She said that "essentially, the earlier you do the hysterectomy, the earlier the onset of dementia." She is "very concerned about" how in a few decades "we're going to have an absolute wave of young females, 40–50 years old, with early-onset cognitive decline" in assisted-living facilities. She said that "some people who are trans and have dementia forget that they're trans" and if they don't have written consent to continue their transition, they "might be cut off." She worries that "we have not considered all of the implications of this."

The next speaker was Nathan Bruemmer, Florida's LGBTQ Consumer Advocate. He opposed the proposed rule "on behalf of healthcare consumers," saying that consumers "must be provided with accurate information, education, choice, safety, representation, and regress." He said that

[3] Note that news organizations have reported that Ms. Littlejohn was aware of her child's choice to change names and pronouns at school and told the school she would not stop them from doing so. She later filed a lawsuit against the school. *See, e.g.*, Leyla Santiago, *Fact Check: Emails Show One of Desantis's Stories Backing the Rationale for So-Called 'Don't Say Gay' Law Didn't Happen as the Governor Says*, CNN Politics (Apr. 6, 2022), https://www.cnn.com/2022/04/06/politics/fact-check-desantis-dont-say-gay-family-narrative/index.html.

"documented, well-researched standards of care have been established, are based on a wide range of evidence, and conclude that gender-affirming medical care is medically necessary and safe and effective." In other words, "gender-affirming care *is* the standard of care." Bruemmer said that the proposed rule would "deny health care consumers . . . access to the standard of care." He said that agencies must defend the rights of all Floridians, including transgender Floridians, and that this includes the right to non-discriminatory healthcare coverage. He said we should work to increase access to healthcare, not lessen or remove it. Bruemmer said that he is "one of . . . tens of thousands of transgender Floridians" who have had access to gender-affirming care, and who are "happy, and successful, and thriving." He said that transgender Floridians "deserve the rights and benefits afforded to all."

The next speaker's name was inaudible, but he also spoke in support of the proposed rule. He told examples of his fifteen-year-old son making bad decisions, including speeding on his dirt bike and wanting to leave home, as proof that "these kids can['t] make a decision on what they want that's going to be with them for the rest of life." He said that the doctors who spoke previously "are despicable," "need to have their licenses taken away," and "are a disgrace to the human race."

A panelist thanked him for his comment and said, "we respect everybody's comments, including the doctors that you referenced."

Dottie McPherson spoke next on behalf of the Florida Federation of Republican Women. She said that even at the age of eighteen "children don't have the maturity to handle certain responsibilities given them" like driving and alcohol, and that "even older adults don't." She said that state programs include "programs for abused and neglected children, but not gender decisions." She urged the panel to "prevent funding the destruction of children's genitalia and hormonal balance." McPherson urged the panel to consider unintended consequences, such as "taxpayer money that will need to be used for lawsuits by those whose lives were ruined from surgeries that they got while they were immature or too young to understand," parents whose "parental rights were denied to protect their children's future." She said that "life isn't fair" and we have to "stop giving in to the 'poor pitiful me' syndrome." McPherson said that government "has no business funding these things."

Maria Caulkins spoke next in support of the proposed rule. She said that taxpayer money should not be spent on funding surgeries that are "unnecessarily and tremendously harmful." She said that there is "a war on our children" and that we need to "protect our children" and "support our governor" by being on the "right side" of this war.

James Caulkins also spoke in support of the rule, saying that we're "in a battle in this country." He said that the people of Florida "have spoken" by electing "the greatest governor in the United States," to which the audience cheered and applauded. Caulkins said that we "don't need this stuff, this evil, this Medicaid funding for transgender surgery" and that Florida should lead other states against "this evil."

The final speaker, whose name was also inaudible, spoke in support of the proposed rule. She said that, years ago, she was told by a doctor that she needed to undergo hormone therapy, but

she "saw the risks involved." She said that hormone therapy is an attempt to "prevent . . . natural things from occurring," such as menstruation, and we can't expect it not to have any problems. She cited to Bill Maher, who pointed out that transgender procedures were only occurring in major cities where "social engineering is happening and where people are being influenced" but not in the rest of the country. She lamented that she can't go to the media and say anything against transgender individuals because it will be "criticized and condemned" which "isn't fair." She said that "the government should not be involved in supporting any kind of procedure to these young kids."

A panelist thanked everyone for their comments and then clarified the purpose of the rule. He said that it is *not* "a ban on treatment for gender dysphoria," but rather lack of Medicaid coverage for services mentioned in the proposed rule. He also said that "there are other comprehensive coverage of services for gender dysphoria currently in the Florida Medicaid program" before reading some of those services (community-based services, psychiatric services, emergency services and inpatient services, and behavioral health services in schools).

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Hi (b)(6)

(b)(5); (b)(7)(C)

Please let us know if you would be available to join a call with the region on this matter.

Best, David

From: Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>
Sent: Tuesday, August 2, 2022 11:05 AM
To: (b)(6) (b)(6) (HHS/OCR) (b)(6) Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Kaplan, Amy (HHS/OCR) <Amy.Kaplan@HHS.GOV>
Cc: Smith, Marisa (HHS/OCR) <Marisa.Smith@HHS.GOV>; (b) (b)(6) (b)(6) (HHS/OCR)

(b)(6) Roman, David (OS/OCR) <David.Roman@hhs.gov>
Subject: RE: GAC Case Against Maryland Medicaid MCO

Hi Everyone:

(b)(5); (b)(7)(C)

Thanks

Alisha

From: (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, June 22, 2022 5:20 PM
To: Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>; Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Kaplan, Amy (HHS/OCR) <Amy.Kaplan@HHS.GOV>
Cc: Smith, Marisa (HHS/OCR) <Marisa.Smith@HHS.GOV>; (b) (b)(6) (b)(6) (HHS/OCR) (b)(6) Roman, David (OS/OCR) <David.Roman@hhs.gov>
Subject: RE: GAC Case Against Maryland Medicaid MCO

Hi all,

Thanks for meeting with us today. Below is some additional information that we discussed:

(b)(5); (b)(7)(C)

(b)(5); (b)(7)(C)

(b)(5); (b)(7)(C)

(b)(5); (b)(7)(C)

Thanks, (b)(6)

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, June 16, 2022 5:42 PM
To: Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>; Roman, David (OS/OCR) <David.Roman@hhs.gov>
Cc: Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Smith, Marisa (HHS/OCR) <Marisa.Smith@HHS.GOV>; (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: GAC Case Against Maryland Medicaid MCO

Hi Alisha,

Thanks for your patience. We have taken a look at your questions and think it's best to have a call to discuss. Are you able to propose a time next week, maybe Wednesday? From CRD, David, (b)(6) and I would participate.

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>
Sent: Thursday, June 9, 2022 3:39 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6) Roman, David (OS/OCR) <David.Roman@hhs.gov>
Cc: Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Smith, Marisa (HHS/OCR) <Marisa.Smith@HHS.GOV>
Subject: RE: GAC Case Against Maryland Medicaid MCO

Thanks. Will do!

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Thursday, June 9, 2022 3:39 PM
To: Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>; Roman, David (OS/OCR) <David.Roman@hhs.gov>
Cc: Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Smith, Marisa (HHS/OCR) <Marisa.Smith@HHS.GOV>
Subject: RE: GAC Case Against Maryland Medicaid MCO

Thanks, Alisha!

We're in the final push, but should be able to take a look and get back to you shortly. If you don't hear from us by next Thursday, please feel free to follow up. In the interim, can you please send to David for collaboration?

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Welch, Alisha (HHS/OCR) <Alisha.Welch@hhs.gov>
Sent: Thursday, June 9, 2022 3:25 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6) Roman, David (OS/OCR) <David.Roman@hhs.gov>
Cc: Rahn Ballay, Jamie (HHS/OCR) <Jamie.Rahn@hhs.gov>; Smith, Marisa (HHS/OCR) <Marisa.Smith@HHS.GOV>
Subject: GAC Case Against Maryland Medicaid MCO

Hi (b)(6) and David:

I hope all is well with you. I know you are likely busy with the final 1557 push, so no need to respond to this email until you have a chance to catch your breath

(b)(5); (b)(7)(C)

(b)(5); (b)(7)(C)

(b)(5); (b)(7)(C)

We would be happy to set up a time to discuss this complaint further

Thanks!

Alisha Welch
Acting Deputy Regional Manager
DHHS, Office for Civil Rights, Mid-Atlantic Region

801 Market Street, Suite 9300

Philadelphia, PA 19107

215-861-4439 (voice)

1-800-537-7697 (TTY)

215-861-4431 (fax)

please do not read, copy or forward this message. Please permanently delete all copies and any attachments and notify the sender immediately by reply email.

Sender:	Roman, David (OS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=USER5D5A5775 <David.Roman@hhs.gov>
Recipient:	(b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6) (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=e90ef156ed05483f959d8c4039d9b906(b)(6) (b)(6)
Sent Date:	2022/08/12 13:12:07
Delivered Date:	2022/08/12 13:12:21

Page 066

Withheld pursuant to exemption

(b)(5) ; (b)(7)(C)

of the Freedom of Information Act

Page 067

Withheld pursuant to exemption

(b)(5) ; (b)(7)(C)

of the Freedom of Information Act

Committee on Education and Labor

"Examining the Policies and Priorities of the U.S. Department of Health and Human Services"

Wednesday, April 6, 2022 9:00 a.m. (Eastern Time)

Questions for the Record for Secretary Xavier Becerra

(b)(5)

Page 069

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information Act

Page 070

Withheld pursuant to exemption

(b)(5)

of the Freedom of Information Act

From:	Seeger, Rachel (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=3090EF9B170D45969ADD4FF475A95583-RACHEL SEEG <Rachel.Seeger@hhs.gov>
To:	(b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-Dekervor, D (b)(6) Barron, Pamela (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=d55f83440f074842ac94e1f27f11fa9e-Barron, Pam <Pamela.Barron@hhs.gov>
Subject:	RE: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care
Date:	2022/02/22 14:57:58
Priority:	Normal
Type:	Note

Thanks, (b)(6)

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Tuesday, February 22, 2022 2:57 PM
To: Seeger, Rachel (HHS/OCR) <Rachel.Seeger@hhs.gov>; Barron, Pamela (HHS/OCR) <Pamela.Barron@hhs.gov>
Subject: RE: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care

Thanks so much, Rachel.

(b)(5)

Statement of Interest: https://www.justice.gov/file/1405411/download
Amicus: https://www.justice.gov/crt/case-document/file/1468236/download

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Seeger, Rachel (HHS/OCR) <Rachel.Seeger@hhs.gov>
Sent: Tuesday, February 22, 2022 2:54 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6) Barron, Pamela (HHS/OCR) <Pamela.Barron@hhs.gov>
Subject: FW: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care

For awareness. No action at this time.

From: Ladjevardian, Sima (HHS/IEA) <Sima.Ladjevardian@hhs.gov>
Sent: Tuesday, February 22, 2022 1:48 PM

To: Akpa, Stephanie (HHS/OCR) <Stephanie.Akpa@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>; Smith, Jessica (HHS/IEA) <Jessica.Smith@hhs.gov>
Cc: Pino, Lisa (HHS/OCR) <Lisa.Pino@hhs.gov>; Seeger, Rachel (HHS/OCR) <Rachel.Seeger@hhs.gov>
Subject: Re: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care

No real deadline. (b)(5)
(b)(5)
Thank you so much
Sima

Sima Ladjevardian, J.D.
She/Her
Regional Director, Region VI: AR, LA, NM, OK, TX
Office of the Secretary
US Department of Health and Human Services
Cell: (b)(6)

From: Akpa, Stephanie (HHS/OCR) <Stephanie.Akpa@hhs.gov>
Sent: Tuesday, February 22, 2022 12:46:21 PM
To: Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>; Ladjevardian, Sima (HHS/IEA) <Sima.Ladjevardian@hhs.gov>; Smith, Jessica (HHS/IEA) <Jessica.Smith@hhs.gov>
Cc: Pino, Lisa (HHS/OCR) <Lisa.Pino@hhs.gov>; Seeger, Rachel (HHS/OCR) <Rachel.Seeger@hhs.gov>
Subject: RE: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care

Hi Lee,

Thank you for flagging this! Looping in our director and comms guru. We'll take this back and get back to you. Is there a deadline?

Thank you,
Stephanie

From: Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Sent: Tuesday, February 22, 2022 1:36 PM
To: Ladjevardian, Sima (HHS/IEA) <Sima.Ladjevardian@hhs.gov>; Smith, Jessica (HHS/IEA) <Jessica.Smith@hhs.gov>
Cc: Akpa, Stephanie (HHS/OCR) <Stephanie.Akpa@hhs.gov>
Subject: RE: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care

Thanks, Sima. (b)(5)
(b)(5)

Hi Stephanie- I don't think we've had the chance to meet but I serve as Senior Advisor at the Office of Intergovernmental and External Affairs. Sima Ladjevardian is our new Regional

Director in Region 6, Dallas. She received the inquiry below regarding AG Paxton's recent interpretation of health care for transgender children. Is there anything that we can say in response?

Best,

Lee Stevens

Lee Stevens
Senior Advisor to the Director
Office of Intergovernmental and External Affairs
U.S. Department of Health and Human Services
Washington, DC 20201
(202) 401-5639

From: Ladjevardian, Sima (HHS/IEA) <Sima.Ladjevardian@hhs.gov>
Sent: Tuesday, February 22, 2022 1:14 PM
To: Smith, Jessica (HHS/IEA) <Jessica.Smith@hhs.gov>; Stevens, Lee (OS/IEA) <Lee.Stevens@hhs.gov>
Subject: Fwd: DMN Feb. 21 - Ken Paxton on Transgender Children Medical Care

Hi all
I was approached by the Legacy health. Centers (big FQHCs here) they are very worried about this
They are looking to us tohave a statement/ directive as to how this should be handled
Like saying this kind of care is actually healthcare.
Wanted to see who I should flag this for and talk to?
Thank you so much
Sima

Sima Ladjevardian, J.D.
She/Her
Regional Director, Region VI: AR, LA, NM, OK, TX
Office of the Secretary
US Department of Health and Human Services
Cell: (b)(6)

Texas Attorney General Ken Paxton: Health care for transgender children is abuse

- • Lauren McGaughy - The Dallas Morning News (TNS)

- • Feb 21, 2022 Updated 19 hrs ago

AUSTIN — Attorney General Ken Paxton has issued a new interpretation of state law that says medical care for transgender children is abuse, a dramatic change contrary to medical standards that could make Texas one of the most aggressive states in targeting trans youth access to health care.

On Monday, Paxton issued an opinion stating his office believes gender-affirming health care for transgender youth – including common treatments like hormone therapy and puberty blockers – is a form of child abuse. The move comes despite opposition from the top medical and child welfare groups, who for months have urged Paxton not to take this step.

"There is no doubt that these procedures are 'abuse' under Texas law, and thus must be halted," Paxton said in a news release. "The Texas Department of Family and Protective Services has a responsibility to act accordingly. I'll do everything I can to protect those who take advantage of and harm young Texans."

It's unclear what Paxton's opinion could mean for transgender children. Attorney general opinions do not have the force of law and are meant as written interpretations of current statute. Paxton issued his opinion after state Rep. Matt Krause, R-Fort Worth, asked him to weigh in on the issue.

Spokespeople for the Department of Family and Protective Services and Texas Health and Human Services said the agencies would be reviewing the opinion.

Paxton's opinion comes as Republican politicians, jockeying for power ahead of one of the most competitive re-election seasons in years, increasingly put transgender children under the spotlight.

Last year, GOP lawmakers tried and failed to change state law to ban gender-affirming care for transgender minors. In August, after pressure from Gov. Greg Abbott, the child protective services agency changed its definition of abuse to include transgender

"reassignment surgery" for minors and promised to investigate any allegations after Gov. Greg Abbott directed them to look into the issue.

In November 2021, a prominent Dallas-based clinic treating trans kids called Genecis stopped taking new patients.

Gender dysphoria is the feeling of discomfort or distress that can occur in people who identify as a gender that is different from the gender or sex assigned at birth, according to the Mayo Clinic.

For children who have not reached puberty, mental health care is the primary form of treatment for gender dysphoria. Best standards dictate that medical interventions like hormones should be explored only for youth who have experienced the onset of puberty and after undergoing mental health evaluation.

Surgery to treat gender dysphoria is not recommended until a patient has reached the legal age of maturity and lived continuously for at least a year in the gender role consistent with their gender identity, according to best practices set out by the World Professional Association for Transgender Health, or WPATH, the group that authors the standards of care for the health of gender-diverse people.

Limiting access to gender dysphoria treatment options such as puberty blockers would place Texas among a small number of states that have taken steps to cut transgender youth access to certain medical services. Last year, Tennessee passed a law banning hormone treatment for prepubescent minors.

Arkansas also passed a law to ban doctors from providing or referring minors to receive medical treatment for gender dysphoria. A federal judge put the law on hold last year while it is being challenged in the courts. Paxton and several other attorneys general recently filed an amicus brief supporting the Arkansas law and calling trans care "experimentation" on kids.

By contrast, major state and national medical groups have opposed limiting transgender kids' access to care.

The American Medical Association, American Psychiatric Association and American Academy of Pediatrics all support providing age appropriate, individualized care for children experiencing gender dysphoria.

Many of the state's largest health care and child advocacy groups have also repeatedly begged state agencies and elected officials to consider scientific evidence that age appropriate, individualized care for transgender children helps save lives, The Dallas Morning News has learned.

Just days after child protective services issued its new guidance in August, the Texas Pediatric Society sent the agency a letter urging it to make its decision based on science.

"Gender-affirming care is part of the comprehensive primary care we provide to our patients and should not be criminalized or stigmatized," Dr. Seth Kaplan, the society's then-president, wrote to DFPS Commissioner Jaime Masters Aug. 16 on behalf of its 4,600 pediatrician, pediatric subspecialist and medical student members.

The News obtained the Aug. 16 letter through a public records request.

Julia L. Lothrop, M.S.
Executive Officer
U.S. Department of Health and Human Services
Office of the Regional Director
1301 Young Street, Suite 1124
Dallas, Texas 75202
214.767.3190 Phone
214.767.3617 Fax
(b)(6) Cell

Sender: Seeger, Rachel (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=3090EF9B170D45969ADD4FF475A95583-RACHEL SEEG <Rachel.Seeger@hhs.gov>

Recipient: (b)(6) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) (b)(6)
Barron, Pamela (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=d55f83440f074842ac94e1f27f11fa9e-Barron, Pam <Pamela.Barron@hhs.gov>

Sent Date: 2022/02/22 14:57:57

Delivered Date: 2022/02/22 14:57:58

GOVERNOR GREG ABBOTT

February 22, 2022

The Honorable Jaime Masters
Commissioner
Texas Department of Family and Protective Services
701 West 51st Street
Austin, Texas 78751

Dear Commissioner Masters:

Consistent with our correspondence in August 2021, the Office of the Attorney General (OAG) has now confirmed in the enclosed opinion that a number of so-called "sex change" procedures constitute child abuse under existing Texas law. Because the Texas Department of Family and Protective Services (DFPS) is responsible for protecting children from abuse, I hereby direct your agency to conduct a prompt and thorough investigation of any reported instances of these abusive procedures in the State of Texas.

As OAG Opinion No. KP-0401 makes clear, it is already against the law to subject Texas children to a wide variety of elective procedures for gender transitioning, including reassignment surgeries that can cause sterilization, mastectomies, removals of otherwise healthy body parts, and administration of puberty-blocking drugs or supraphysiologic doses of testosterone or estrogen. *See* TEX. FAM. CODE § 261.001(1)(A)–(D) (defining "abuse"). Texas law imposes reporting requirements upon all licensed professionals who have direct contact with children who may be subject to such abuse, including doctors, nurses, and teachers, and provides criminal penalties for failure to report such child abuse. *See id.* §§ 261.101(b), 261.109(a-1). There are similar reporting requirements and criminal penalties for members of the general public. *See id.* §§ 261.101(a), 261.109(a).

Texas law also imposes a duty on DFPS to investigate the parents of a child who is subjected to these abusive gender-transitioning procedures, and on other state agencies to investigate licensed facilities where such procedures may occur. *See* TEX. FAM. CODE § 261.301(a)–(b). To protect Texas children from abuse, DFPS and all other state agencies must follow the law as explained in OAG Opinion No. KP-0401.

Sincerely,

Greg Abbott
Governor

GA:jsd

Enclosure

cc: Ms. Cecile Young, Executive Commissioner, Health and Human Services Commission
Mr. Stephen B. Carlton, Executive Director, Texas Medical Board
Ms. Katherine A. Thomas, Executive Director, Texas Board of Nursing
Dr. Tim Tucker, Executive Director, Texas State Board of Pharmacy
Mr. Darrell Spinks, Executive Director, Texas Behavioral Health Executive Council
Mr. Mike Morath, Commissioner, Texas Education Association
Ms. Cristina Galindo, Chair, Texas State Board of Educator Certification
Ms. Camille Cain, Executive Director, Texas Juvenile Justice Department

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 18, 2022

The Honorable Matt Krause
Chair, House Committee on General
Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. KP-0401

Re: Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

You ask whether the performance of certain medical and chemical procedures on children—several of which have the effect of sterilization—constitute child abuse.[1] You specifically ask about procedures falling under the broader category of "gender reassignment surgeries." Request Letter at 1. You state that such procedures typically are performed to "transition individuals with gender dysphoria to their desired gender," and you identify the following specific "sex-change procedures":

> (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue.

Id. at 1 (footnotes omitted). Additionally, you ask whether "providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility" constitutes child abuse. *See id.* at 1–2. You include the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males. *See id.*

[1] *See* Letter from Honorable Matt Krause, Chair, House Comm. on Gen. Investigating, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0426KP.pdf ("Request Letter"); *see also* Letter from Honorable Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Honorable Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.) (hereinafter "Commissioner's Letter").

You qualify your question with the following statement: "Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request." *Id.* at 2. In other words, in rare circumstances, some of the procedures you list are borne out of medical necessity. For example, a minor male with testicular cancer may need an orchiectomy. This opinion does not address or apply to medically necessary procedures.

I. Executive Summary

Based on the analysis herein, each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A).

- These procedures and treatments can "caus[e] or permit[] the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." *Id.* § 261.001(1)(B).

- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." *Id.* § 261.001(1)(C).

- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. *Id.* § 261.001(1)(D).

In addition to analysis under the Family Code, we discuss below the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards. Each of the procedures and treatments you ask about can constitute child abuse when performed on minor children.

II. Nature and context of the question presented

Forming the basis for your request, you contend that the "sex change" procedures and treatments you ask about are typically performed to transition individuals with gender dysphoria to their desired gender. *See* Request Letter at 1. The novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children. While you refer to these procedures as "sex changes," it is important to note that it remains medically impossible to truly change the sex of an individual because this is determined biologically at

conception. No doctor can replace a fully functioning male sex organ with a fully functioning female sex organ (or vice versa). In reality, these "sex change" procedures seek to destroy a fully functioning sex organ in order to cosmetically create the illusion of a sex change.

Beyond the obvious harm of permanently sterilizing a child, these procedures and treatments can cause side effects and harms beyond permanent infertility, including serious mental health effects, venous thrombosis/thromboembolism, increased risk of cardiovascular disease, weight gain, decreased libido, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease, benign pituitary prolactinoma, lowered and elevated triglycerides, increased homocysteine levels, hepatotoxicity, polycythemia, sleep apnea, insulin resistance, chronic pelvic pain, and increased cancer and stroke risk.[2]

While the spike in these procedures is a relatively recent development,[3] sterilization of minors and other vulnerable populations without clear consent is not a new phenomenon and has an unsettling history. Historically weaponized against minorities, sterilization procedures have harmed many vulnerable populations, such as African Americans, female minors, the disabled, and others.[4] These violations have been found to infringe upon the fundamental human right to procreate. Any discussion of sterilization procedures in the context of minor children must, accordingly, consider the fundamental right that is at stake: the right to procreate. Given the uniquely vulnerable nature of children, and the clear dangers of sterilization demonstrated throughout history, it is important to emphasize the crux of the question you present today—*whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse.*

The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures. The prevalence of gender dysphoria in children and adolescents has never been estimated, and there is no scientific consensus that these sterilizing procedures and treatments even serve to benefit minor children dealing with gender dysphoria. As stated by the Centers for Medicare and Medicaid Services, "There is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[5] Also, "several studies show a higher rate of regret at being sterilized among younger women than among those

---

[2]*See* Timothy Cavanaugh, M.D., *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf.

[3]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/ (demonstrating a spike in referrals to Gender Identify Development Services around the mid-2010s).

[4]Alexandra Stern, Ph.D., *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*, (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

[5]Centers for Medicare and Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016), http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

who were sterilized at a later age." 43 FED. REG. at 52,151, 52,152. This further indicates that minor children are not sufficiently mature to make informed decisions in this context.

There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention. "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. No studies to date have evaluated the natural course and rate of gender dysphoria resolution among the novel cohort presenting with adolescent-onset gender dysphoria."[6] One of the few relevant studies monitored transitioned individuals for 30 years. It found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established.[7] The lack of evidence in this field is why the Centers for Medicare & Medicaid Services rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration. Similarly, the World Professional Association for Transgender Health states that with respect to irreversible procedures, genital surgery should not be carried out until patients reach the legal age of majority to give consent for medical procedures in a given country.[8]

Generally, the age of majority is eighteen in Texas. TEX. CIV. PRAC. & REM. CODE § 129.001. With respect to consent to sterilization procedures, Medicaid sets the age threshold even higher, at twenty-one years old. Children and adolescents are promised relief and asked to "consent" to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do, and when they are considered by the State in most regards to be without legal capacity to consent, contract, vote, or otherwise. Legal and ethics scholars have suggested that it is particularly unethical to radically intervene in the normal physical development of a child to "affirm" a "gender identity" that is at odds with bodily sex.[9]

State and federal governments have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Thus, states routinely regulate the medical profession and routinely update their regulations as new trends arise and new evidence becomes available. In the opioid context, for instance, states responded to an epidemic caused largely by pharmaceutical companies and medical professionals. Dismissing as "opioidphobic" any concern that "raising pain treatment to a 'patients' rights' issue could lead to overreliance on opioids," these experts created new pain standards and assured doctors that

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[6]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/.

[7]*See* Cecilia Dhejne, et al., *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE, Issue 2, 5 (Feb. 22, 2011) (19 times the expected norm overall (Table 2), and 40 times the norm for biological females (Table s1)), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885.

[8]WORLD PROFESSIONAL ASS'N FOR TRANSGENDER HEALTH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* at 59 (7th ed. 2012), available at https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

[9]Ryan T. Anderson & Robert P. George, Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited, PUBLIC DISCOURSE: THE JOURNAL OF THE WITHERSPOON INSTITUTE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

prescribing more opioids was largely risk free.[10] *Id.* As we know now, the results were—indeed, *are*—nothing short of tragic.[11] There is always the potential for novel medical determinations to promote purported remedies that may not improve patient outcomes and can even result in tragic harms. The same potential for harm exists for minors who have engaged in the type of procedures or treatments above.

The State's power is arguably at its zenith when it comes to protecting children. In the Supreme Court's words, that is due to "the peculiar vulnerability of children." *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth."). The Supreme Court has explained that children's "inability to make critical decisions in an informed, mature manner" makes legislation to protect them particularly appropriate. *Bellotti*, 443 U.S. at 634. The procedures that you ask about impose significant and irreversible effects on children, and we therefore address them with extreme caution, mindful of the State's duty to protect its children. *See generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), *cert. denied*, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*. In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's *parens patriae* interest in preserving and promoting the welfare of the child.") (citation omitted).

III. To the extent that these procedures and treatments could result in sterilization, they would deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.

A. The procedures you describe can and do cause sterilization.

The surgical and chemical procedures you ask about can and do cause sterilization.[12] Similarly, the treatments you ask about often involve puberty-blocking medications. Such medications suppress the body's production of estrogen or testosterone to prevent puberty and are being used in this context to pause the sexual development of a person that occurs during puberty. The use of these chemical procedures for this purpose is not approved by the federal Food and Drug Administration and is considered an "off-label" use of the medications. These chemical procedures prevent a person's body from developing the capability to procreate. There is insufficient medical evidence available to demonstrate that discontinuing the medication resumes a normal puberty process. *See generally Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing *Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274,

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[10] *See* David W. Baker, *The Joint Commission's Pain Standards: Origins and Evolution* 4 (May 5, 2017) (footnotes omitted), https://perma.cc/RZ42-YNRC ("[N]o large national studies were conducted to examine whether the standards improved pain assessment or control.").

[11] *See generally* U.S. HEALTH & HUMAN SERVS., WHAT IS THE U.S. OPIOID EPIDEMIC?, https://www.hhs.gov/opioids/about-the-epidemic/index html.

[12] *See* Philip J. Cheng, *Fertility Concerns of the Transgender Patient*, TRANSL ANDROL UROL. 2019;9(3):209-218 (explaining that hysterectomy, oophorectomy, and orchiectomy "results in permanent sterility"), https://www ncbi nlm nih.gov/pmc/articles/PMC6626312/.

¶ 134 (Dec. 1, 2020) (referring to *Bell's* conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental). Thus, because the procedures you inquire about can and do result in sterilization, they implicate a minor child's constitutional right to procreate.

B. The United States Constitution protects a fundamental right to procreation.

The United States Supreme Court recognizes that the right to procreate is a fundamental right under the Fourteenth Amendment. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Almost a century ago, the Court explained the unique concerns sterilization poses respecting this fundamental right:

> The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.

Id. To the extent the procedures you describe cause permanent damage to reproductive organs and functions of a child before that child has the legal capacity to consent, they unlawfully violate the child's constitutional right to procreate. *See generally* 43 FED. REG. at 52,146–52,152 (discussing ripeness for coercion and regret rates among minor children).

C. Because children are legally incompetent to consent to sterilization, procedures and treatments that result in a child's sterilization are unauthorized and infringe on the child's fundamental right to procreate.

Under Texas law, a minor is a person under eighteen years of age that has never been married and never declared an adult by a court. *See* TEX. CIV. PRAC. & REM. CODE § 129.001; TEX. FAM. CODE §§ 1.104, 101.003 (including a minor on active duty in the military, one who does not live with a parent or guardian and who manages their own financial affairs, among others). State law recognizes seven instances in which a minor can consent to certain types of medical treatment on their own. *See id.* § 32.003. None of the express provisions relating to a minor's ability to consent to medical treatment addresses consent to the procedures used for "gender-affirming" treatment. *See generally id.*

The lack of authority of a minor to consent to an irreversible sterilization procedure is consistent with other law. The federal Medicaid program does not allow for parental consent, has established a minimum age of 21 for consent to sterilization procedures, and imposes detailed requirements for obtaining that consent. 42 C.F.R. §§ 441.253(a); 441.258 ("Consent form requirements"). Federal Medicaid funds may not be used for any sterilization without complying with the consent requirements, meaning a doctor may not be reimbursed for sterilization procedures performed on minors. *Id.* § 441.256(a).

The higher age limit for sterilization procedures was implemented due to a number of special concerns, including historical instances of forced sterilization. *See* 43 FED. REG. 52146, 52148. "[M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In addition, the 21-year minimum age-of-consent rule accounted for concerns that minors were more susceptible to coercion than those over 21 and that younger women had higher rates of regret for sterilization than those who were sterilized at a later age. 43 FED. REG. at 52,151 (pointing to comments suggesting that "persons under 21 are more susceptible to coercion than those over 21 and are more likely to lack the maturity to make an informed decision" and acknowledging "these considerations favor protecting such individuals by limiting their access to the procedure"); *see id.* at 52,151–52,152 (pointing to "several studies [that] show a higher rate of regret at being sterilized among younger women than among those who were sterilized at a later age").

Regarding parental consent, Texas law generally recognizes a parent's right to consent to a child's medical care. TEX. FAM. CODE § 151.001(a)(6) ("A parent of a child has the following rights and duties: . . . (6) the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment . . ."). But this general right to consent to certain medically necessary procedures does not extend to elective (not medically necessary) procedures and treatments that infringe upon a minor child's constitutional right to procreate. Indeed, courts have analyzed the imposition of unnecessary medical procedures upon children in similar circumstances in the past to determine whether doing so constitutes child abuse.

One such situation that the law has addressed is often referred to as "Munchausen by proxy" or "factitious disorder imposed on another":

> [A] psychological disorder that is characterized by the intentional feigning, exaggeration, or induction of the symptoms of a disease or injury in oneself or another and that is accompanied by the seeking of excessive medical care from various doctors and medical facilities typically resulting in multiple diagnostic tests, treatments, procedures, and hospitalizations. Unlike the malingerer, who consciously induces symptoms to obtain something of value, the patient with a factitious disorder consciously produces symptoms for unconscious reasons, without identifiable gain.[13]

In situations such as this, an individual intentionally seeks to procure—often by deceptive means, such as exaggeration—unnecessary medical procedures or treatments either for themselves or others, usually their children. In Texas, courts have found that these "Munchausen by proxy" situations can constitute child abuse. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure

[13] *Factitious disorder*, MERRIAM-WEBSTER.COM DICTIONARY, https://www merriam-webster.com/dictionary/factitious%20disorder.

may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code).[14]

In the context of elective sex change procedures for minors, the Legislature has not provided any avenue for parental consent, and no judicial avenue exists for the child to proceed with these procedures and treatments without parental consent. By comparison, Texas law respecting abortion requires parental consent and, in extenuating circumstances, permits non-parental consent for a minor to obtain an abortion. TEX. OCC. CODE § 164.052(19) (requiring written consent of a child's parent before a physician may perform an abortion on an unemancipated minor); TEX. FAM. CODE § 33.003 (authorizing judicial approval of a minor's abortion without parental consent in limited circumstances). But the Texas Legislature has not decided to make those same allowances for consent to sterilization, and thus a parent cannot consent to sterilization procedures or treatments that result in the permanent deprivation of a minor child's constitutional right to procreate.[15] Thus, no avenue exists for a child to consent to or obtain consent for an elective procedure or treatment that causes sterilization.

IV. The procedures and treatments you describe can constitute child abuse under the Family Code.

Having established the legal and cultural context of this opinion request, we now consider whether these procedures and treatments qualify as child abuse under the Family Code. *See* Request Letter at 1. Where, as a factual matter, one of these procedures or treatments cannot result in sterilization, a court would have to go through the process of evaluating, on a case-by-case basis, whether that procedure violates any of the provisions of the Family Code—and whether the procedure or treatment poses a similar threat or likelihood of substantial physical and emotional harm. Thus, where a factual scenario involving non-medically necessary, gender-based procedures or treatments on a minor causes or threatens to cause harm or irreparable harm[16] to the child—comparable to instances of Munchausen syndrome by proxy or criminal injury to a child—or demonstrates a lack of consent, etc., a court could find such procedures to constitute child abuse under section 261.001.

A. The Texas Legislature defines child abuse broadly.

Family Code chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* TEX. FAM. CODE §§ 261.001–.505; *see also* TEX. PENAL CODE § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. TEX. FAM. CODE § 261.001(1); *see also In re Interest of*

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[14] *See also* Tex. Dep't of Fam. & Protective Servs., Tex. Practice Guide for Child Protective Servs. Att'ys, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp.

[15] Federal Medicaid programs will not reimburse for these types of procedures on minors, regardless of whether the child or parent consents, because of the numerous concerns outlined in the Federal Register provisions discussed above. *See* 43 FED. REG. at 52,146–52,159.

[16] For example, a non-medically necessary procedure or treatment that seeks to alter a minor female's breasts in such a way that would or could prevent that minor female from having the ability to breastfeed her eventual children likely causes irreparable harm and could form the basis for a finding of child abuse.

S.M.R., 434 S.W.3d 576, 583 (Tex. 2014). Of course, this broad definition of abuse would apply to and include criminal acts against children, such as "female genital mutilation"[17] or "injury to a child."[18]

Your questions implicate several components of section 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Offering some clarity to the scope of "abuse" under subsection 261.001(1), the Texas Department of Family and Protective Services ("Department") adopted rules giving meaning to the key terms and phrases used in the definition. The Department acknowledges that emotional abuse is a subset of abuse that includes "[m]ental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." 40 TEX. ADMIN. CODE § 707.453(a) (Tex. Dept. of Fam. & Protective Servs., What is Emotional Abuse?). The Department's rules provide that "[m]ental or emotional injury" means

> [t]hat a child of any age experiences significant or serious negative effects on intellectual or psychological development or functioning. . . . and exhibits behaviors indicative of observable and material impairment . . . . mean[ing] discernable and substantial damage or deterioration to a child's emotional, social, and cognitive development.

Id. § 707.453(b)(1)–(2).

With respect to physical injuries, the Department further clarified the meaning of the phrase "[p]hysical injury that results in substantial harm to the child," explaining that it means in relevant part a

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[17]A person commits an offense if the person: (1) knowingly circumcises, excises, or infibulates any part of the labia majora or labia minora or clitoris of another person who is younger than 18 years of age; (2) is a parent or legal guardian of another person who is younger than 18 years of age and knowingly consents to or permits an act described by Subdivision (1) to be performed on that person; or (3) knowingly transports or facilitates the transportation of another person who is younger than 18 years of age within this state or from this state for the purpose of having an act described by Subdivision (1) performed on that person. TEX. HEALTH & SAFETY CODE § 167.001.

[18]A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual: (1) serious bodily injury; (2) serious mental deficiency, impairment, or injury; or (3) bodily injury. TEX. PENAL CODE § 22.04.

> real and significant physical injury or damage to a child that includes but is not limited to . . . [a]ny of the following, if caused by an action of the alleged perpetrator directed toward the alleged victim: . . . *impairment of or injury to any bodily organ or function*; . . . .

Id. § 707.455(b)(2)(A) (emphasis added). The Department's rules also define a "[g]enuine threat of substantial harm from physical injury" to include the

> *declaring or exhibiting the intent or determination to inflict real and significant physical injury or damage to a child.* The declaration or exhibition does not require actual physical contact or injury.

Id. § 707.455(b)(1) (emphasis added).

Subsection 261.001(1) and these rules define "abuse" broadly to include mental or emotional injury in addition to a physical injury. To the extent the specific procedures about which you ask may cause mental or emotional injury or physical injury within these provisions, they constitute abuse.

Further, the Legislature has explicitly defined "female genital mutilation" and made such act a state jail felony. *See* TEX. HEALTH & SAFETY CODE § 167.001(a)–(b). While the Legislature has not elsewhere defined the phrase "genital mutilation", nor specifically for males of any age,[19] the Legislature's criminalization of a particular type of genital mutilation supports an argument that analogous procedures that include genital mutilation—potentially including gender reassignment surgeries—could constitute "abuse" under the Family Code's broad and non-exhaustive examples of child abuse or neglect.[20] *See* TEX. FAM. CODE § 261.001(1)(A)–(M); *see generally* Commissioner's Letter at 1 (concluding that genital "mutilation may cause a genuine threat of substantial harm from physical injury to the child"). Thus, many of the procedures and treatments you ask about can constitute "female genital mutilation," a standalone criminal act. But even where these procedures and treatments may not constitute "female genital mutilation" under Texas law, a court could still find that these procedures and treatments constitute child abuse under section 261.001 of the Family Code.

B. Each of these procedures and treatments can constitute abuse under Texas Family Code § 261.001(1)(A), (B), (C), or (D).

The Texas Family Code is clear—causing or permitting substantial harm to the child or the child's growth and development is child abuse. Courts have held that an unnecessary surgical

[19]Your letter does not mention nor request an analysis under federal law. However, under federal law, there are at least two definitions of female genital mutilation, 8 U.S.C § 1374 and 18 U.S.C. § 116. For purposes of this opinion, we have not considered federal statutes, nor have we undertaken any analysis under state or federal constitutions beyond that included here.

[20]The Eighty-seventh Legislature considered multiple bills that would have amended Family Code subsection 261.001(1) to expressly include in the definition of abuse the performing of surgery or other medical procedures on a child for the purpose of gender transitioning or gender reassignment. Those bills did not pass. *See, e.g.*, Tex. H.B. 22, 87th Leg., 3d C.S. (2021).

procedure that removes a healthy body part from a child can constitute a real and significant injury or damage to the child. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code). The *Williamson* case involved a "victim of medical child abuse, sometimes referred to as Munchausen Syndrome by Proxy." *Id.* at 5. Munchausen syndrome by proxy is "where an alleged perpetrator . . . attempts to gain medical procedures and issues for [their] child for secondary gain for themselves . . . . [A]s a result, the children are subjected to multiple diagnostic tests, therapeutic procedures, sometimes operative procedures, in order to treat things that aren't really there." *Williamson*, 356 S.W.3d at 11. In the *Williamson* case, the abuse was perpetrated on the child when he was five and six years old by his mother. *Id.* The evidence showed that two surgeries performed on the child "were not medically necessary and that [his mother] knowingly and intentionally caused the unnecessary procedures to be performed by fabricating, exaggerating, and inducing the symptoms leading to the surgeries." *Id.*

Similarly, in *Austin v. State*, a court of appeals upheld the conviction for felony injury of a child of a mother suffering from Munchausen syndrome by proxy who injected her son with insulin. *See* 222 S.W.3d 801, 804 (Tex. App.—Austin 2007, pet. ref'd); *see also In re McCabe*, 580 S.E.2d 69, 73 (N.C. Ct. App. 2003) (concluding that abuse through Munchausen syndrome by proxy was abuse under state statute defining abuse in a similar manner as chapter 261); *Matter of Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993), *aff'd sub nom. Matter of Suffolk Cnty. Dep't of Soc. Servs on Behalf of Aaron S.*, 626 N.Y.S.2d 227 (App. Div. 1995) (finding that a mother neglected her son by subjecting him to a continuous course of medical treatment for condition which he did not have and that he was a neglected child under state statute governing abuse of a child). In guidance documents published for its child protective services attorneys, the Texas Department of Family and Protective Services explains that "Munchausen by proxy syndrome is relatively rare, but when it occurs, it is frequently a basis for a finding of child abuse."[21] Whether motivated by Munchausen syndrome by proxy or otherwise, it is clear that unnecessary medical treatment inflicted on a child by a parent can constitute child abuse under the Family Code.

By definition, procedures and treatments resulting in sterilization cause "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child" by surgically altering key physical body parts of the child in ways that render entire body parts, organs, and the entire reproductive system of the child physically incapable of functioning. Thus, such procedures and treatments can constitute child abuse under section 261.001(1)(C). Even where the procedure or treatment does not involve the physical removal or alteration of a child's reproductive organs (*i.e.* puberty blockers), these procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning" by subjecting a child to the mental and emotional injury associated with lifelong sterilization—an impairment to

[21] TEX. DEP'T OF FAM. & PROTECTIVE SERVS., TEX. PRACTICE GUIDE FOR CHILD PROTECTIVE SERVS. ATT'YS, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp (citing *Reid v. State*, 964 S.W.2d 723 (Tex. App.—Amarillo 1998, pet. ref'd) (mem. op.) (expert testimony admitted regarding general acceptance of Munchausen diagnosis as a form of child abuse)).

one's growth and development. Therefore, a court could find these procedures and treatments to be child abuse under section 261.001(1)(A). Further, attempts by a parent to consent to these procedures and treatments on behalf of their child may, if successful, "cause or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning[,]" and could be child abuse under section 261.001(1)(B). Additionally, the failure to stop a doctor or another parent from conducting these treatments and procedures on a minor child can constitute a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" and this "failure to make a reasonable effort to prevent" can also constitute child abuse under section 261.001(1)(D). Any person that conducts or facilitates these procedures or treatments could be engaged in child abuse, whether that be parents, doctors, counselors, etc.

It is important to note that anyone who has "a reasonable cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report" as described in the Family Code. TEX. FAM. CODE § 261.101(a). Further, "[i]f a professional has reasonable cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has reasonable cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first has reasonable cause to believe that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code." TEX. FAM. CODE § 261.101(b). The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers. *Id.* A failure to report under these circumstances is a criminal offense. TEX. FAM. CODE § 261.109(a).

SUMMARY

Each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

When considering questions of child abuse, a court would likely consider the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards.

Very truly yours,

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Subject: Transgenderism's lies have a cost

Date: 2022/06/15 16:58:47

Priority: Normal

Type: Note

FYI

The Heritage Foundation has published a lengthy report on "gender-affirming care," i.e. hormonal and medical interventions for gender-confused persons, and its effect on suicide rates. The study found that, contrary to what gender ideologues claim, providing children and adolescents with easy access to puberty blockers and other cross-sex treatments does not reduce these youths' chances of suicide. In fact, such interventions might actually *increase* the likeliness of suicidal thoughts and attempts among young adults, accordin

The study is important for a number of reasons. First, it offers a good summary of the many methodological problems with past studies that endorsed gender-affirming care for minors. Most, if not all, of these past studies, for example, relied upon surveys of trans-identifying patients recruited by LGBT activist organizations, and few included gender-dysphoric patients whose problems were resolved without medical intervention. That's a major problem, considering more than 70% of all minors who struggle with gender dysphoria end up growing out of it naturally.

Moreover, not one study that supported gender-affirming care could point to a statistically significant control group against which to test its findings. For example, one of the most frequently cited studies by gender ideologues, the Tordoff study, attempted to provide a control group of children who were not given access to medical intervention, only to have 80% of the control patients leave before the study had ended. As independent journalist Jesse Singal noted, the study's authors "offer no explanation" as to why the vast majority of their untreated control group left prematurely and "little reason for us to trust that any observed differences between the groups are attributable to accessing [gender-affirming care] rather than any of a host of other potential confounding factors."

Another flaw in pro-medical intervention studies is that they fail to account for the fact that gender-confused persons seeking medical and hormonal treatment have to be deemed "psychologically stable" first. In other words, those suffering from suicidal thoughts are more likely to be denied treatment in the first place on account of their mental state. And past studies made no attempt to determine whether suicidal patients who were denied care were suicidal beforehand or whether their suicidal ideation was directly the result of being denied care.

Heritage's study goes on to argue that giving gender-confused children and young adults access to hormonal and medical intervention actually worsens their mental health. In states with provisions granting minors access to these interventions without parental consent, suicide rates among young people are 14% higher than in states where consent is required or these interventions are banned altogether, the report found.

To be sure, Heritage's study isn't perfect as far as methodology goes. But no study on this issue will be as long as our top medical and academic institutions refuse to subject cross-sex treatments to large-scale, randomized, controlled trials.

Heritage's study, however, is still much more reliable than anything else that's come before it, simply because it's rooted in common sense. Gender ideology holding that a person can switch genders and become something they are not is an impossible premise for which there is no solution. It is physically impossible for a man to become a woman — all he can hope to do is look a little bit more like one. So to sell "gender reassignment" procedures and hormonal treatment as the be-all-end-all solution to gender dysphoria is to sell a lie.

Gender ideologues are deluding young adults into believing that these treatments will take away the anxiety and confusion they feel. But no matter how many procedures one undergoes, no matter how many rounds of hormonal therapy are prescribed, the fact remains that a woman will always be a woman, and a man will always be a man. No wonder, then, that gender-confused persons who undergo experimental interventions in the hopes that this reality will have changed are struck by despair and hopelessness when they realize it has not.

The effort to deny biological reality is doing irreversible harm to people's bodies and minds. It is not compassionate it's cruel. And as Heritage's study shows, its consequences are all too often fatal.

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BACKGROUNDER
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Puberty Blockers, Cross-Sex Hormones, and Youth Suicide

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KEY TAKEAWAYS

U.S. policymakers are seeking to make it easier for minors to access puberty blockers and cross-sex hormones based on the claim that doing so reduces suicide risk.

Studies finding that "gender-affirming" interventions prevent suicide fail to show a causal relationship and have been poorly executed.

A superior research design shows that easing access to puberty blockers and cross-sex hormones by minors without parental consent increases suicide rates.

Adolescents who are confused about their gender suffer from an abnormally high suicide rate.[1] Though research demonstrates that gender confusion generally resolves itself without medical intervention,[2] some educators and medical professionals encourage teens, and even pre-teens, to take puberty blockers or cross-sex hormones so that their secondary sex characteristics, such as body and facial hair, breast tissue, muscular build, and fat composition, align more closely with the gender with which they identify.[3] While the World Professional Association for Transgender Health (WPATH) acknowledges that these interventions can have significant complications, it warns that delaying intervention also has serious risks:

> Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an

This paper, in its entirety, can be found at **http://report.heritage.org/bg3712**

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> appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.[4]

Other advocates, members of the media, and even White House staff invoke scientific authority to assert that cross-sex medical interventions reduce the risk of suicide. Sarah Harte, director for the Washington, DC, branch of an organization that provides medical intervention and support for youth called The Dorm, stated with confidence that "[l]aws and systems barring gender-affirming healthcare will contribute to higher rates of significant mental health problems, including deaths by suicide."[5] The CEO of The Trevor Project, Amit Paley, said, "It's clear that gender-affirming care has the potential to reduce rates of depression and suicide attempts."[6]

In an opinion piece in *The Washington Post*, University of Virginia Law School professors Anne Coughlin and Naomi Cahn claimed that cross-sex medication "has been shown to reduce the risk of depression and suicide for transgender youth," and that "banning it creates an excruciating conflict for parents, as the steps they take to preserve their children's lives may lead the state to investigate and punish them."[7] Even former White House press secretary Jen Psaki referred to such medical interventions as "medically necessary, lifesaving healthcare for [kids]."[8]

The danger of adolescents committing suicide if they do not receive these medical interventions is thought to be so urgent that the Biden Administration recently issued a statement "confirming the positive impact of gender affirming care on youth mental health," while referencing "the evidence behind the positive effects of gender affirming care."[9] A number of states have also considered or enacted legislation making it easier for minors to access cross-sex interventions without their parents' knowledge or consent. For example, California recently enacted a new law, AB 1184, to prevent insurance companies from notifying parents if children on their policies receive "sensitive services," which were defined to include "gender affirming care."[10]

However, young people may also experience significant and irreversible harms from such medical interventions.[11] This *Backgrounder* reviews existing research on the relationship between cross-sex interventions and suicide, and then presents a new empirical analysis that examines whether easing access by adolescents to these interventions is likely to result in fewer adolescent suicides. The new analysis presented here finds that the existing literature on this topic suffers from a series of weaknesses that

prevent researchers from being able to draw credible causal conclusions about a relationship between medical interventions and suicide. Using a superior research design, the new analysis finds that increasing minors' access to cross-sex interventions is associated with a significant increase in the adolescent suicide rate. Rather than facilitating access by minors to these medical interventions without parental consent, states should be pursuing policies that strengthen parental involvement in these important decisions with life-long implications for their children.

The Context

Around 1990, some doctors in the Netherlands began to use drugs designed to delay the onset of puberty in teenagers who were confused about their gender.[12] Puberty-blocking therapies, such as gonadotropin-releasing hormone analogues, were meant to prevent children entering puberty from developing the secondary sex characteristics, such as facial hair for men or breasts for women, if those features did not align with the gender with which they identified. Puberty blockers would be followed by the use of sex hormones, such as testosterone, for girls who identify as male, and estrogen for boys who identify as female, so that they could develop secondary sex characteristics that were associated with the sex that they identified with.[13]

This treatment protocol of puberty blockers followed by cross-sex hormones among adolescents did not exist in the United States prior to 2007 and was extremely rare before 2010. Cross-sex hormones were available as a medical intervention for adolescents before 2010, but their use was extremely limited. Starting in 2010, however, the use of both puberty blockers and cross-sex hormones for adolescents who identified as transgender rose dramatically and was widely available by 2015.

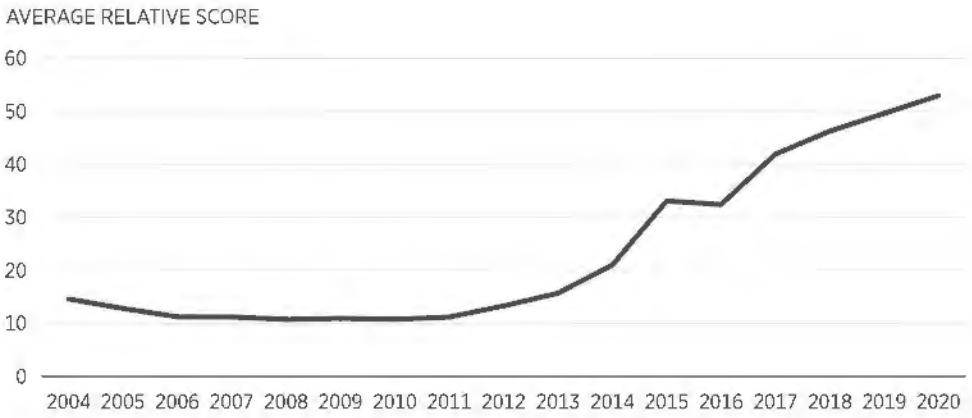
Precise data are not available on how often puberty blockers and cross-sex hormones have been given to teenagers over time in the United States, but it is possible to track a proxy for these interventions. Google Trends provides data on the relative frequency that terms have been used for searches since 2004. A score of 100 in Google Trends indicates the peak frequency for the term. Before August 2007, Google Trends reports a 0 for the term "puberty blockers," meaning that it was searched so infrequently in the U.S. that "there was not enough data for this term." The term "puberty blockers" did not average 5, or one-twentieth of its peak popularity, in any year before 2015.[14]

The average of the Google Trends scores for the terms, "puberty blockers," "transgender," "gender identity disorder," and "gender dysphoria," yields a reasonable proxy for how common cross-sex interventions have been over

CHART 1

Google Search Terms

Google Trends scores for the terms "puberty blockers," "transgender," "gender identity disorder," and "gender dysphoria," have been increasing since 2010.



SOURCE: Authors' calculations based on data from Google Trends, https://trends.google.com/trends/?geo=US (accessed April 20, 2022). For more information, see footnotes 17 and 18 in this *Backgrounder*.

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time.[15] As shown in Chart 1, these four terms were searched infrequently until about 2015, when there was a dramatic increase that continued through the end of 2020. This picture is consistent with anecdotal reports of how the use of puberty blockers and cross-sex hormones only became widely available in the past several years.

There is also a lack of precise information on where cross-sex medical interventions are more readily available to adolescents. A reasonable proxy for that data is to identify the states that have a legal provision allowing minors to access routine health care without the consent of their parents or guardian, at least under some circumstances. In states that have those provisions, puberty blockers and cross-sex hormones should be more easily available to teenagers.

The organization SchoolHouse Connection tracks state laws covering the ability of minors to access medical care without their parents' consent as part of its advocacy on behalf of homeless children.[16] SchoolHouse Connection documents that 33 states and the District of Columbia have some

legal provisions that allow minors to obtain routine health care without parental consent.[17] Seventeen states have no such provisions.

In states that do have such legal provisions, it is possible for adolescents to obtain puberty blockers and cross-sex hormones, at least under some circumstances, as those medical interventions have come into broader use for youth who identify as transgender.[18] In states without such legal provisions, there is no regular process that allows adolescents to obtain puberty blockers or cross-sex hormones without their parents' consent.

The conditions under which minors can access routine health care without parental consent are extremely limited in some states. For example, in Arizona a minor must be legally married, or documented as homeless, in order to access routine health care without parental consent.[19] In other states, such as Minnesota, minors can obtain routine health care without parental consent if they live separately from their parents, regardless of the duration of that separation, and manage their own finances, regardless of their source of income.[20] In other states, such as Alabama, Louisiana, and Oregon, there only appears to be a minimum age or a required determination by the health care provider that the minor is mentally competent to obtain health care without parental consent.[21]

There is no obvious geographic, demographic, or partisan pattern to whether states have these provisions. As seen in Appendix Table 1, states without a provision are Connecticut, Georgia, Iowa, Kentucky, Michigan, Mississippi, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, South Dakota, Tennessee, Vermont, West Virginia, and Wisconsin. The states with a provision are similarly diverse and settled on their legal arrangements long ago for reasons unrelated to the transgender issue.[22]

Prior Research

The effects of puberty blockers and cross-sex hormones as a medical intervention for adolescents who identify as transgender have never been subjected to a large-scale randomized controlled trial (RCT), like the kind that is typically required for approval of new medications.[23] Puberty blockers and sex hormones had been developed originally for other purposes. Puberty blockers were originally designed to delay precocious puberty among very young children who began puberty well before their peers. Sex hormones were developed primarily to treat people who were unable to produce enough of the hormones of their biological sex. These were the uses for which these drugs were originally tested and approved. These drugs have been prescribed for young people wishing to change their secondary sex

characteristics without undergoing testing and formal approval for these new uses. The lack of any experimental evidence of the effects of these medical interventions prevents the gold-standard research one would normally expect in order to isolate the causal effects of these interventions.[24]

The use of puberty blockers and sex hormones to address gender issues is also relatively recent, with widespread adoption occurring only within the past few years.[25] The fact that randomized experiments were not required for this use of puberty blockers and sex hormones, and that this novel use of these drugs is relatively recent, means that only a handful of studies examine their effects, and all these studies use inferior correlational research designs.

The main defect of studies relying on correlational research designs is that they are unable to determine with confidence whether any relationships between receiving these drugs and later health outcomes are causal. That is, one can never know with confidence whether the drugs cause those outcomes, or whether other factors that make people more likely to receive the drugs were the causes. This inherent weakness in correlational research is precisely why regulators, such as the U.S. Food and Drug Administration, typically require randomized experiments before approving a drug.[26] In an experiment, the only thing that determines whether people receive the medical intervention is chance, so any differences in outcomes between those who did and did not get the treatment would have to be caused by the intervention and not another factor.

This weakness of correlational research designs can be illustrated by examining one of the most prominent studies claiming to find that adolescents who receive cross-sex hormones have a lower risk of suicide.[27] That study, led by Jack Turhan of Stanford Medical School and published in *PLOS ONE* in 2022, examines the results of a 2015 survey of more than 27,000 American adults who identify as transgender. The survey was not meant to be representative of all such adults because its participants were recruited as a convenience sample, largely through transgender support groups. Subjects were asked whether they had ever sought cross-sex hormones, and then whether they had ever received them. Respondents who never sought cross-sex hormones were excluded from the analysis. The main comparison examined in the study was between those who had sought and received the hormones, and those who had sought but never received them when they were between 14 and 17.

The obvious defect in this comparison is that there are reasons why some people were able to get the hormones while others could not, even though all of them report wanting to get them. The reasons that allowed some to access them but not others are likely strongly related to later mental health. One

of the most important reasons why some adolescents were able to access the hormone therapies while others could not is that parental consent is often, though not always, required to get these drugs. As is well known from research on gender-confused youth, as well as more generally, closer and more positive relationships between children and parents promote mental well-being and is protective against suicide.

The problem, then, with the Turban study, is that it is impossible to know whether the reduced odds of contemplating suicide among adults who sought and received hormone therapy as children were a result of the relationship with their parents who gave consent for this intervention or a result of the intervention itself. If a close and positive relationship between parents and children struggling with gender identity is the key to successful outcomes for those adolescents, then the hormones themselves might make no difference, or even be harmful. But that effect would be masked by the kind of parent–child relationship that exists when parents are more likely to consent.

Turban's own data show enormous differences in relationships between children and parents among those who obtained the hormones and those who did not, despite desiring them. Of those who were unable to get the hormones, 35 percent had not "come out" to their parents, compared to 3 percent among those who ohtained hormones at ages 14 and 15, and 4 percent among those who obtained hormones at ages 16 and 17. Among those who got the hormones as teenagers, nearly 80 percent reported feeling supported by their parents, compared to 33 percent of those who were unable to get the drugs.

Turban attempts to control statistically for these reported differences, but that adjustment cannot fully fix the bias, especially when the differences between the groups being compared are so stark and when the measures of parent–child relationship are imprecise. This would be like trying to adjust for the effects of family income during childhood knowing only whether someone reports having felt poor. Memories are imperfect, and simply dividing people into poor and not-poor categories fails to capture the difference between the children of billionaires and those raised in public housing projects. Adolescents who can get their parents' consent for hormone therapy have dramatically different relationships with their parents than those who cannot, and that difference in relationship can affect mental health later in life, even if the hormones themselves have no benefit, or are harmful.

Another important factor that determines whether young people get cross-sex hormones is their psychological condition when they are seeking that intervention. According to guidelines issued by WPATH, a key condition for prescribing cross-sex hormones is that "any coexisting

psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment."[28] The difference between those who desired hormone therapy and received it and those who sought it but were unable to receive it could be the state of their mental health at the time they tried to get the drugs.

The Turban study lacks information on, and therefore cannot make any statistical adjustments for, the mental health at the time the subjects sought hormone therapy. The respondents who were unable to get hormone therapy despite saying they wanted it may have worse mental health outcomes because they *began* with more severe psychological issues that prevented them from obtaining the hormones. The pre-existing mental health challenges could be the cause of later outcomes, not whether they received the hormones.

The inability to sort out this kind of uncertainty about what is causing differences in mental health outcomes is inherent in the correlational research design employed by Turban and his colleagues. These same concerns apply to an earlier study by Turban and his colleagues published in *Pediatrics* in 2020. This study examines the relationship between puberty blockers and later mental health outcomes and relies on the same correlational research design to analyze data from the same survey as the cross-sex hormone study.[29] The use of a correlational research design also makes it impossible to draw causal conclusions from a study by Amy Green and colleagues that analyzes the mental health effects of adolescents receiving cross-sex hormones based on data from a different survey.[30]

The two studies led by Turban, and the one led by Green, are the only three studies that examine the relationship between cross-sex medical interventions by teenagers and suicide risks that make any use of a comparison group. As the 2020 Turban study describes itself, "This is the first study in which associations between access to pubertal suppression and suicidality are examined."[31] The 2022 Turban study observes that there have been six studies that track the mental health outcomes of teens who received hormone treatments, but emphasizes that "these studies did not include a comparison group of adolescents who did not access GAH [gender affirming hormones]."[32] Studies that track adolescents who receive these medical interventions are even weaker than correlational studies in their ability to draw causal conclusions about the effects of those interventions, because they have no information on how those individuals would have fared had they not received the interventions.

The prior research on this subject is not only weak because it contains no credibly causal studies and only a handful of correlational studies, but also because those correlational studies are poorly executed. For example, the 2022 Turban study combines the use of testosterone for natal females and estrogen for natal males and only reports the combined effects of hormones. When Michael Biggs analyzes the same data and disaggregates the hormone by type, he finds that: "Males who took estrogen are more likely to plan suicide, to attempt suicide, and to require hospitalization for a suicide attempt."[33] This negative effect is masked in Turban's study by the failure to report the separate effects by type of hormone.

Similarly, the 2022 Turban study finds that 16- and 17-year-olds who received hormones were more than twice as likely to report a "past-year suicide attempt requiring inpatient hospitalization," but that finding fails to achieve statistical significance by setting the standard for significance higher than is conventional.[34] Only by adopting a standard for statistical significance that is different from the one more commonly used in empirical research does the study avoid concluding that this significant harm from hormone therapy exists.

The two Turban studies do not consistently use the same set of control variables when generating their adjusted-odds ratio, even changing what is controlled when analyzing different outcomes within the same study. The two Turban studies also change the main outcome of interest from lifetime suicidal ideation in the study on puberty blockers to suicidal ideation in the last 12 months in the study on hormones. Researchers should determine which confounding variables to control and which outcome variable to examine in their statistical models based on sound theory and prior empirical research, and then consistently apply those decisions, especially within the same study. Changing which factors are controlled in the statistical analysis of each outcome variable, as well as which outcome on which to focus, opens the door to p-hacking, the process of changing empirical models in an ad hoc fashion to yield desired, though likely spurious, results.

The bottom line is that the most influential recent research on the relationship between adolescent cross-sex interventions and later mental health outcomes, including suicide risk, does not provide convincing evidence. Only a small number of studies make comparisons to a control group—and those studies employ correlational research designs that do not allow causal conclusions, nor have those correlational studies been conducted properly.

A Better Research Approach

Of all the adolescents who seek medical interventions for gender issues, there are reasons why some receive interventions while others do not. The defect of correlational research designs is that they cannot separate the effects of those reasons from the effects of the interventions themselves. A better research design would be built around the reasons why some do and others do not get the intervention, which have nothing to do with possible later outcomes. The gold standard of research designs is the RCT because then only chance determines whether some people get the treatment, not a factor that could be related to later outcomes.

Short of using lotteries to determine who gets the intervention, there are quasi-experiments or natural policy experiments,[35] whereby the reason people, whether adults or minors, can or cannot get the intervention is determined primarily by policies that were adopted for reasons that have nothing to do with the later outcomes of treated individuals. This circumstance approximates a randomized experiment. By chance, some find themselves living under rules that allow them to access treatment, while others find themselves under different rules that do not allow them to do so.

There exists a natural policy experiment of this type with respect to the ability of minors to access gender-related medical interventions without their parents' consent. As described above, some states have policies that provide a path by which minors can access routine medical care without the consent of a parent, while other states do not. These policies were developed for reasons that have nothing to do with gender identity. Whether adolescents live in a state that imposes fewer or no restrictions on accessing puberty blockers and cross-sex hormones is effectively random and should have nothing to do with later outcomes other than through the mechanism of receiving those interventions or not.

The analysis presented in this *Backgrounder* exploits this natural policy experiment to compare suicide rates over time among those ages 12 to 23 in states that have a provision allowing minors to access health care without parental consent relative to states that have no such provision. Annual suicide rates by age and state between 1999 and 2020 were obtained from the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention.[36] Information on whether states had policies allowing minors to access routine health care without parental consent was obtained from SchoolHouse Connection, an organization focused on caring for homeless youth.[37]

The analysis presented here uses a statistical model to predict the suicide rate among those ages 12 to 23 in each state between 1999 and 2020. The analysis focuses on this age range because it encompasses a consistent age group of those who could have entered puberty between 2010 and 2020 when puberty blockers and cross-sex hormones became available as a gender-related treatment in the United States. To control for the possibility that there are enduring cultural, religious, or other state-specific features that account for why some states have higher suicide rates among young people than other states, the model controls for average suicide rates in this age group in each state at baseline (during the first three years observed).

To control for the possibility that there are state-specific factors that account for why some states may generally experience changes in annual suicide rates, the model also controls for the suicide rate in each state in each year among those ages 28 to 39. The Heritage model controls for the suicide rate among that age group because it is a consistent age group in which no one would have been a minor in 2010 when puberty blockers and cross-sex hormones became available in the U.S. Because even the 28-year-olds in 2020 would have been 18 in 2010, none of them would be affected by variation in state policies regulating the ability of minors to receive health care without parental consent when these medical interventions began to be used.

The model also includes an indicator variable for each year between 1999 and 2020 to control for any year-specific national changes in suicide rates. And, because there may be correlations between the suicide rates within each state across the years examined, the model clusters the standard error estimates by state.

The independent variable of interest is a dichotomous measure of whether the state has a policy that allows minors to access health care without parental consent. If making it easier for minors to access puberty blockers and cross-sex hormones is protective against suicide, one should expect the frequency of youth suicide to be lower in states that have a provision allowing minors to get these drugs without parental consent after 2010. There should be no difference in trends in the suicide rate among young people based on whether states have a provision allowing minors to access health care without parental consent before 2010. If Turban and his colleagues are correct, the trends between these two groups of states should diverge after 2010 as cross-sex interventions became more widely available.

The trends are modeled statistically in a few ways. The most precise approach is to examine whether the suicide rate among young people is elevated as those interventions become more widely available in the states where it is easier for minors to access them. The model uses the prevalence

of gender-related medical terms in Google Trends as a proxy for how widely available those interventions are over time.

Another approach would be to model the increased suicide rate in states where minors can access health care without parental consent over time. This could be done by including in the model an "interaction" variable that estimates the effect of whether states have a provision for minors accessing health care without parental consent each year separately. This variable would estimate the difference in youth suicide rates between states based on whether they have such a policy for each year between 1999 and 2020.

Yet another way to model the trend over time would be to estimate the combined effect of whether states have a policy along with a time variable that counts the number of years since 1999. This approach would identify any extant linear trend across time that differs between the two groups of states. It would also be possible to determine whether the two groups of states differ in their level or trend in youth suicide rates before and after 2010, when puberty blockers and cross-sex hormones become available.

The results remain substantively the same in their general magnitude, direction, and statistical significance regardless of the approach.

The Results

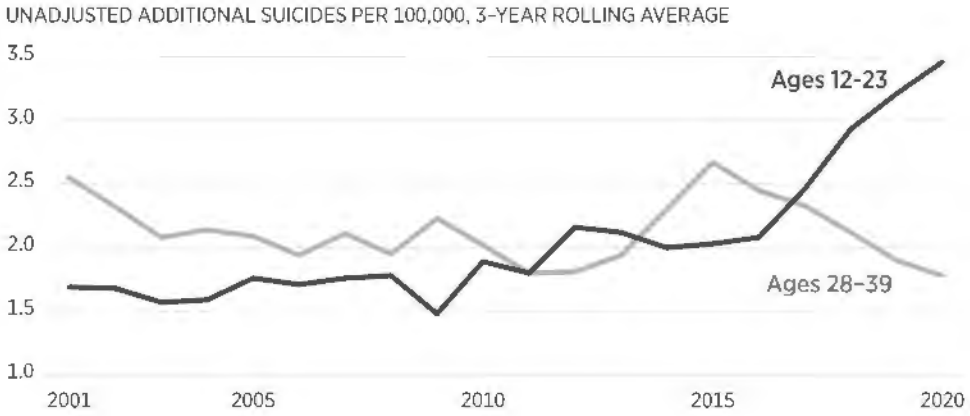
In the past several years, the suicide rate among those ages 12 to 23 has become significantly *higher* in states that have a provision that allows minors to receive routine health care without parental consent than in states without such a provision. Before 2010, these two groups of states did not differ in their youth suicide rates. Starting in 2010, when puberty blockers and cross-sex hormones became widely available, elevated suicide rates in states where minors can more easily access those medical interventions became observable.

Rather than being protective against suicide, this pattern indicates that easier access by minors to cross-sex medical interventions without parental consent is associated with higher risk of suicide. The Heritage model plotted the difference in a three-year rolling average of suicide rates between states with minor access provisions and states with no such provision. Chart 2 plots the trend in this difference for those ages 12 to 23 who could have been affected by the policy when cross-sex medical interventions became available. For comparison, Chart 2 also shows the trend in this difference for a group ages 28 to 39, who could not have been affected by these policies, since the people in this group would have been at least 18 when puberty blockers and cross-sex hormones became available.

CHART 2

States with Minor Access Provisions See Spike in Youth Suicides after Cross-Sex Treatments Become Available

Suicide rates among those ages 12 to 23 rose in states with provisions that allow minors to access health care without parental consent, after cross-sex treatments became available.



"Additional suicides" refers to the increase in suicide rates in states with a minor access provision relative to states that have no such health care provision.

SOURCE: Authors' calculations based on data from Centers for Disease Control and Prevention, WISQARS, https://www.cdc.gov/injury/wisqars/index.html (accessed April 20, 2022), and "State Laws on Minor Consent for Routine Medical Care," September 3, 2021, https://schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care/ (accessed April 20, 2022).

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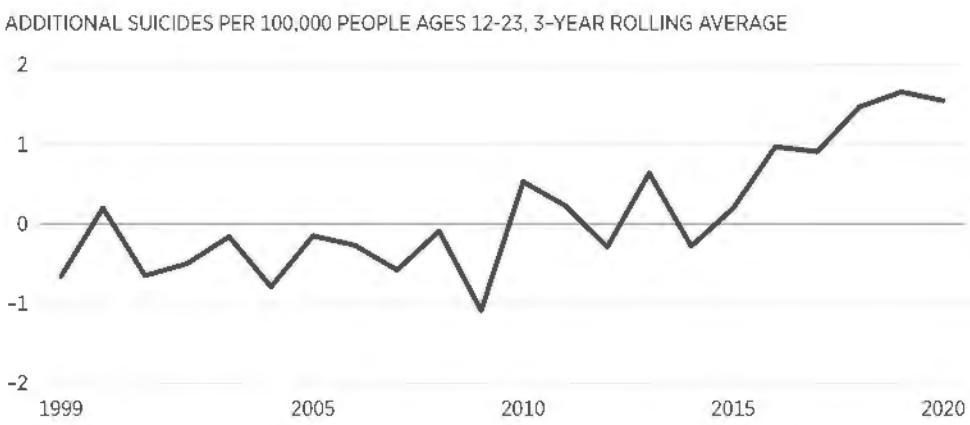
Without making any adjustments, suicide rates among those ages 12 to 23 (blue line) begin to spike in states that have provisions that allow minors to access health care without parental consent relative to states that have no such provision around 2016, after cross-sex medical interventions became more common. By 2020, there are about 3.5 more suicides per 100,000 people ages 12 to 23 in states with easier access than in states without an access provision. There is no similar spike in suicide rates among those ages 28 to 39 (grey line) at that time.

It is also clear that the states with a provision always had somewhat higher suicide rates than the states with no provision. To isolate the effect of this provision on youth suicide rates, it is better to control statistically for the youth suicide rate in each state at baseline as well as the suicide rate in each state in each year among the older and unaffected age group.

CHART 3

Adjusted Additional Suicides in States with Minor Access Provision



"Additional suicides" refers to the increase in suicide rates in states with a minor access provision relative to states that have no such health care provision.

SOURCE: Authors' calculations based on data from Centers for Disease Control and Prevention, WISQARS, https://www.cdc.gov/injury/wisqars/index.html (accessed April 20, 2022), and "State Laws on Minor Consent for Routine Medical Care," September 3, 2021, https://schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care/ (accessed April 20, 2022).

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Making these adjustments and plotting three-year rolling averages yields the trend pictured in Chart 3. It is clear that the presence of a state-level provision for minors to access health care without parental consent makes no difference in suicide rates among those ages 12 to 23 until about 2010, when the suicide rate begins to drift up in states with *easier* access. In 2015, the estimated increase in suicide rates in states with easier access accelerates. By 2020, there are about 1.6 more suicides per 100,000 people ages 12 to 23 in states that have a policy allowing minors to access health care without parental consent than in states without such a policy. The average state suicide rate in this age group between 1999 and 2020 was 11.1, making an additional 1.6 suicides per 100,000 an increase of 14 percent in the suicide rate.

This increase in suicide rates in states where it is easier for minors to access puberty blockers and cross-sex hormones increased at almost the same time, and to the same degree, as those interventions became available. Using Google Trends results for the terms associated with those medical interventions as a proxy for their availability shows that increased suicide rates in states with easier access almost perfectly track the prevalence of those terms. (Compare Charts 1 and 3.)

This elevated rate of youth suicide is statistically significant at conventional levels, and robust to different approaches to modeling the trend over time. (See Appendix Tables 2–5 for regression results.)

It is useful to conduct a "placebo test" to examine whether the elevated rate of suicides among young people in states where it was easier for minors to access cross-sex interventions also existed among slightly older people who could not have been affected by minor access provisions. Using the same exact regression model while replacing the suicide rate among those ages 12 to 23 with the rate for those ages 28 to 39 in the same states as the dependent variable shows no relationship between the ease of accessing cross-sex medical care and suicide rates among those too old to have been affected by these state policies. (See Appendix Table 6.) This placebo test strongly indicates that making it easier for minors to access puberty blockers and cross-sex hormones when those interventions became available is causally related to increased suicide rates, because no similar increase was seen by those slightly older who would have been unaffected.

Discussion

The results presented in this *Backgrounder* provide strong evidence for the claim that suicides among young people have increased significantly since 2010 in states that have a policy allowing minors to access routine health care without parental consent. That increase in suicide rates accelerated around 2015. Prior to 2010, whether a state had such a policy or not had no significant effect on the trend in suicide rates among those ages 12 to 23. The timing of the increase in suicide rates only among young people, only after puberty blockers and cross-sex hormones are introduced and used widely, and only in states where minors could access those medical interventions without parental consent raises serious concerns about their effects on suicide risks.

The research presented here does not directly examine whether the individuals who receive gender-related medical interventions are at a higher risk of suicide, but it does directly examine the state policies that facilitate minors accessing those interventions without parental consent and finds that those policies raise suicide risks among young people.

To believe that easier access to puberty blockers and cross-sex hormones are not the cause of elevated suicide risk in those states, one would have to be able to imagine other medical interventions that only became widely available after 2010 and would only affect young people. The lack

of theoretically plausible alternatives strengthens the case for concluding that cross-sex medical interventions are the cause of the observed increase in suicide among young people.

State Policy Recommendations

At a minimum, the results presented in this *Backgrounder* demonstrate that efforts to lower legal barriers for minors to receive cross-sex medical interventions do not reduce suicide rates and likely lead to higher rates among young people in states that adopt those changes. States that currently facilitate minors' access to routine health care without the consent of a parent or legal guardian should consider revising such policies. States should also adopt parental bills of rights that affirm that parents have primary responsibility for their children's education and health, and that require schools to receive permission from parents before administering health services to students, including medication and gender-related counseling to students under age 18.

This research adds to the well-established wisdom that children are better off if they are not allowed to make major life decisions without their parents' involvement and permission. In general, parents are better positioned than anyone else, including the children themselves, to understand the needs of their children when making important decisions. State policies that undermine this relationship between parents and children are dangerous and should be repealed. Similarly, those who work with children in professional capacities, including health, education, and counseling, should be careful about substituting their own judgment for that of the parents. The research presented here supports the view that children fare significantly better when their parents have the authority to know about, and help to make, major decisions for their own children.

Lastly, given the danger of cross-sex treatments demonstrated in this *Backgrounder*, states should tighten the criteria for receiving these interventions, including raising the minimum eligibility age.

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APPENDIX TABLE 1

States by Minor Access Provision Status

States without Minor Access Provision	States with Minor Access Provision	
Connecticut	Alabama	Massachusetts
Georgia	Alaska	Minnesota
Iowa	Arizona	Missouri
Kentucky	Arkansas	Montana
Michigan	California	Nevada
Mississippi	Colorado	New Mexico
Nebraska	Delaware	North Dakota
New Hampshire	District of Columbia	Oklahoma
New Jersey	Florida	Oregon
New York	Hawaii	Pennsylvania
North Carolina	Idaho	Rhode Island
Ohio	Illinois	South Carolina
South Dakota	Indiana	Texas
Tennessee	Kansas	Utah
Vermont	Louisiana	Virginia
West Virginia	Maine	Washington
Wisconsin	Maryland	Wyoming

SOURCE: "State Laws on Minor Consent for Routine Medical Care," September 3, 2021, https://schoolhouseconnection.org/state-laws-on-minor-consent-for-routine-medical-care/ (accessed April 20, 2022)

APPENDIX TABLE 2

Output of Regression Model of Youth Suicide Rates Using Google Trends Data

Variable	Point Estimate	Standard Error	P Value
Intercept	4.29	0.75	0.00
Minor Access Provision	-0.85	0.48	0.08
Google Trends	-0.10	0.01	0.00
Minor Access Provision, Google Trends	0.04	0.02	0.02
Youth Baseline Suicide Rate	-1.04	0.07	0.00
Adult Suicide Rate	-0.15	0.03	0.00
2005	0.06	0.41	0.89
2006	0.05	0.37	0.90
2007	0.64	0.31	0.04
2008	-0.33	0.34	0.33
2009	-0.27	0.39	0.49
2010	-0.97	0.54	0.07
2011	-1.07	0.42	0.01
2012	-0.70	0.40	0.08
2013	-1.16	0.48	0.02
2014	-0.99	0.40	0.01
2015	-0.72	0.45	0.11
2016	-0.99	0.36	0.01
2017	-1.48	0.40	0.00
2018	-1.34	0.35	0.00
2019	-0.64	0.31	0.04

NOTES: N=826. Adjusted R^2 = 0.82.
SOURCE: Authors' calculations.

APPENDIX TABLE 3

Output of Regression Model of Youth Suicide Rates with Interaction Terms for the Minor Access Provision Variable and Annual Dummy Variables (Page 1 of 2)

Variable	Point Estimate	Standard Error	P Value
Intercept	2.57	0.55	0.00
Youth Baseline Suicide Rate	-1.02	0.05	0.00
Adult Suicide Rate	-0.14	0.03	0.00
2000	-0.57	0.83	0.49
2001	0.28	0.54	0.60
2002	0.35	0.35	0.31
2003	0.48	0.45	0.29
2004	0.05	0.55	0.93
2005	0.04	0.38	0.92
2006	0.19	0.49	0.69
2007	0.90	0.50	0.08
2008	-0.22	0.48	0.65
2009	0.17	0.33	0.61
2010	-1.06	0.64	0.10
2011	-1.11	0.45	0.01
2012	-0.75	0.48	0.12
2013	-1.70	0.50	0.00
2014	-1.66	0.43	0.00
2015	-2.53	0.79	0.00
2016	-3.02	0.67	0.00
2017	-4.27	0.47	0.00
2018	-4.67	0.63	0.00
2019	-4.32	0.74	0.00
2020	-3.91	0.60	0.00
Minor Access Provision, 1999	-0.66	0.52	0.21
Minor Access Provision, 2000	0.20	0.65	0.76
Minor Access Provision, 2001	-0.65	0.54	0.23
Minor Access Provision, 2002	-0.50	0.69	0.47
Minor Access Provision, 2003	-0.16	0.42	0.71
Minor Access Provision, 2004	-0.79	0.46	0.09
Minor Access Provision, 2005	-0.15	0.56	0.80
Minor Access Provision, 2006	-0.27	0.71	0.71
Minor Access Provision, 2007	-0.58	0.54	0.29
Minor Access Provision, 2008	-0.09	0.64	0.89
Minor Access Provision, 2009	-1.09	0.84	0.19
Minor Access Provision, 2010	0.53	0.86	0.54

APPENDIX TABLE 3

Output of Regression Model of Youth Suicide Rates with Interaction Terms for the Minor Access Provision Variable and Annual Dummy Variables (Page 2 of 2)

Variable	Point Estimate	Standard Error	P Value
Minor Access Provision, 2011	0.23	0.53	0.66
Minor Access Provision, 2012	−0.29	0.62	0.65
Minor Access Provision, 2013	0.64	0.76	0.41
Minor Access Provision, 2014	−0.28	0.52	0.59
Minor Access Provision, 2015	0.20	0.99	0.84
Minor Access Provision, 2016	0.97	0.74	0.19
Minor Access Provision, 2017	0.91	0.97	0.35
Minor Access Provision, 2018	1.47	0.98	0.13
Minor Access Provision, 2019	1.66	0.87	0.06
Minor Access Provision, 2020	1.55	0.71	0.03

NOTES: N=1,065. Adjusted R^2 = 0.81.
SOURCE: Authors' calculations.

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APPENDIX TABLE 4

Output of Regression Model of Youth Suicide Rates with Time Measured as a Continuous Variable

Variable	Point Estimate	Standard Error	P Value
Intercept	2.63	0.44	0.00
Minor Access Provision	-0.95	0.36	0.01
Youth Baseline Suicide Rate	-1.02	0.05	0.00
Adult Suicide Rate	-0.14	0.02	0.00
Minor Access Provision, Time	0.09	0.04	0.02
2000	-0.31	0.60	0.60
2001	0.22	0.39	0.57
2002	0.31	0.32	0.32
2003	0.52	0.34	0.13
2004	-0.15	0.41	0.71
2005	0.02	0.29	0.93
2006	0.11	0.37	0.77
2007	0.66	0.38	0.08
2008	-0.31	0.40	0.43
2009	-0.28	0.31	0.36
2010	-1.01	0.48	0.04
2011	-1.19	0.38	0.00
2012	-1.03	0.45	0.02
2013	-1.71	0.41	0.00
2014	-2.01	0.45	0.00
2015	-2.75	0.62	0.00
2016	-3.01	0.57	0.00
2017	-4.31	0.44	0.00
2018	-4.54	0.54	0.00
2019	-4.16	0.64	0.00
2020	-3.82	0.57	0.00

NOTES: N=1,065. Adjusted $R^2 = 0.81$.
SOURCE: Authors' calculations.

APPENDIX TABLE 5

Output of Regression Model of Youth Suicide Rates with Time Measured as a Binary Variable Where 1 Corresponds to the Year 2010 or Later

Variable	Point Estimate	Standard Error	P Value
Intercept	2.49	0.46	0.00
Minor Access Provision	-0.43	0.28	0.12
Youth Baseline Suicide Rate	-1.02	0.05	0.00
Adult Suicide Rate	-0.14	0.02	0.00
Minor Access Provision, Year 2010	1.12	0.44	0.01
2000	-0.28	0.60	0.64
2001	0.28	0.39	0.46
2002	0.41	0.31	0.19
2003	0.64	0.34	0.06
2004	0.01	0.39	0.99
2005	0.21	0.28	0.44
2006	0.32	0.38	0.39
2007	0.92	0.36	0.01
2008	-0.03	0.35	0.94
2009	0.03	0.29	0.92
2010	-1.04	0.49	0.04
2011	-1.19	0.37	0.00
2012	-1.00	0.43	0.02
2013	-1.65	0.40	0.00
2014	-1.92	0.41	0.00
2015	-2.62	0.60	0.00
2016	-2.85	0.53	0.00
2017	-4.12	0.42	0.00
2018	-4.32	0.51	0.00
2019	-3.91	0.57	0.00
2020	-3.53	0.47	0.00

NOTES: N=1,065. Adjusted R^2 = 0.82.
SOURCE: Authors' calculations.

APPENDIX TABLE 6

Placebo Test, Output of Regression Model of Young Adult Suicide Rates Using Google Trends Data

Variable	Point Estimate	Standard Error	P Value
Intercept	3.30	1.05	0.00
Minor Access Provision	-0.54	0.53	0.31
Google Trends	-0.11	0.02	0.00
Adult Baseline Suicide Rate	-0.85	0.07	0.00
Youth Suicide Rate	-0.45	0.05	0.00
Minor Access Provision, Google Trends	-0.02	0.02	0.51
2005	0.12	0.49	0.81
2006	-0.29	0.57	0.61
2007	-0.58	0.50	0.24
2008	-1.02	0.61	0.10
2009	-0.62	0.54	0.25
2010	-0.74	0.74	0.32
2011	-0.82	0.68	0.23
2012	-1.66	0.44	0.00
2013	-0.65	0.50	0.19
2014	-0.73	0.48	0.13
2015	0.14	0.54	0.80
2016	-0.73	0.48	0.13
2017	-0.02	0.49	0.96
2018	0.84	0.56	0.13
2019	0.21	0.42	0.62

NOTES: N= 826. Adjusted $R^2 = 0.80$.
SOURCE: Authors' calculations.

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The Tavistock's Experiment with Puberty Blockers*

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(version 1.0.1, 29 July 2019)

In 1994 a 16-year-old girl who wished to be a boy, known to us as B, entered the Amsterdam Gender Clinic. She was unique for having her sexual development halted at the age of 13, after an adventurous paediatric endocrinologist gave her a Gonadotropin-Releasing Hormone agonist (GnRHa). Originally developed to treat prostate cancer, these drugs are also used to delay puberty when it develops abnormally early: in girls younger than 8, and boys younger than 9. The endocrinologist's innovation was to use the drug to stop normal puberty altogether, in order to prevent the development of unwanted secondary sexual characteristics—with the aim of administering cross-sex hormones in later adolescence. Dutch clinicians used B's case to create a new protocol for transgendering children, which enabled physical intervention at an age far below the normal age of consent (Cohen-Kettenis and Goozen 1998).

The Dutch protocol promised to create a more passable simulacrum of the opposite sex than could be achieved by physical intervention in adulthood. It was therefore embraced by trans-identified children and their parents, by older transgender activists, and by some clinicians specializing in gender dysphoria. The Gender Identity Development Service (GIDS), part of the Tavistock and Portman NHS Foundation Trust, treats children with gender dysphoria from England, Wales, and Northern Ireland. It launched an experimental study of "puberty blockers"—the more friendly term for GnRHa when administered to children with gender dysphoria—in 2011. The experiment gave triptorelin to 44 children, which in all or almost all cases led eventually to cross-sex hormones. This paper describes the origins and conduct of this study and scrutinizes the evidence on its outcomes. It draws on information obtained by requests under the Freedom of Information Act to the Tavistock, to the NHS Health Research Authority, and to University College London (UCL). I will argue that the experimental study did not properly inform children and their parents of the risks of triptorelin. I will also demonstrate that the study's preliminary results were more negative than positive, and that the single published scientific article using data from the study is fatally flawed by a statistical fallacy. My conclusion is that GIDS and their collaborators at UCL have either ignored or suppressed negative evidence. Therefore the NHS had no justification for introducing the Dutch protocol as general policy in 2014.

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* Some of this material was first posted on Transgender Trend (Biggs 2019a, 2019b); most will appear in an edited volume (Moore and Brunskell-Evans 2019). Earlier drafts were shared with reporters at *The Times* (including Lucy Bannerman) and BBC Newsnight (including Deborah Cohen). Special thanks are due to Stephanie Davies-Arai, Elin Lewis, Susan Matthews, and an anonymous former clinician at GIDS for sharing their extensive knowledge, and to Sherena Kranat for her steadfast support. Credit is due also to three woke students taking the Sociology MSc who exhorted me to educate myself on the subject of transgendered children.

Origins

GnRHa drugs have never been licensed for treating children suffering from gender dysphoria. The particular drug used in Britain, as in the Netherlands, is triptorelin, which is licensed to treat advanced prostate cancer and sexual deviance in men; endometriosis and uterine fibroids in women (for no longer than six months); and precocious puberty in children (Electronic Medicines Compendium 2019). Using GnRHa to treat gender dysphoria is "a momentous step in the dark", for it is "presumptuous to extrapolate observations from an intervention that suppresses pathologically premature puberty to one that suppresses normal puberty" (Richards et al. 2018). Therefore the origins of the Tavistock's experiment needs some explanation.

The Dutch protocol became well known in Britain before the first scientific article was published. A television documentary showed girls who wished to be boys travelling to meet their peers in the Netherlands, who were taking GnRHa as young as 13 (Channel 4 1996). This inspired Stephen Whittle—who led the transgender campaigning organization Press for Change—to argue for a legal right to access "pubertal suppression"; doctors who failed to provide drugs could be vulnerable to litigation (Downs and Whittle 2000; Wren 2000: 224). This argument was first advanced at a conference at Oxford in 1998, whose keynote speaker was the head of the Amsterdam Gender Clinic. There was little movement, however, over the next few years. Guidelines issued by the British Society for Paediatric Endocrinology and Diabetes (BSPED) in 2005 still insisted that children had to reach full sexual development (known as Tanner Stage 5)—around the age of 15—before being prescribed GnRHa drugs.

A crucial role was played by organizations that campaign for the transgendering of children: the Gender Identity Research and Education Society (GIRES) and Mermaids. GIRES organized a symposium in London in 2005 to develop "guidelines for endocrinological intervention". Additional funding came from Mermaids, two medical charities—Nuffield Foundation and King's Fund—and the Servite Sisters Charitable Trust Fund. This brought together the creators of the Dutch protocol, American clinicians like Norman Spack in Boston, and key British figures such as Domenico Di Ceglie, the Director of GIDS, and Polly Carmichael and Russell Viner, both at Great Ormond Street Hospital. (The latter two would lead the 2011 experiment.) Some of the participants vigorously lobbied for the Dutch protocol. Veronica Sharp from Mermaids "described users' and parents' views of the available treatments, and the anguish they may experience when hormone blocking is delayed" (GIRES 2005). The symposium ended with agreement to push for amendments to guidance from bodies like BSPED, and to conduct collaborative research between London, Amsterdam, and Boston. There was another meeting in Amsterdam in the following year, but the collaboration did not eventuate.

International developments did enable parents to circumvent the NHS. GIRES (2006) warned that "those who can in any way afford to do so have to consider taking their children to the USA". The first was Susie Green, who later became the chief executive of Mermaids. In 2007 she took her son Jackie, aged 12, to Boston, to purchase a prescription for GnRHa from Spack; the drug was supplied by an online Canadian pharmacy (*Sun*, 19 October 2011). A presentation at Mermaids, presumably by Green, instructed parents in this medical tourism (Mermaids 2007). Spack treated a further seven British children over the next few years (*Times*, 22 January 2012).

By 2008, GIRES was more strident in criticizing British clinicians. One of its founders, Terry Reed, denounced them as "transphobic":

> They are hoping that during puberty the natural hormones themselves will act on the brain to 'cure' these trans teenagers. What we do know is what happens if you don't offer hormone blockers. You are stuck with unwanted secondary sex characteristics in

> the long term and in the short term these teenagers end up suicidal. (*Guardian*, 14 August 2008)

Reed was clearly drawing on the experience of her own child, who transitioned two decades before. This feature article in the *Guardian* signalled that the controversy was becoming newsworthy. GIRES objected to the fact that the Royal Society of Medicine had not invited many advocates for the Dutch protocol to its conference on gender dysphoria in adolescents. The conference was noteworthy as the occasion for a rare public protest by transgender activists (Brown 2018: 311). They targeted Kenneth Zucker from Toronto, a leading psychologist, who was denounced as a "transphobic doctor who supports repression and torture of gender-variant children" (Kennedy 2008). Criticism was not confined to activists. The psychiatrist Richard Green, formerly head of Britain's Gender Identity Clinic for adults, arranged a rival conference:

> Medical experts from the US, Canada and the Netherlands who treat young teenage transsexuals with puberty-blocking medications at the first signs of body change will discuss their programmes. Teenage Dutch transsexuals and their parents will discuss their positive experiences with blocking puberty. A UK family will report how their desperation led to them travelling to the US for treatment. (*Guardian*, 28 August 2008)

Contributors included a medical ethicist at the University of Manchester who denounced Viner's caution about the risks of GnRHa, on the grounds that "anything is better than life in an alien body" (Giordano 2008: 583). As the decade drew to a close, the demand for puberty blockers was irresistible.

Experiment

Shortly after Carmichael became Director of GIDS in 2009, she decided to offer GnRHa to younger children as part of a research project (BBC News 2009). The chief investigator was Viner at UCL; co-investigators included Carmichael and Di Ceglie, who had moved to Director of Training, Development, and Research. The proposal—"Early pubertal suppression in a carefully selected group of adolescents with gender identity disorder" —was rejected by the NHS Research Ethics Committee, on the grounds that it was not a proper randomized trial and therefore could not yield valid results (GIDS 2019b). The revised proposal (Viner 2010) argued that a randomized trial was not practical. Just as importantly, perhaps, it was submitted to a different Research Ethics Committee. This Committee approved the experiment in February 2011. Aside from the absence of any control group, what is surprising is how the proposal failed to maximize information on the effects of GnRHa. Children were asked to consent to completing questionnaires only until they were 16. If they had been asked to give consent for the researchers to access their medical records in perpetuity, then GIDS would have been able to analyze effects of the drugs over the long term. Although the proposal called this a "study", I prefer the word "experiment" (following Davies-Arai 2018) to underline the fact that it involved a drug regime that has never been licensed for this condition anywhere in the world.

The research proposal provided a comprehensive review of the potential benefits and risks of GnRHa. "It is not clear what the long term effects of early suppression may be on bone development, height, sex organ development, and body shape and their reversibility if treatment is stopped during pubertal development" (Viner 2010). Viner spoke frankly in a later newspaper interview:

> If you suppress puberty for three years the bones do not get any stronger at a time when they should be, and we really don't know what suppressing puberty does to your brain development. We are dealing with unknowns. (*Daily Mail*, 25 February 2012)

This caution echoed previous comments by Carmichael: "the debate revolves around the reversibility of this intervention—physical and also psychological, in terms of the possible influence of sex hormones on brain and identity development" (Carmichael and Davidson 2009: 917).

When the Tavistock announced the study, however, it claimed that GnRHa treatment "is deemed reversible" (Tavistock 2011). More disturbing is the fact that the Patient Information Sheet provided to children when they gave consent also minimized the risks acknowledged in the research proposal.[1] Although the sheet ran to four pages, it omitted the fact that GnRHa has never been certified as safe and effective for treating gender dysphoria. The words "experiment" or "trial" did not appear. Under "the possible benefits of taking part" came this astonishing statement:

> If you decide to stop the hormone blockers early your physical development will return as usual in your biological gender [sic]. The hormone blockers will not harm your physical or psychological development.

This directly contradicted the chief investigator's own statements.

As for side effects, there was a vague warning that the drug "could affect your memory, concentration and the way you feel". The triptorelin formulations used by GIDS—Gonapeptyl® Depot and Decapeptyl® SR—carry detailed warnings of side effects. Depression is common, affecting between 1% and 10% of patients (Ferring Pharmaceuticals 2016), and "may be severe" (Ipsen 2017). Other side effects affecting up to 10% of children treated for precocious puberty include "pain in abdomen, pain bruising [sic], redness and swelling at injection site, headache, hot flushes, weight gain, acne, hypersensitivity reactions" (Ipsen 2017). None are mentioned in the Patient Information Sheet.

One further absence deserves emphasis. The 2005 Symposium had noted the paradox that blocking a boy's puberty left him with stunted genitalia, which were then not sufficient to transform into a pseudo-vagina. "Although there are surgical means to deal this difficulty, the patient and her parents or guardians should be fully informed about its implications" (GIRES 2005). The Patient Information Sheet failed to mention this.

All these omissions might be explained by the input of parents who saw GnRHa as an elixir that would enable their child to change sex. "The wording … was agreed with a number of families with whom the draft had been discussed" (Di Ceglie 2019: 149). Whatever the cause, GIDS and UCL gave children and parents incomplete and misleading information, which contradicted the research proposal. Whether they could provide informed consent, in such circumstances, is open to serious question.

The basic parameters of the experiment are not entirely clear. It is known that GnRHa was administered to 44 children, starting from June 2011 (Tavistock 2019b). A conference presentation and published abstract described "baseline characteristics of a UK cohort beginning early intervention" but rather confusingly these numbered 50 subjects (Gunn et al. 2015a; Gunn et al. 2015b). The additional six, "included to improve the sample size", "were not eligible for this study due to being further developed in puberty and were treated at 15 years" (GIDS 2019b). Apparently the last child to enter the experiment was recruited in April 2014 (GIDS 2019b) and presumably some months elapsed before he or she was actually prescribed GnRHa.

There is contradictory information on the age of the subjects. GIDS recently stated that the youngest gave consent at the age of 12 years and one month (Tavistock 2019b). According to the initial presentation, however, the youngest child was 10.3 years "at hormone blockers" (Gunn et. al. 2015a: slide 17). The proposal approved by the Ethics Committee explicitly

[1] Version 1.0, 4 November 2010, obtained from UCL under the Freedom of Information Act. One portion is reproduced by Di Ceglie (2019: 149).

specified "age 12 and above" in the inclusion criteria (Viner 2010), and so the administration of drugs below this age would be a serious breach. Possibly the figure in the presentation was a typographical error, but another slide gives the age range at referral to the endocrine clinic as "10–15 years" (slide 14). A subsequent report gives the mean age at "start GnRHa" as 13.16, with a standard deviation of 1.06 (GIDS, 2015: 50). A Normal distribution with these parameters would have 14% of observations below 12; if you drew 44 observations from this distribution, the probability that none fell below 12 is only 0.2%. This is conjectural, of course, but it is difficult to reconcile these parameters with a minimum age of 12.

Results

Three years after the experiment began, Carmichael announced success to the tabloid press. "Now we've done the study and the results thus far have been positive we've decided to continue with it" (*Mail on Sunday*, 17 May 2014). Her statement was at best misleading. Six months earlier, she had already planned to continue the experiment indefinitely (*Sunday Times*, 17 November 2013). Then the sole justification was the large number of parents demanding drugs. At that point, the experiment had started only 23 children on triptorelin. These pronouncements make a mockery of Carmichael's earlier bromide: "as professionals we need to be looking at the long term and making sure this treatment is safe" (*Daily Telegraph*, 15 April 2011). Given the uncertainty surrounding the minimum age, it is telling that when she announced the experiment's success, she envisaged recruiting younger children. "Twelve is an arbitrary age. If they started puberty aged nine or ten instead of 12, as long as they're monitored and the bone density doesn't suffer, then it is right that the aim is to stop the development of secondary sex characteristics" (*Mail on Sunday*, 17 May 2014).

Where are these "positive" results described by Carmichael in 2014?[2] The current GIDS webpage on the evidence for puberty blockers states that "research evidence for the effectiveness of any particular treatment offered is still limited" (GIDS 2019a). There is no mention of its own experiment; it cites only research from the Netherlands. This is curious seeing that Carmichael told the World Professional Association for Transgender Health (WPATH) that "our results have been different to the Dutch" (Carmichael 2016). Di Ceglie stated last year that the "project is ongoing and the results are yet to be published" (Di Ceglie 2018: 14).

After my own investigation (Biggs 2019a; *Daily Telegraph*, 8 March 2019) pointed out the absence of published results, GIDS (2019b) posted a belated update on the experiment. It lists a total of two scientific publications; both are one-page abstracts on the physical effects of GnRHa. One describes the height of 14 of the subjects after they continued to cross-sex hormones (Catanzano and Butler 2018). Another reports bone density for children on GnRHa, some of whom were subjects in the experiment (Tobin, Ting, and Butler 2018). Density was measured over three years for 31 children.[3] The authors state reassuringly that bone density did not decline in absolute terms. This is misleading, because growing children need density to *increase* (Laidlaw 2018). The abstract acknowledges that the children experienced a decline relative to the norm for their age group, and this decline was especially marked for girls. By year three, the average girl on GnRHa had lower bone density than 97.7% of the population in her age group. Surely this raises serious concerns?

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[2] I emailed the address listed on the webpage announcing the study (communications@tavi-port.nhs.uk) on 1 February 2018, inquiring after the results. There was no reply.

[3] It is not clear whether "year 1" refers to the baseline before GnRHa or to one year after GnRHa. My email of 11 July to the authors requesting clarification has not yet been answered.

Diligent searching has uncovered unpublished results on the psychological effects. Most revealing is an appendix to Carmichael's report to the Tavistock's Board of Directors (GIDS 2015).[4] It tracks 30 of the children on triptorelin, measuring changes after one year of the drug regime; presumably the remaining 14 subjects had not completed their first year on the drug.[5] The text is sometimes internally inconsistent and occasionally contradicts the tabulated figures, suggesting that the appendix was prepared in haste. But we can summarize those changes that were reported as statistically significant (p-value < .05). Only one change was positive: "according to their parents, the young people experience less internalizing behavioural problems" (as measured by the Child Behavior Checklist). There were three negative changes. "Natal girls showed a significant increase in behavioural and emotional problems", according to their parents (also from the Child Behavior Checklist, contradicting the only positive result). One dimension of the Health Related Quality of Life scale, completed hy parents, "showed a significant decrease in Physical well-being of their child". What is most disturhing is that "a significant increase was found in the first item 'I deliberately try to hurt or kill self'" (in the Youth Self Report questionnaire). Astonishingly, the increased risk of self-harm attracted no comment in Carmichael's report. Given that puberty blockers are prescribed to treat gender dysphoria, it is paradoxical that "the suppression of puberty does not impact positively on the experience of gender dysphoria" (measured by the Body Image Scale). When differentiated by sex, the impact was positive for boys on one aspect of body image, but negative for girls on two aspects.

Results for the 44 children after one year on triptorelin were given in two presentations to WPATH in 2016. Unfortunately only the abstracts are obtainable.

> For the children who commenced the blocker, feeling happier and more confident with their gender identity was a dominant theme that emerged during the semi-structured interviews at 6 months. However, the quantitative outcomes for these children at 1 years time suggest that they also continue to report an *increase in internalising problems and body dissatisfaction*, especially natal girls. (Carmichael et al. 2016, my emphasis)
>
> Expectations of improvement in functioning and relief of the dysphoria are *not* as extensive as anticipated, and psychometric indices do *not* always improve *nor* does the prevalence of measures of disturbance such as deliberate self harm improve. (Butler 2016, my emphasis)

Where are the positive results announced by Carmichael in 2014? Curiously, both presentations are omitted from the recent list of publications on the experiment (GIDS 2019b).

In evaluating the psychometric evidence, we should remember that children and parents alike had a clear bias towards reporting favourable outcomes; after all, they had enrolled in the experiment because they wanted to take GnRHa. This positive bias increases the probative value of negative evidence. Why were these negative results never published?

There is one article on the outcome of puberty blockers, coauthored by Carmichael, which apparently includes some data from the experiment (Costa et al. 2015). The article discusses 101 children given GnRHa at GIDS, starting at ages ranging from 13 to 17. Given the date of publication, most or all of those children who started at ages 13 and 14 (and perhaps 15?) must have been part of the 2011 experiment. But the age range also indicates the exclusion of

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[4] My annotated version is available at http://users.ox.ac.uk/~sfos0060/Annotated_GIDS_results.pdf.

[5] As the final subject was recruited in April 2014, it is surprising that so many had not completed a year on triptorelin by the time the report was issued in June 2015. I previously (Biggs 2019a) erred badly in describing these results as pertaining to 44 subjects, which is the number given on the first page (GIDS 2015: 50).

the experimental subjects who commenced GnRHa before the age of 13. Excluding some subjects without justification is poor practice, and raises suspicion of cherry picking. Nevertheless, we should consider this article as having some bearing on the 2011 experiment.

The abstract proclaims that "adolescents receiving also puberty suppression had significantly better psychosocial functioning after 12 months of GnRHa … compared with when they had received only psychological support" (Costa et al. 2015: 2206). The literature treats this article as providing evidence in favour of puberty blockers (e.g. Butler et al. 2018; Heneghan and Jefferson 2019). But the abstract is misleading: the analysis actually *failed to detect any difference* between children who were given GnRHa and those who were not. To understand this, we need to scrutinize the article in detail. (Statistically minded readers will recognize the fallacy described by Gelman and Stern 2006.)

The analysis starts with 201 adolescents diagnosed with gender dysphoria. The children were divided into two groups: those deemed eligible for puberty blockers immediately, and those who needed more time due to "comorbid psychiatric problems and/or psychological difficulties". This second group did not receive any physical intervention during the time of analysis, and so serves as a comparison group. Both groups received psychological support. The article chooses one outcome, psychosocial functioning as measured by the Children's Global Assessment Scale (CGAS). This scale was administered at the outset, and then after six, twelve, and eighteen months. It is suspicious that the article omits all the outcomes that were negative in the preliminary results of the 2011 experiment (GIDS 2015): the Child Behavior Checklist, the Youth Self Report Questionnaire, the Health Related Quality of Life scale, and the Body Image Scale.

The authors graph the CGAS results, but without confidence intervals—which indicate the extent of random statistical variation or noise. (The graph is redrawn with confidence intervals in Biggs 2019a.) The smaller the sample, the greater this noise. These samples shrank over time: after eighteen months, the group getting drugs numbered only 35, and the comparison group 36. The article does not explain why two thirds of the subjects disappeared. Presumably they did not stop the medication, because none of the children in the 2011 experiment quit GnRHa in the first two years (Gunn et al. 2015b).

The group given puberty blockers from six months onwards showed improvement at eighteenth months: the average CGAS score had increased from 61 to 67. This improvement is statistically significant, and it is the one that the authors chose to highlight. However, these children also received psychological support, and so attributing this improvement to medical intervention is unjustified. The crucial comparison is between the group receiving GnRHa and the comparison group. The latter's average CGAS score after eighteen months was lower, 63 compared to 67. This is hardly surprising because the comparison group was composed of children with more serious psychological problems. Anyway, this difference is *not statistically significant*: a two-tailed t-test for the difference between group means yields a p-value of .14, far beyond the conventional .05 threshold. In other words, the samples were so small, and there was such wide variation in scores within each group, that we can draw no conclusions. There is no evidence that puberty blockers improve psychosocial functioning. No wonder that GIDS' own webpage on the evidence for medical intervention does not cite this article, nor does the recent update on the experiment (GIDS 2019a, 2019b).

The failure to fully publish the results of the experiment—for all 44 children given triptorelin, on all the outcomes that the study measured—suggests that it was a pretext to administer unlicensed drugs rather than an attempt to acquire scientific knowledge.

Consequences

The absence of comprehensive publications would be serious enough if the unlicensed use of triptorelin had been confined to the 44 experimental subjects. Sometime around 2013, however, the Director of GIDS transitioned from scientific caution to enthusiastic advocacy. Her new attitude was manifested in a BBC television documentary—aimed at children aged 6 to 12—broadcast in November 2014. It followed a 13-year-old girl who wished to be a boy, Leo, who was one of the experimental subjects. Carmichael appears on camera to reassure Leo:

> The blocker is an injection that someone has every month which pauses the body and stops it from carrying on to grow up into a man or a woman. … And the good thing about it is, if you stop the injections, it's like pressing a start button and the body just carries on developing as it would if you hadn't taken the injection. (BBC 2014)

To emphasize this point for the juvenile audience, the film superimposes a pause button on the screen. The clearest indictment of her statement to children comes from her own words a year later:

> The blocker is said to be completely reversible, which is disingenuous because nothing's completely reversible. It might be that the introduction of natal hormones [those you are born with] at puberty has an impact on the trajectory of gender dysphoria. (*Guardian*, 12 September 2015)

By 2015, however, GIDS had embraced the Dutch protocol with enthusiasm. "The Early Intervention Clinic will continue to follow the Service's 2011 research protocol, which *following evaluation*, has now become established practice, with the exception that hormone blockers will now be considered for any children under the age of 12 if they are in established puberty" (NHS England 2015: 26, my emphasis). By 2017, GIDS (including its satellite operation in Leeds) had prescribed GnRHa for a total of 800 adolescents under 18, including 230 children under 14 (*Mail on Sunday*, 30 July 2017). New prescriptions were running at 300 per year (BBC News, 2018). Freedom of Information requests submitted at the end of 2018 revealed that neither GIDS nor University College London Hospitals NHS Foundation Trust (which provides endocrinology services) kept precise records of the number of children given GnRHa; "work is currently in progress to manually enter all hormone blocker prescription data onto a database, pending future meetings with UCLH and LGI [Leeds General Infirmary] to ascertain who is collecting this info and how it is to be reported."[6] A subsequent request, however, revealed that 267 children under 15 were referred to the endocrine clinic and consented to puberty blockers from the beginning of 2012 to the end of 2018 (Tavistock 2019a). This figure includes most of the 44 experimental subjects, excepting perhaps half a dozen who started in 2011.

The abstract describing the baseline characteristics of the children in the experiment concluded: "Assessment of growth, bone health and psychological outcomes will be important to assess the medium and *long-term safety and effectiveness* of early intervention" (Gunn et al. 2015b: A198, my emphasis). This aspiration was never implemented. GIDS recently acknowledged that it loses track of its patients after they turn 18, blaming "the frequent change in nominal and legal identity, including NHS number in those referred on to adult services"—"to date they have not been able to be followed up" (Butler et al. 2018: 635).[7] By contrast, the Amsterdam clinic does attempt to trace its patients over time. The

[6] Internal Review (18-19312) of Susan Matthews' Freedom of Information request to the Tavistock (18-19230), 24 February 2019.

[7] Transgender activists successfully lobbied the NHS to provide new numbers to patients as well as to change the sex on their medical records (Birch 2014).

pioneer, B, has been followed to the age of 35. He did not regret transition, but scored high on the measure for depression. Owing to "shame about his genital appearance and his feelings of inadequacy in sexual matters", he could not sustain a romantic relationship (Cohen-Kettenis et al. 2011: 845). To the clinicians, however, this case exemplifies the success of the Dutch protocol.

Conclusion

GIDS and UCL launched an experiment in 2011 to use GnRHa to stop puberty in children suffering from gender dysphoria. The impetus for this unlicensed treatment came from children and parents, along with transgender activists and some clinicians, who seized on the notion that blocking puberty was akin to alchemy—it would enable a child to change sex, as long as he or she started young. Given unrelenting pressure from Mermaids and GIRES, supported by the climate of opinion among the *Guardian*-reading classes, the Tavistock arguably had to concede to the demand for GnRHa below the age of 16. From the outset, however, the experiment was flawed. The Patient Information Sheet understated the risks of this unlicensed treatment, despite those risks being acknowledged explicitly in the research proposal. Worse was to come. Before the experiment had run its course, Carmichael claimed "that the results thus far have been positive" in order to justify what must have been a premeditated decision to incorporate the Dutch protocol into the policy of GIDS. She even appeared on children's television to disingenuously promote GnRHa.

In fact, the initial results showed predominantly negative outcomes. The only tabulated data available, for 30 of the subjects after a year on triptorelin, showed that children reported greater self-harm; girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body—so drugs exacerbated gender dysphoria (GIDS 2015). The fact that these outcomes have never been published is a serious indictment of Carmichael, Viner (now President of the Royal College of Paediatrics and Child Health), Di Ceglie, and the other scientists who proposed the research.[8] The failure can be highlighted by comparing another use of triptorelin: the treatment of hypersexuality in men, for which it is licensed. The chemical castration of seven dangerous sex offenders in Broadmoor Hospital resulted in a report spanning two pages, which detailed the adverse side effects experienced by three patients (Ho et al. 2012). The use of triptorelin on 44 adolescents—off license—has produced only two single-page abstracts reporting outcomes for subsets of the subjects (Catanzano and Butler 2018; Tobin, Ting, and Butler 2018).

Some of the experimental subjects were apparently included with older adolescents from GIDS in one published article (Costa et al. 2015). It examines a single outcome measure—notably not one of the measures that yielded negative effects in the preliminary results. This article misrepresents its finding. Properly analyzed, it shows no evidence for the effectiveness of drugs: there was no statistically significant difference in psychosocial functioning between the group given triptorelin and the comparison group given only psychological support.

My critique has evaluated the Tavistock's experiment in accord with its own aims, as laid out in the 2010 research proposal. For reasons of space, this paper has not discussed three additional serious problems attending the use of GnRHa to block puberty. The Dutch protocol was originally touted as diagnostic aid as well as treatment; it would give the child time to ponder her or his gender identity (Cohen-Kettenis and van Goozen 1998). In fact, however, children given GnRHa almost invariably progress to cross-sex hormones. The 2011 experiment was typical insofar as none of the children is known to have stopped the drug regime after one or two years (Gunn et al. 2015; Carmichael et. al 2016). (GIDS has never

[8] Names were redacted in the copy obtained from the Health Research Authority.

revealed the proportion who went on to cross-sex hormones.) Before the introduction of puberty blockers, around four fifths of young children with gender dysphoria would grow out of it naturally, typically becoming gay, lesbian, or bisexual adults (e.g. Zucker 2019). Using GnRHa to block puberty does not mean pressing a pause button, as Carmichael asserted—it is more like pressing fast forward into cross-sex hormones and ultimately surgery.

The second problem is obvious. Blocking puberty effectively destroys the individual's ability to have children. If the adolescent stops taking GnRHa, fertility should recover, but as we have seen, stopping is exceptional. The third problem is rarely admitted. Blocking puberty impedes the development of sexual functioning; some children given GnRHa never develop the capacity for orgasm (Jontry 2018). There is a strong taboo against mentioning this. The word 'orgasm' did not appear in the proposal for the 2011 experiment, and never appears on the GIDS website. When the endocrinologist at GIDS, Gary Butler, was asked about the effect of GnRHa on the ability to orgasm, he refused to answer.[9]

Since my critique was initially posted in March (Biggs 2019a), GIDS has responded with prevarication and obfuscation. When a parliamentary question was asked on my behalf, the House of Lords was told on 22 May that the Tavistock "plans to publish the data once all of the young people in the study have reached the stage when a clinical decision is made about moving from pubertal suppressants to cross-sex hormones, which the Trust expects to occur in the next 12 months" (Blackwood 2019). Just over a month later, GIDS belatedly posted a webpage providing an update on the experiment. "The study concluded in February 2019 when the last cohort member began the next stage of therapy (cross-sex hormones) at age 17 years" (GIDS 2019b). How can these two statements be reconciled? If the study had really finished in February, coincidentally just before my critique appeared, why was Parliament told in May that it would finish in the next twelve months?

"Analysing and extrapolating from different data sets out of context can be misleading" states the Tavistock (*Daily Telegraph*, 8 March 2019), downplaying my revelation of negative results. My analysis was dictated by the fact that GIDS and UCL produced a congeries of inconsistent data. The number of subjects varies from 30 (GIDS 2015) to 31 (Tobin, Ting, and Butler 2018) to 44 (e.g. Carmichael et al. 2016) to 50 (e.g. Gunn et al. 2015a) to 101 (Costa et al. 2015). It has taken me—along with Elin Lewis, Susan Matthews, and two others who must remain anonymous—many months of painstaking effort to reconstruct the course and results of the experiment. To dispel this confusion, Viner and Carmichael could simply tabulate *all* the various outcomes for *all* 44 children given GnRHa in this experiment. If the results were really positive, why the secrecy? Even after the experiment has come under scrutiny, GIDS still seems to be concealing negative findings. "Outcomes and outputs from the study" (GIDS 2019b) notably omits unpublished sources that showed psychological outcomes to be disappointing (Butler 2016) or negative (GIDS 2015; Carmichael et al. 2016). The conference presentation disclosing that the youngest child given GnRHa was 10 (Gunn et al. 2015a) has now vanished from the website.

By now the experiment has been running for eight years. According to the original research proposal, "At the end of the *first three years* the data will be analysed and an interim report will be produced giving a provisional evaluation in line with the objectives of the study" (Viner 2010, my emphasis). That commitment to produce a report with evaluation in 2014 has never been met. Subsequently, Carmichael's keynote address to WPATH in 2016 promised that "we're about to publish" results of the early intervention research (Carmichael 2016). That was three years ago. The first child consented to GnRHa in June 2011; the final subject must have started on the drug by late 2014. Therefore the entire cohort must have

[9] The question was posed by Susan Matthews after Butler's talk to the European Society for Paediatric Endocrinology's symposium on the Science of Gender, London, 19 October 2018.

completed three years of the drug regime by the end of 2017. The results should have been closely monitored and the outcomes published in scientific journals. The Tavistock has failed not just the scientific community, but more importantly the children in its care.

The Health Research Authority also emerges as negligent. After approving the research in 2011 (and an amendment in 2012 to enable children with very low bone density to take part), the Research Ethics Committee did nothing to ensure that the experimental findings were reported. From 2013 onwards, Viner as chief investigator did not submit the requisite annual progress report. The Committee posted occasional reminders, the final one in August 2015. It then seems to have forgotten the study.[10]

The Tavistock Trust now boasts of winning £1.3 million to conduct research (with UCL and two other universities) into the long-term outcomes for young children who use the service, "including both those who go on to use physical interventions such as hormone blockers and those who do not" (Tavistock 2019c). Given the failure of GIDS and UCL to publish the comprehensive data they have been gathering for eight years, why fund them to collect more? There is also a more insidious problem. Carmichael pronounced the results of the experiment to be "positive" back in 2014, and used this to justify a general policy of blocking puberty. Since then, GnRHa has been administered to more than 200 children under 15. How can GIDS and UCL now objectively analyze data from the experiment, when they naturally have a vested interest in justifying their longstanding policy of treating gender dysphoria with GnRHa?

What, then, is to be done? Richard Byng (2019) recently demanded a moratorium on the use of GnRHa for children suffering from gender dysphoria until there is robust evidence that this drug regime is safe and effective. A team of independent researchers must be given access to all the data from the 2011 experiment. They will need expertise in statistics, psychiatry, and endocrinology; most importantly, they must have no vested interests in the promotion of GnRHa. Given that this experiment has been used since 2014 to justify the provision of these drugs to children under the NHS, the outcomes of this experiment—on all the physical and psychological measures that were collected—must be published urgently.

[10] I wrote to the Chair of the London-Bloomsbury Research Ethics Committee, James Linthicum, on 11 April 2019 to convey my serious concerns; he never replied.

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

BRIANNA BOE, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**Case No. 2:22-cv-184-LCB**
	)	
STEVE MARSHALL, *et al.*,	)	
	)	
Defendants.	)	

ORDER

This case raises a constitutional challenge to the Alabama Vulnerable Child Compassion and Protection Act. Defendants[1] now move to compel the United States Government—intervening on behalf of Plaintiffs[2]—to answer eight interrogatories. (Doc. 250 at 1, 6–7). For the reasons below, the Court grants in part and denies in part Defendants' motion.

I. BACKGROUND

Plaintiffs and the Government challenge the constitutionality of Section 4(a)(1)–(3) of the Alabama Vulnerable Child Compassion and Protection Act. (Doc.

[1] Defendants are Alabama Attorney General Steve Marshall, Montgomery County District Attorney Daryl Bailey, Cullman County District Attorney C. Wilson Baylock, Lee County District Attorney Jessica Ventiere, Jefferson County District Attorney Danny Carr, and District Attorney for the 12th Judicial Circuit Tom Anderson. (Doc. 159 at 6–7).

[2] Plaintiffs are five transgender minors (Minor Plaintiffs), their parents (Parent Plaintiffs), a clinical child psychologist, and a pediatrician. (Doc. 159 at 3–5).

159 at 2–5). Put simply, Section 4(a)(1)–(3) makes it a crime to administer or prescribe puberty blockers and hormone therapies to a minor for purposes of transitioning the minor's gender. S.B. 184, ALA. 2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The Act defines "minor" as anyone under the age of nineteen. *Id.* § 3(1); ALA. CODE § 43-8-1(18).

In May 2022, the Court enjoined Defendants from enforcing Section 4(a)(1)–(3) of the Act pending trial. (Doc. 107 at 32). The Court found in part that Parent Plaintiffs were substantially likely to succeed on their claim that the Act violates their constitutional right to direct the upbringing of their children and that Minor Plaintiffs were substantially likely to succeed on their claim that the Act unconstitutionally discriminates against them based on their sex. *Id.* at 14–24. Defendants appealed the decision to the United States Court of Appeals for the Eleventh Circuit, and the parties began discovery. (Doc. 108 at 1); (Doc. 134 at 4). This dispute followed.

II. LEGAL STANDARD

Federal Rule of Civil Procedure 26 establishes the general scope of discovery. Under that rule, a party may obtain discovery on "any nonprivileged matter that is relevant to any party's claim or defense and proportional to the needs of the case, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties'

resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit." FED. R. CIV. P. 26(b)(1). Relevant discovery includes "any matter that bears on, or that reasonably could lead to other matters that could bear on, any issue that is or may be in the case." *Oppenheimer Fund, Inc., v. Sanders*, 437 U.S. 340, 351 (1978).

During the course of discovery, a party may serve on any other party written interrogatories relating to "any matter" within the scope of discovery. FED. R. CIV. P. 33(a)(2). Federal Rule of Civil Procedure 37(a)(3)(B)(iii) provides that, should an interrogatory go unanswered, the party seeking discovery may move to compel an answer. The party who opposes production bears the burden to prove that the requested information falls outside the permissible scope of discovery. *See Panola Land Buyers Ass'n v. Shuman*, 762 F.2d 1550, 1559 (11th Cir. 1985).

III. DISCUSSION

Defendants move to compel the Government[3] to answer eight interrogatories. (Doc. 250 at 1, 6–17). Below, the Court considers whether each interrogatory falls within the scope of discovery.[4]

[3] In their motion, Defendants specify that the eight interrogatories are directed to the United States Department of Health and Human Services (HHS), "the agency within the United States most likely to possess relevant information." (Doc. 250 at 8).

[4] The Government initially argued that HHS is not a party to this suit for purposes of discovery. (Doc. 254 at 5–9). At oral argument, however, the Government withdrew that argument. The Court therefore presumes that HHS is a party for purposes of this discovery dispute.

A. Interrogatory 11

Interrogatory 11 reads as follows: "Identify (including by identifying the specific persons or entities involved) any ways in which You monitor, or have monitored, the health outcomes of Minors, in Alabama or elsewhere, who receive Puberty Blockers, Cross-Sex Hormones, and/or surgical interventions to treat Gender Dysphoria and/or Related Conditions." (Doc. 250 at 6). This case, at least in part, turns on whether puberty blockers and hormone therapies are a safe and effective way to treat gender dysphoria in minors. Because the Government puts forth no persuasive evidence or argument that answering Interrogatory 11 would be unduly burdensome, the Court grants Defendants' motion with respect to Interrogatory 11.

B. Interrogatory 12

Interrogatory 12 reads as follows: "Identify any ways in which You track and/or review, or have tracked and/or reviewed, evidence related to the efficacy or safety of using Puberty Blockers, Cross-Sex Hormones, and/or surgical interventions to treat Minors suffering from Gender Dysphoria and/or Related Conditions." (Doc. 250 at 6). For the reasons provided *supra* Section III.A, the Court grants Defendants' motion with respect to Interrogatory 12.

C. Interrogatory 13

Interrogatory 13 reads as follow: "Identify (including by identifying the specific persons or entities involved) any ways in which You track and/or review, or have tracked and/or reviewed, evidence or instances of Desistance or Detransition." (Doc. 250 at 6–7). For the reasons provided *supra* Section III.A, the Court grants Defendants' motion with respect to Interrogatory 13.

D. Interrogatory 14

Interrogatory 14 reads as follows: "Identify (including by identifying the specific persons or entities involved) any ways in which You identify, define, monitor, track, and/or discourage 'disinformation' related to Transitioning treatments in Minors. *See, e.g.*, AAP Letter to Merrick Garland, Oct. 3, 2022, https://downloads.aap.org/DOFA/DOJ%20Letter%20Final.pdf." (Doc. 250 at 7). Neither the interrogatory itself nor the cited letter defines the term "disinformation." Accordingly, Interrogatory 14 is impermissibly vague and overbroad. The Court therefore denies Defendants' motion with respect to Interrogatory 14.

E. Interrogatory 15

Interrogatory 15 reads as follows: "Identify (including by identifying the specific persons or entities involved) any ways in which You are reviewing WPATH's Standards of Care 8 (SOC-8) or using SOC-8 to update Your guidance or practices." (Doc. 250 at 7). As the Court has previously explained, WPATH's

standards for treating gender dysphoria in minors goes to "the very heart" of this case. (Doc. 246 at 64). The Government provides no persuasive evidence or argument that answering Interrogatory 15 would be unduly burdensome. Thus, the Court grants Defendants' motion with respect to Interrogatory 15.

F. Interrogatory 16

Interrogatory 16 reads as follows: "Identify any studies You are funding, conducting, or helping to fund or conduct—or have funded, conducted, or helped to fund or conduct—related to Transitioning treatments in Minors." (Doc. 250 at 7). For the reasons provided *supra* Sections III.A, III.E, the Court grants Defendants' motion with respect to Interrogatory 16.

G. Interrogatory 17

Interrogatory 17 reads as follows: "Identify (including by identifying the specific persons or entities involved) any ways in which You collaborate or work, or have collaborated or worked, with WPATH, USPATH, the American Academy of Pediatrics, and/or Endocrine Society regarding the use of Transitioning treatments in Minors." (Doc. 250 at 7). For the reasons provided *supra* Sections III.A, III.E, the Court grants Defendants' motion with respect to Interrogatory 17.

H. Interrogatory 18

Interrogatory 18 reads as follow: "Identify (including by identifying the specific persons or entities involved) any ways in which You have provided, are

providing, or have decided to provide funding for Transitioning Minors." (Doc. 250 at 7). For the reasons provided *supra* Sections III.A, III.E, the Court grants Defendants' motion with respect to Interrogatory 18.

IV. CONCLUSION

Defendants' motion to compel (Doc. 250) is **DENIED** with respect to Interrogatory 14 and **GRANTED** in all other respects.

DONE and **ORDERED** March 27, 2023.

LILES C. BURKE
UNITED STATES DISTRICT JUDGE

From: Kumar, Vatsala (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC510606A9034939AC2EB2C237DD8CF3-KUMAR, VATS <Vatsala.Kumar@hhs.gov>
To: (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care
Date: 2022/08/10 15:24:55
Priority: Normal
Type: Note

Hi (b)(6)

I'd requested a transcript of the hearing on the Florida rule back when I first started drafting the memo, and I just finally received that. There shouldn't be much in here that isn't in my original appendix, but I'm attaching it anyway in case it's useful for us or CMS.

See you soon!

Vatsala

From: Kumar, Vatsala (HHS/OCR)
Sent: Friday, August 5, 2022 12:44 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Sorry for the delay on getting this back to you! As you'll see, I ended up going a little past just the article and including some other critiques about authors/works that were cited in the report. I also want to flag that many of these authors/works were cited in the comments to the 2019 NPRM that I reviewed earlier this summer.

Please let me know if I can do anything further on this! It's definitely not comprehensive (I didn't go through everything they cited), but focuses just on some of the bigger/more obvious issues. I'm happy to do a deeper dive if that would be useful.

Have a good weekend!

Best,
Vatsala

From: Kumar, Vatsala (HHS/OCR)
Sent: Wednesday, August 3, 2022 3:01 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

(b)(5)

Have a safe flight!

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, August 3, 2022 3:00 PM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Thank you! I sent this to myself to read also!

(b)(5)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Sent: Wednesday, August 3, 2022 2:58 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Vice published this article today where 10 authors of studies cited in the Florida Medicaid Report said that their work was distorted, misrepresented, etc.

(b)(5)

Thanks!

Best,
Vatsala

From: Kumar, Vatsala (HHS/OCR)
Sent: Monday, August 1, 2022 4:33 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Updated version attached; I also made the tweak that Lauren had in track changes.

(b)(5)

Best,
Vatsala

From: Kumar, Vatsala (HHS/OCR)
Sent: Monday, August 1, 2022 3:39 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

(b)(5)

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Monday, August 1, 2022 3:36 PM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi Vatsala,

(b)(5)

Thank you!
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Sent: Friday, July 22, 2022 2:58 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Please find attached a memo about the Florida proposed rule. While the document is pretty long, note that the memo itself is only the first six pages, and the rest is a rundown of the public hearing that was held.

This focuses primarily on public and written comments I was able to find and some of the major issues that have come up therein, but I'm keeping an eye on the news to see if there are any other developments.
Please let me know if I can do any follow-up on this today or next week!

Have a great weekend!

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, July 20, 2022 11:15 AM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Yup!

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Sent: Wednesday, July 20, 2022 11:14 AM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Yes! Can do. Is Friday an okay timeline for this?

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, July 20, 2022 11:12 AM

To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: FW: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi Vatsala,

We are meeting with CMS to discuss the below FL proposed rule next week; are you able to do some research to find out the latest? Maybe there is a transcript or recording of the public hearing as well?

If you can draft up the information as a briefing memo for the Director, that would be great. I have attached a sample for format of the header, and for the body you can include the headers of Background, Current Status, and maybe next steps? Also if there is any information about organizations working in FL on the issue that would be good to know.

Once we have a time, I'll send you the invite.

Thank you!
(b)(6)

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Tuesday, June 21, 2022 9:32 AM
To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; Katch, Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>
Cc: Barron, Pamela (HHS/OCR) <Pamela.Barron@hhs.gov>
Subject: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Good morning all,

I am sure you have all seen the news, but I am flagging the State of Florida's proposed rule 59G-1.050, published in the Florida Administrative Record on Friday (6/17/2022), to prohibit Florida Medicaid coverage of the below services "for treatment of gender dysphoria": 1. Puberty blockers; 2. Hormones and hormone antagonists; 3. Sex reassignment surgeries; and 4. Any other procedures that alter primary or secondary sexual characteristics. Proposed 59G-1.050(7)(a). The proposed rule futher states that for the "purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C. Proposed 59G-1.050(7)(b). I have attached the notice here for ease of reference.

There is a public hearing scheduled for July 8, 2022 from 3:00 – 5:00 p.m. in Tallahassee, FL.

I'm not sure if calls are already happening on this, but since they implicate both CMS and OCR equities it seems like coordination would be beneficial.

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her) | Section Chief
Office for Civil Rights
U.S. Department of Health &Human Services

200 Independence Ave. S.W., Room 532E
Washington, D.C. 20201
Phone: (b)(6) (b)(6)
Email: (b)(6)

Please note I will be out of the office with no email access July 4 – 18, 2022.

Sender: Kumar, Vatsala (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC510606A9034939AC2EB2C237DD8CF3-KUMAR, VATS <Vatsala.Kumar@hhs.gov>

Recipient: (b) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) (b)(6)

Sent Date: 2022/08/10 15:24:50

Delivered Date: 2022/08/10 15:24:55

TAPED PROCEEDINGS
IN RE: PROPOSED RULE 59G-1.050
HELD ON JULY 8, 2022

Transcribed by:

CLARA C. ROTRUCK

Court Reporter

TAPED PROCEEDINGS

MS. COLE: My name is Chloe Cole, and I am a 17-year-old detransitioner from the Central Valley of California. I was medically transitioned from ages 13 to 16. My parents took me to a therapist to affirm my male identity. The therapist did not care about causality or encourage me to learn to be comfortable in my body because of -- partially due to California's conversion therapy bans. He brushed off my parents' concerns about that because he had hormones, puberty blockers, and surgeries. My parents were given a suicide threat as a reason to move me forward in my transition.

My endocrinologist, after two or three appointments, put me on puberty blockers and injectable testosterone. At age 15, I asked to remove my breasts.

My therapist continued to affirm my transition. I went to a top surgery class that was filled with around 12 girls that thought they were men -- I thought that they were men. Most were my age or younger. None of us were going to be men. We were just fleeing from the uncomfortable feeling of becoming women.

I was unknowingly physically cutting off my

true self from my body, irreversibly and painfully. Our transidentities were not questioned.

I went through with the surgery. Despite having therapists and attending the top surgery class, I really didn't understand all of the ramifications of any of the medical decisions I was making. I wasn't capable of understanding it, and it was downplayed consistently.

My parents, on the other hand, were pressured to continue my so-called gender journey with the suicide threat.

I have been forced to realize that I will never be able to breastfeed a child, despite my increasing desire to as I mature. I have blood clots in my urine. I am unable to fully empty my bladder. I do not yet know if I am capable of carrying a child to full term. In fact, even the doctors who put me on puberty blockers and testosterone do not know.

No child should have to experience what I have. My consent was not informed and I was filled by (inaudible).

A VOICE: Thank you for your comment.

(Applause.)

A VOICE: The next speaker will be Sophia

Galvin.

MS. GALVIN: My name is Sophia Galvin. I am a detransitioner. I began detransitioning at 17 and a half socially. At 18 was when I began detrans- -- I mean transitioning medically.

I had a history of mental illness. I had suicidal ideation and I would self-harm. And my wanting to transition was all in an effort to escape the fear of being a woman in this society and because of traumas that I had been through in my life.

So I continued down the process, and then I ended up removing my breasts at 19 years old because I was trapped, afraid to go back to my original ideo- -- to my original sex, and basically look crazy to the people around me.

When I detransitioned -- after I detransitioned, it was very difficult because I didn't have any support. The doctor basically just told me to stop the hormones. I didn't have anyone to speak to about it, I didn't go to a mental health counselor, and I didn't prepare anything. I just really want to say that this is not good for children. I was harmed by this, and it should not be covered under Medicaid.

A VOICE: Thank you for your comments.

(Applause.)

A VOICE: The next speaker is Katie Caterbury.

MS. CATERBURY: At the age of 14, my once healthy and happy daughter was convinced by the Gay-Straight Alliance at school that she was my son. At the age of 16, a physician injected her with testosterone without my consent and without my knowledge. At the age of 17, Medicaid paid surgeons to perform a double mastectomy and a hysterectomy as an outpatient. At age 19, Medicaid paid for her to undergo a phalloplasty.

She had and still has private insurance that was bypassed. I fought against what happened to my daughter every step of the way, but to no avail.

How can any rational adult, much less a physician, not know that it is impossible to change one's biological sex? Why are there doctors convincing trusting parents to affirm the lie that biological sex is changeable? They prescribe irreversible puberty-blocking drugs and powerful wrong-sex hormones and amputate healthy breasts and remove reproductive organs from children against the protests of their parents.

Affirming the false notion to a child that it

is possible to change one's sex is child abuse. Administering powerful hormones that cause irreversible changes to their bodies and their brains is child abuse. Amputating the healthy body parts of a child whose brain has not reached full decision-making maturity is simply criminal.

Why are these doctors not criminally charged? Why is this being funded with taxpayer dollars? This must be stopped.

Three years ago, I traveled to Washington, DC -- Washington, DC, to speak to federal lawmakers. I begged their staff to do something. Democrats and Republicans, no one seemed to care. But I will not give up trying until this medical experiment on children is over.

To every single person fighting for the health and lives of our children, I am profoundly grateful. Thank you.

(Applause.)

A VOICE: Just so we get through all the speakers, we'd ask that you hold your applause until the end of the program.

Next speaker will be Jeanette Cooper.

MS. COOPER: My name is Jeanette Cooper, and I am here on behalf of Partners for Ethical Care, a

nonpartisan, nonprofit organization that has no paid staff.

No therapy is better than bad therapy, and children are suffering because parents cannot find professionals to serve the psychological needs of their families and children, and they are being met with a medical treatment for a psychological condition. We need to make space in the public sphere for ethical therapists by removing the medical treatment option.

Nearly every therapist who publicly speaks is a cheerleader for gender identity affirmation, gluing that poisoned bandage on the skin of children, causing permanent psychological and physical harm by solidifying an idea that maybe you were born in the wrong body.

We are here to state the obvious. No child can or ever will be born in the wrong body. Everyone knows what a woman is, but some people are afraid to say it. We are not afraid.

Our organization was founded by a handful of mothers who realized that no one was coming to protect these children. We could not wait any longer for help to arrive.

Families are desperate to find actual support.

They do not want a poisoned bandage that cosmetically covers a wound that grows deeper when covered and left untreated. Affirmation is a poisoned bandage that does not help to heal, but hides a deep need that will not be helped by injections and surgeries.

The state has no business using taxpayer funding to turn children into permanent medical patients. The state has no business assisting doctors in selling disabilities to vulnerable, suffering children by prescribing puberty blockers, cross-sex hormones, and extreme cosmetic body modification. These so-called treatments are not real health care.

The state should, however, fund legitimate and proven care. For many children, a transidentity is a crutch. It is a placeholder that stands in for real suffering that hasn't been named. If they can find a pediatrician, family therapist, or other professionals who will address their actual needs, children discard their transidentity and move forward with self-actualization, rather than staying in a state of stunted psychological and physical growth, surviving with superficial, short-term validation like a street drug that needs

to be injected every day. Our job is to protect children, and we have to step in because the medical field is failing these families.

Thank you for stepping in now before it costs the State of Florida much more than dollars. Thank you for this proposed rule. We support you.

(Applause.)

A VOICE: Thank you for your comments.

Next speaker, Donna Lambart.

MS. LAMBART: Hello. My name is Donna Lambart. I am here on behalf of concerned parents to speak in support of the rule to stop allowing Medicaid to pay medical transition of children in Florida.

Today I appeal to you on behalf of over 2,600 parents in our group. As parents, we know our kids. As people, we know right from wrong. But the health care professionals are presenting many of us with a false and painful choice: Accept what we know will permanently harm our children or lose them to suicide. These false ideas are being stated in the presence of children. This is not only cruel, it's simply not true. There is no data to prove that medically transitioning minors prevents suicide.

Society, the Internet, media, schools, and government convince kids that their parents que- -- if their parents question -- if their parents question their identity, it is because their parents hate them. Parents who are unwilling to drop all rational thinking and surrender to the affirmation-only model of care pay a social, emotional, and custodial price no parent should ever have to pay.

Parents lose their children every day to people who help them transition, leading them down a dangerous medical path that permanently -- permanently harming their healthy bodies with off-label drugs and experimental surgeries.

I interact with parents on a -- every day whose children are instantly derailed as a result of adopting a transgender identity. These children become angry and hostile and resentful. They begin lashing out at anyone who will not agree with their new-found identity. Parents are left -- have been forced to rely on each other to figure out how best to navigate this destructive social phenomenon.

The current one-size-fits-all affirmation model cuts parents out of the equation, charging forward with a rigid, transition-only course of

action.

A VOICE: Ma'am, excuse me, your time is up. Could you please wrap it up?

MS. LAMBART: Yes.

I would just like to say that on behalf of thousands of loving parents, we ask Florida -- the health -- to stand up for the protection of children and teens who are under -- who are being offered a magic fix. Parents deserve support and children deserve sound care.

Thank you for your support and your time.

(Applause.)

A VOICE: Thank you for your comments.

The next speaker is Gerald Buston.

MR. BUSTON: Ladies and gentlemen, I am here as a Christian pastor. 71 years ago, I gave my life to Jesus Christ and chose to live my life according to the Word of God, the Bible. The Bible teaches that God makes people male and female, and it says that repeatedly. Jesus said that himself. And for us to try to transition people away from what God did should be -- well, it definitely is a sin, but it should be a criminal abuse of children, especially when they're not at the age where they can properly process what they're doing to

themselves or allowing to be done to themselves.

I urge Medicaid don't support this. I urge the State of Florida to pass laws against it and not allow our children to be abused the way they are being abused by people that have one goal in mind, and that is depopulating the world by cutting back on the birth rate and by cutting back on the population we have in our world right now.

So I support the bill that we do not pay for this kind of stuff, and I would say let's go further and pass laws against it and make that extreme child abuse to do that to children that don't have the right to know.

(Applause.)

A VOICE: The next speaker is -- I believe it's Brady or perhaps Brandy Andrews.

MS. ANDREWS: Hey there, Brandy Andrews. I'm here to speak in support of banning Medicaid funding for transgender surgeries and treatments.

Transgender surgeries, puberty blockers, and cross-sex hormone treatments have been shown to be extremely harmful, especially to minors, causing sterility and irreversible physical and psychological damage.

Physically healthy, gender-confused girls are

being given double mastectomies at 13 and hysterectomies at 16, while males are referred for surgical castration and penectomies at 16 and 17, respectively.

How have we reached this point in life where we're allowing this at such a young age, but yet you have to be 16 to drive a car, 18 to buy a pack of cigarettes, where we're allowing children to change their genders before they've even reached puberty or shortly after?

Pharmaceutical companies are unethically enriching themselves off the destruction of countless young lives that are being fed puberty blockers, which these companies are advertising children. It's just straight-up child abuse, and it's preying on our society's most vulnerable youth.

Let kids be kids. I am asking Medicaid to stop funding experimental medical treatments on minors. Thank you.

(Applause.)

A VOICE: If I could remind folks to please state your name before you start your comments.

Next speaker is Sabrina Hartsfield.

MS. HARTSFIELD: Good afternoon. My name is

Sabrina Hartsfield, and I am speaking just from my own opinions. I am an alumni of Florida State University and I am a born-again Christian.

Because of this conviction, I believe we as human beings have an obligation to ensure poor and marginalized people of all ages have adequate medical care through the Medicaid program.

Without gender-affirming health care, transgender and gender nonconforming individuals will die. According to every major legitimate medical organization, gender affirming care is the treatment for gender dysphoria.

I am here today to speak against Rule 59G-1.050, the Florida Medicaid trans and medical care ban, from being put into place.

Gender-affirming care is medically necessary and life-saving treatment that should be decided between a patient, their caregivers, and a health care professional, not big government.

Florida is about freedom from big government overreach. Medicaid should cover all medically-necessary treatment, and under the right to privacy found in Florida's constitution, this is, again, a decision that should be hands -- in the hands of the patient and their health care

providers.

This rule also violates the nondiscrimination protections for people of all gender identities found in the Affordable Care Act and the Medicaid Act.

Transgender and gender nonconforming people who have gender dysphoria are already at increased risk for negative health outcomes, such as being diagnosed with anxiety or depression, battling a substance use disorder, and attempting suicide. Denying medical care that has been determined to be the best practice by every major medical association from the American Psychological Association to the American Medical Association to the Endocrine Society will be life-threatening. Denying transgender and gender nonconforming people medical care can lead to depression, self-harming, social rejection, and suicidal behavior.

If the trans medical care ban is enacted, it will be putting the lives of over 9,000 transgender Floridians in danger.

Please block proposed Rule 59G-1.050.

(Applause.)

A VOICE: The next speaker is Simone Chris.

MS. CHRIS: Good afternoon. My name is Simone

Chris and I'm an attorney. I'm the director of the Transgender Rights Initiative Southern Legal Council. We are a statewide, not-for-profit, public interest civil rights law firm that utilizes federal impact litigation policy reform and individual advocacy to ensure communities that we serve have access to justice and freedom from discrimination.

We vehemently oppose the proposed rule based both on the science and evidence supporting the medical necessity of treatment for gender dysphoria and our own extensive experience working with hundreds of transgender adults and minors and witnessing the tremendous benefits that access to such care provides.

In effect, the proposed rule creates a blanket exclusion for coverage of medically-necessary health care for one of the most vulnerable populations in our state, eliminating the right of all transgender Floridians with Medicaid to even have their health care needs subjected to a medical-necessity analysis. The insidiousness of this rule is exacerbated by the fact that it places in its cross-hairs the individuals in our state who are already disproportionately likely to experience

poverty, homelessness, unemployment, poor mental and physical health outcomes, and to have the least access to resources in health care as it is.

We urge AHCA to reject these proposed changes to the rule excluding the coverage for all medically-necessary gender-affirming care because it directly contravenes the widely accepted, authoritative standards of care and the consensus of every major medical association in our country. It will cause significant harm to the individuals that we serve by depriving them of critical, life-saving medical care. It interferes with and substitutes the state's judgment in place of the doctor/patient relationship, the rights of the individual, and the fundamental rights of a parent to determine appropriate medical treatment for their own child, and it is a shameful waste of state resources.

Similar exclusions have been enjoined or struck down by courts across the country as inconsistent with the rights guarantee to Medicaid recipients under the Medicaid Act, under the equal protection clause of the 14th Amendment, the Affordable Care Act. And this litigation that the state will certainly find itself embroiled in is

wasting valuable state resources that could be better utilized enhancing the lives of Floridians rather than attacking them.

Thank you.

(Applause.)

A VOICE: Matthew Benson.

DR. BENSON: My name is Matthew Benson. I'm a board-certified pediatrician and pediatric endocrinologist in the state, and I agree with this rule. I think the data on which the gender affirmative model is based is not scientific.

The National Board of Health and Welfare of Sweden has recently enacted in that country pretty significant restrictions. And if we're going to do this type of care, it needs to be under an IRB-approved protocol and it needs to be based on the best data.

I'm used to prescribing these medications in the sense of puberty blockers. And one of the largest studies that came from Sweden was published around 2016, and basically what they showed is that in those individuals who are transgender and receive these types of procedures, the rates of overall mortality compared to the general population was three times that of the general

population; completed suicide, 19 times that of the general population; five times suicide attempts of the general population. Similarly, in Denmark, out of a 20-year period, by the time a similar study was done, 10 percent of the population had died.

We need better data. We need long-term perspective trials where we can look at adverse effects. We need much more robust data to justify these kinds of very aggressive therapies. And we've already seen two individuals, Chloe and Sophia, testify here today about how they were harmed by these procedures.

Thank you for your time.

(Applause.)

A VOICE: Next speaker, Karen Shoen.

MS. SHOEN: My name is Karen Shoen. I'm with the Florida Citizens Alliance and I'm a former teacher.

I would like to know why .03 percent of the population is dictating to 99.97 percent of the population to accept and pay for an elective surgery. Kids change their minds. I can tell you as a teacher, one day they want to be a fireman, the next day they want to be an engineer, and then they go into being something else.

The problem is we are not explaining the wonders of what it is to be comfortable in your body with both our parents and in our biology and hygiene glasses. So kids become fearful. It's our job to take that fear away as a teacher, not to force them into something else.

The children may be afraid of maturing, they may be afraid of a lot of things, but we're not looking for the root cause, we are now suggesting and implanting in their brains that they're not comfortable in their body.

I'd like to leave you with this thought: Can I drive a car? No, you're 13. Can I have a drink? No, you're 13. Can I shoot a gun? No, you're 13. Can I change my gender? Yes, you're in charge. How is that possible?

(Applause.)

A VOICE: Next speaker, Bill Snyder.

MR. SNYDER: Thank you. Bill Snyder. I (inaudible) Monticello.

I want to talk about a disease that has infected society today called reality disease. Charlie had reality disease. He woke up one morning and wouldn't get out of bed and go to work. His wife said, "Charlie, you've got to get up,

you've got to go to work." He said, "I can't, I'm dead." His wife said, "You're not dead, you're talking to me. I can see you breathing." Charlie says, "I can't get up and go to work, I'm dead." The wife called in a psychologist. Psychologist gave Charlie a lengthy interview. At the end of the interview, the psychologist said, "Charlie, come on, we're going to go downtown." They went downtown to the morgue. The psychologist opened a locker, (inaudible) out a cadaver on a tray, pulled the sheet back over the feet of the cadaver, said, "Charlie, dead people's hearts don't beat, they don't have circulation, they do not bleed." He took the toe of the cadaver, stuck a pin in it. No blood came out. The psychologist said, "See, Charlie, dead people don't bleed. Now, give me your thumb." Took Charlie's thumb, stuck a pin in it, out came bright, red blood. The psychologist said, "See, Charlie, you're not dead. That's blood." Charlie said, "What do you know? Dead people do bleed."

The further we live from reality, the further we move from morality, the further we move from virtue, the more secular we become. The more secular we become, the less freedom we have.

Please approve this proposed rule change. Thank you.

(Applause.)

A VOICE: Next speaker, Ingrid Ford.

MS. FORD: Yes. Good afternoon. I'm Ingrid Ford. Thank you for the opportunity. I'm with Christian Family Coalition. I've been a college counselor 15 years, and I'm here in support -- I'm to speak in support of Rule 59G-1.050 to ban Medicaid funding from transgender surgeries and treatments.

This rule will protect Florida residents, especially minors, from harmful transgender surgeries, harmful blockers, and other unnatural therapies being promoted by radical gender ideals and with no basis in science.

This rule also will protect taxpayers from being forced to subsidize these highly unethical and dangerous procedures, which can cost upwards of $300,000.

Thank you.

(Applause.)

A VOICE: Next speaker, Richard Carlins.

MR. CARLINS: Hello, my name is Richard Carlins and I am in support of the rule and I'm

just going to speak from the heart a little bit. I feel like I'm walking in a house of mirrors or something or it's just -- it's surreal, the world that I live in today from the world that I grew up in.

I had a traditional family, a mother and father. We're saying the Pledge of Allegiance in schools and having prayer in schools. We were founded upon Biblical principles. Our constitution goes hand in hand with that. We're battling with each other right now, you know, over things that were clearly right and wrong before.

Seriously, a kid has no idea. They're being indoctrinated. They're being indoctrinated even through commercials, Disney World, Coca-Cola commercials, the restaurants they go to. And then when they want to be what it is that they were pushed to be, we mutilate their bodies and it's irreversible. It's horrendous. It's a horrendous evil.

And with that, I go. I just can't believe where we're at. And we're -- God raises up nations and he brings down nations, and we are in judgment right now. This is wrong, we need to be able to admit that it is wrong and to help the children to

have wholesome lives that history prior to us -- this is just recent this -- what we're battling with right now. I'm just -- you know, not well-studied or anything, but I think it's 1,500 years that we've been living in Judeo-Christian principles, you know, and it's just recently that we're throwing any mention of God, the Bible, under the bus. They're not allowed to hear it. They're not allowed to know it. If you feel like you want to have pleasure this way or that way, with this, with that, you can and we're going to support it and do whatever it is so that you can never change your mind again and give you nothing wholesome to hold onto. That's all.

(Applause.)

A VOICE: Amber Hand. Amber Hand.

MS. HAND: Hi, I'm Amber Hand and I am just with the body of Christ.

So I come today because I represent -- well, I come from a family, my mom was gay and my dad was gay. He struggled with his identity his whole life, but he fought against it because he was a Christian. And I was taught by my dad I was a little girl, and by mom, I was a little boy. And so I got real confused, you know what I mean, and

I'm 36 today and I just realized -- last year I was thinking about getting a sex change still. I've always thought about it. And when I was a kid, I was like, "When I get boobs, I'm going to cut them off with a butter knife," you know what I mean?

And when we're kids, we're so impressionable. I remember my sister going and seeing my dad use the bathroom, and she went to use the bathroom like him, but he corrected her, you know, because we have to teach these kids right from wrong. And it's wrong to take kids and teach them, "Hey, you can make whatever decision you want and you don't even know mentally what you're really going through as a child." We need to take Medicaid and treat people for psychiatric problems and depression and teach them like you can be a female, it's okay to be a female today and say that you're a woman, you know, like -- and I just realized now at 36 that I want to have a baby, and if I had done that, I would have never been able to have a child.

And I just have to say that the Bible says, "Beloved, I wish above all things that thou mayest prosper and be in health even as thy soul prospers." And when we struggle with identity, our souls are in turmoil. And if we just begin to

realize that we just need to teach these kids right from wrong and that it's not okay to change your identity when God made you a male or a female, and when a little boy puts on a high heel because he sees his mother wearing a high heel, it's just play, like it's okay, but that's not what you wear, and teach him what to wear. We just don't understand as kids what's going on until somebody teaches us. We have learned behavior. We're programming kids these days with everything --

A VOICE: Time's up. Please wrap it up.

MS. HAND: -- (inaudible) around us to be somebody we're not. God bless.

(Applause.)

A VOICE: Shauna Peace.

MS. PEACE: Hi, my name is Shauna Peace, and I am just am here to speak in support of Rule 59G-1.050 to ban Medicaid funding on transgender surgery and treatment.

Children are being pressured and socialized at a very young age to identify as transgender. Much of the pressure is coming from on-line social networking sites that celebrate and encourage transgenderism while denying normal heterosexual behaviors. It accounts for much of the metric rise

in the children's identifying as transgender in the recent years. It has doubled since 2017, according to the news sensors for the Centers for Disease Control and Prevention.

The most thorough followup of sex reassignment people, which was conducted in Sweden, documented that 10 to 15 years after surgical reassignment, the suicide rate is twenty times to comparable peers. The alarmingly high suicide rate among post-operative transgender demonstrates the deep regret that may feel after irreversible mutilating their bodies with these barbaric procedures.

I am here today because I have had children that have battled with identity and sexual identity, and that my stepson is now identified as female. He wanted to when he was younger in years, to change, but now that he has gotten into his 20s, he has now decided that he wants to have children, and if you mutilate these children's bodies at an early age, they don't understand that they will never be able to procreate ever again. Whether you go female or male or male or female, neither sex will be able to procreate ever again. And I just think it's mutilating and it's not right.

Thank you very much.

(Applause.)

A VOICE: The next speaker, Leonard Lord.

MR. LORD: My name is Leonard Lord. I am much in favor of the bill.

Even as a boy, I wasn't comfortable in my body because I didn't know why I was here. So when I got the age to say, "I want to find out why I'm here," I spent three days fasting, praying, seeking God. He brought me to his Word, and I found out that the only way I got comfortable in my body was to know what I was created for.

And so what I found, either we're playing games, or if we really believe there's a God and the Bible is true, we find out this whole problem happens because we do not retain the knowledge of God in our conscience and are given over onto our own deception.

And now I hear all of the mental problems we're having. Well, it's real simple. God's spirit is the answer to what's missing in our lives. We're only complete in Jesus Christ. And the scripture says in Timothy 1:7, God has not given us a spirit of fear, we ought to fear man or woman, but he's given us power, love, and a sound mind. You take the Bible out of school, you take

God out of school, you take prayer out of school, and what have you got? You have no power, you have no love, and you have no sound mind.

So I'm just saying let's go back to getting mentally right is the only way I can at 75 is to know God created me, his Word is true, live in supernatural peace and joy and know where you'll spend eternity and don't live confused.

A VOICE: Thirty seconds.

MR. LORD: The devil is the author of confusion. Get a pure heart and live in peace and joy and enjoy things. If you spend your life trying to find out if you're a man or a woman, you'll never know why you're here.

All I can say, God bless you, I'm in support of the bill, and hopefully America will wake up and be a shining city on a hill for all the nations one more time. Lord bless you.

(Applause.)

A VOICE: Pam Olsen. Pam Olsen.

A VOICE: Dan or Pam?

A VOICE: Pam.

MS. OLSEN: It's me, Pam Olsen.

Thank you for this proposal. I've read all the pages. It's excellent. I am for stopping

Medicaid from paying for children and teenagers to have sex changes.

I've talked to a lot of kids that are confused, and they are confused. That's what's going on today. There is so much onslaught against these kids, and you've got kids saying, "I'm a boy, I'm a girl; no, I'm a girl, I'm a boy." You have kids today saying, "I'm a furry animal." Are we going to start paying for them to have furry animal body parts put into them? I mean, where does this stop?

And I am so thankful that this has been proposed, that we will stop the madness in Florida and we will not do this. I hope that you guys do approve this today because it matters for the sake of the children. You know, I've got 12 grandkids and I'm going to fight tenaciously, not only for my grandkids, but for their friends and for all the children across our state, our nation. We need to say stop the nonsense and let's do what is right. There are boys, there are girls, there are men, there are women.

Thank you so much for approving this. I believe you will do that. Thank you.

(Applause.)

A VOICE: Jon Harris Maurer.

MR. MAURER: Good afternoon. My name is Jon Harris Maurer and I'm the public policy director for Equality Florida, the state's largest civil rights organization based on securing full equality for Florida's LGBTQ community.

The proposed change to Rule 59G-1.050 is without sound scientific basis, it is without legal basis, and it is clearly discriminatory. The agency should reject it.

The proposed rule is about politics, not public health. We urge you to listen to the numerous medical professionals opposed to the rule. Experts from the country's and the world's leading health organizations disagree with the fundamental premise of the proposed rule. They endorse gender-afforming [sic] care. These organizations represent millions of medical professionals, and they recommend gender-affirming care. We're talking about the American Academy of Pediatrics and its Florida chapter, the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Physicians, the American Psychiatric Association, the American Psychological Association, the

American Academy of Family Physicians, the American Academy of Child and Adolescent Psychiatry, the Endocrine Society, the Society for Adolescent Health and Medicine, the Pediatric Endocrine Society, the World Professional Health Association for Transgender Health, and others; again, representing millions of medical professionals.

Furthermore, AHCA lacks the specific delegated rulemaking authority to adopt the proposed rule. The statutes that AHCA names as its authority to make this proposed rule --

A VOICE: Thirty seconds.

MR. MAURER: -- grant no authority for (inaudible) patient of the individual role for health care practitioners to make decisions with their patients.

The rule is simply discriminatory, it undeniably targets the transgender community. You may not understand what it's like to be transgender --

A VOICE: Fifteen seconds.

MR. MAURER: -- or to be a parent of a transgender kid just trying to find the best care for your kid, but transgender Floridians are here in this audience and they're telling you about how

harmful this rule would be to the more than 9,000 transgender Floridians on Medicaid. We know these therapies are safe because the agency is not opposing them for all Floridians.

A VOICE: Sir, please wrap it up. Your time is up.

MR. MAURER: In conjunction with the state willingly ignoring the body of scientific evidence that supports gender-affirming care, there's no question of the politically-calculated animus behind this proposed rule. Please reject the proposed rule.

(Applause.)

A VOICE: I appreciate your comments. I would just ask for decorum in the crowd. We want to give everybody equal opportunity to speak.

A VOICE: Next speaker, Anthony Verdugo.

MR. VERDUGO: Thank you. Good afternoon. I want to start off by thanking all of you for being here today and for your public service.

My name is Anthony Verdugo. I am the founder and executive director of the Christian Family Coalition. We are a leading human rights and social justice advocacy organization of Florida, and we're here to strongly support Rule 59G-1.050

to ban Medicaid funding for transgender surgeries and treatment.

They call it gender-affirming care. They don't care and it's not affirming. Let's get that straight. And we know that because of heroes who are among us here today, folks like Chloe Cole and Sophia Galvin. They are heroes because they've had the courage to come out and speak the truth in love.

And everyone needs to be respected and treated with dignity, but this is a war on children. These are crimes against humanity. Groomers are using their authority as adults to pressure children and ruin their lives.

I'm going to share with you about a brand, the No. 1 prescribed puberty blocker in America. It's called Lupron. And they themselves list on their package that "Emotional instability is a side effect and warrants prescribers to monitor for development or worsening of psychiatric symptoms during treatment."

These so-called medical organizations which were just listed --

A VOICE: Thirty seconds.

MR. VERDUGO: -- have been discredited.

World-renowned organizations such as the Royal College of General Practitioners in the United Kingdom, Australian College of Physicians, and the American College of Pediatricians -- and I will end with their quote -- say, "Americans are being led astray by a medical establishment driven by a dangerous ideology and economic opportunity, not science and the Hippocratic oath." The suppression of normal puberty, the use of disease-causing cross-sex hormones, and the surgical mutilation and sterilization of children constitute atrocities to be banned, not health care. Let kids be kids.

Thank you.

(Applause.)

A VOICE: Next speaker, Roberto Rodriguez.

MR. RODRIDGUEZ: Thank you very much for this opportunity. I love America as a veteran, ex-police officer, father, grandfather -- let me see what else, you know, and a father of a veteran who is serving in the Navy today as a pilot. And first of all, I wanted to thank you. You guys made me cry. Why? Because, you know, I have a question. Has -- you know, anybody can answer it. Has a doctor ever been wrong? You know, has a parent ever been wrong? Has teachers ever been

wrong? Have scientists ever been wrong? But, then, why are we listening and waiting for scientists and doctors to talk different to what we have evidence here today?

We have the evidence right here today. They came walking in this place and we're being blind to them, and I want to recognize you and I want you to let you know that the true dream is interwoven in every atom of your existence. God will fulfill his true dream to you, no matter what man try to do to you. You have a purpose, you have a reason, and today proves it.

And I'm here to tell you that this rule, we need to go ahead, I support it. We need to stop being ignorant to what faces us and listening to people.

I am from the Centers of God and I have multiple churches that will stand here today. So I'll tell you what, we're bigger than any organization there is right now and represent that we are for this rule.

God bless you and thank you. We love you guys for serving. Thank you.

(Applause.)

A VOICE: Next speaker, Michael Haller, M.D.

All right. Michael Haller, M.D.

DR. HALLER: Good afternoon, everyone. My name is Michael Haller and I am a graduate of the University of Florida's College of Medicine, pediatric residency, and the pediatric endocrinology fellowship. I hold a Master's in clinical investigation and I am the professor and chief of the Pediatric Endocrinology Division at the University of Florida. The views expressed here are, however, my own.

I have trained thousands of medical providers, participated in the development of national guidelines, and have treated tens of thousands of children, including many transgender youth.

I provide this background with full humility, but also to establish myself as an actual expert, both in the management of gender-diverse youth and as one who can review and analyze relevant literature.

The Gapums document and proposed rule change seeking to remove Medicare -- medical -- Medicaid coverage for gender dysphoria makes numerous false claims, uses a biased review of the literature, and relies on more so-called experts who actually lack actual expertise in the care of children with

dysphoria.

While there are a number of flaws, the state's plan following deserves specific commentary.

First, the state's primary assertion that gender-affirming therapy has not demonstrated efficacy and safety is patently false. Nearly every major medical organization that provides care for children, as you heard previously, have provided well-evidenced guidelines supporting gender-affirming care as the standard of care. The assertion from the state, the data included in those guidelines, are not as robust as the state would like them to be --

A VOICE: Thirty seconds.

DR. HALLER: -- is at best a double standard, and is at worst discriminary [sic] political fear. The state is either unwilling or willfully chooses to ignore the totality of evidence in support of gender-affirming care, and the latter seems most likely.

Second, the state's use of --

A VOICE: Fifteen seconds.

DR. HALLER: -- (inaudible) experts as (inaudible) advisers seeking to discredit evidence used (inaudible) of care is laughable. Several of

the state's own experts have been legally discredited from testifying as such in cases regarding gender-affirming care, while others have acknowledged publicly that they have never provided gender-related care to children.

A VOICE: Wrap it up.

DR. HALLER: The proposal to limit gender-affirming care to those dependent on Medicaid is poorly conceived, is likely to cause significant harm to Floridians dependent on Medicaid, and should be rejected. Thank you.

(Applause.)

A VOICE: Next speaker, Robert Yules.

Jason, did you want to comment?

A VOICE: I'm sorry, we have -- the panel has one comment to that. I'm going to refer this to Dr. Van.

DR. V: So just some insight into the support of gender-affirming care by the large societies, medical societies in the United States. The American Academy of Pediatrics has actually made a statement against this -- this, and the Florida chapter as well.

These are not standards of care. Standards of care by definition are an arduous process of

listening to all input from every side, every aspect, of a medical condition, and these individuals get together and they agree on someplace in the middle that they can all live with as a then standard of care.

These are merely guidelines. The guidelines from the Endocrine Society specifically state they are not standards of care. They're just guidelines. They are the opinions of the individuals who wrote the guidelines. The Endocrine Society guidelines were written by nine people in the first go-round and ten in the second go-round, all of which were ideologues from the World Professional Association of Transgender health.

That group -- that interest group excluded world renowned experts in the field and did not listen to their input, didn't include their input on purpose. And so it's not surprising that you come up with one view that does not really represent any kind of standards of care.

So we have to stop using the term "standards of care" when there are absolutely no standards of care in this instance that have been addressed.

(Applause.)

A VOICE: Mr. Yules. Mr. Yules.

DR. HALLER: I would also --

A VOICE: Sir, you've spoken already. If you have further comments, please submit them in writing.

A VOICE: No, I'm sorry, Dr. Haller. If you have further comments, you can -- you can refer them in writing. You can refer them in writing, Doctor.

A VOICE: Robert Yules.

MR. YULES: Yes, my name is Robert Yules. It's an honor and privilege to be here. I was born and raised in St. Petersburg, Florida, and my, how things have changed. Forty-three years ago, my senior high school class came here to view the legislature, and the topic of the day was about dog-catching rules in the state of Florida. My, how far we've come.

This was not even in the purview of anyone at that time. This was not in the purview of anyone ten years ago. This was not in the purview really of anyone five years ago to bring it to the state level, the city level, the classroom level, to be driven by the teachers' unions with all of their ideology, and really it begins and ends when man

proclaims himself as God. The truth begins with me and it ends with me. And our country is in a lot of trouble because people aren't willing to say "No, that's not your truth." There is a truth. That might be your perspective of the truth, but there is not your truth, your truth, your truth, my truth, his truth. It's not the way it works, and we're going down -- just even philosophically and morally, we're going down a very, very slippery road when we start delving into these things.

It's interesting to me also how a child cannot own this or own that or own this, and the thing we've been told for the last ten years, "Well, their brain's not fully developed until around 25." Everybody says that, right? Their brains aren't developed until they're 25, and now our governor caught such flack because he said don't teach kindergarteners --

A VOICE: Thirty seconds.

MR. YULES: -- about transgendering, leave it out till third grade. I think they should leave it out till 12th grade and let parents have those conversations with people. Put it back where parents talk to their own kids, and let's -- let's make school about science, technology,

engineering --

A VOICE: Fifteen seconds.

MR. YULES: -- and mathematics and get back where we need to be.

Thank you so much for your time. Thank you.

(Applause.)

A VOICE: At this time, we would like to remind everyone that they can submit comments in writing to medicaidrulecomments@ahca.myflorida.com. Information is provided on cards at the exit when we are finished, as well as up on the screen. We'll continue with the speakers.

A VOICE: Flaugh. Keith Flaugh.

MR. FLAUGH: Good afternoon. My name is Keith Flaugh. I am one of the founders of an organization called Florida Citizens Alliance, which is a not-for-profit organization of almost 200,000 parents and grandparents, and we focus on K through 12 education.

We have recently completed a detailed study in all 67 county school districts based on 58 novels that we found throughout. I've left a copy with Cole. I would encourage you to read it.

Twenty of those are LGBTQ and gender -- promoting gender dysphoria. Some of these

materials are actually designed for pre-K.

Children in our public schools are being purposefully confused, desensitized, and even pressured into abnormal sexual behavior. Gender idealogues are coaching kids to be into this dysphoria, and even telling them to threaten suicide.

There is a considerable debate in the psychiatric and medical circles about whether the transgender condition is biological or psychological. In numerous public schools, staffs and even teachers are aiding this dysphoria and purposely hiding what they're doing from the parents. Further, taxpayers shouldn't have to pay for this.

Florida Citizens Alliance strongly supports the rule of 59G-1.050, especially to protect minors from the harmful transgender surgeries, hormone blockers, and other unnatural therapies. Thank you.

(Applause.)

A VOICE: Robert Roper.

MR. ROPER: Hi, my name is Robert Roper. I'm here to speak in support of the rule to ban Medicaid funding for transgender surgeries and

treatments. The most important aspect of this rule is that it serves to protect the children of the state of Florida.

Gender confusion is the only disorder that comes with a false assertion that a child can actually be born in the wrong body. They are led to believe that some day they'll actually become a member of the opposite sex. That's impossible. Maybe that's why they call it "transgender." You never actually arrive at the desired outcome.

Gender confusion is the only disorder that the body is mangled to conform to the thoughts of the mind.

Gender confusion is the only disorder that the child actually dictates his or her medical care to medical and -- medical professionals and counselors, instead of the other way around.

Gender confusion is the only disorder that the parent can be completely excluded from determining what is best for their own child.

Gender confusion is the only disorder that the treatment takes the child down a dead-end road literally. What we are seeing in Florida and across the nation is a social media-driven epidemic manufactured by social media influencers making a

lot of money off the very vulnerable element of our society -- that's our children.

While most counselors somehow have been convinced that affirmation is the only way, even the APA would be the first to affirm that a child simply does not have the capacity to make these kinds of long-range decisions. In fact, you don't need to be a doctor --

A VOICE: Thirty seconds.

MR. ROPER: -- of psychology to know this. Ask any parent. They will tell you that a child wants what they want, and they want it now.

What some -- some will call on their faith, some will call on a counselor, but all do so to be delivered from the disorder, not to be sent deeper into it.

A VOICE: Fifteen seconds.

A VOICE: You don't give drugs to a drug addict, alcohol to an alcoholic, porn to someone addicted to pornography. This is not a form of treatment.

In closing, transgender regret is among the fastest-growing movements on social media today --

A VOICE: (Inaudible).

MR. ROPER: -- on Reddit this morning. I

found a thread with 35,600 entries of people regretting their transgenderism. It increased to a hundred more while I drove here today.

Watchful waiting from loving parents yields an exponentially higher success rate of resolving gender disorders than any prescription drugs or surgery, 90 plus percent. This rule will protect Florida residents.

(Applause.)

A VOICE: Carl Charles.

MR. CHARLES: Good afternoon. My name is Carl Charles and I'm a senior attorney in the Atlanta, Georgia, office of Lambda Legal, the nation's oldest and largest legal organization fighting for the rights of LGBT people and everyone living with HIV.

We are here today to share that we strongly oppose and are deeply disturbed by AHCA's notice of proposed rule, which if approved will remove coverage of medically-necessary care for transgender youth and adults from the Florida Medicaid program. This essential and in some cases life-saving care is clinically effective, evidence based, and widely accepted and used by medical professionals across the country to treat gender

dysphoria.

Unlawful exclusions of this kind cause significant harm to a state's most vulnerable residents. Indeed, should this proposed rule be adopted, it will cause serious, immediate, and irreparable harm to transgender Medicaid participants in Florida who already experience well-documented and pervasive stigma, discrimination in their day-to-day lives, including significant challenges, if not all-out barriers to accessing competent health care services.

We are especially concerned by the administration's characterization of this care as experimental and ineffective. This is contrary to all available medical evidence and relies on misrepresentations of the findings of various studies, as well as reports by so-called experts, one of whom is on this panel, who have been discredited and notably do not treat transgender people --

A VOICE: Thirty seconds.

MR. CHARLES: -- in their medical practice.

Finally, I would like to note for the record as to whether or not this was a negotiated rulemaking process and who on the panel is a

transgender Medicaid recipient in Florida. Okay, there's no one.

Finally, singling out transgender Medicaid participants for unequal treatment by denying them coverage for services that non-trans Medicaid participants access plainly violates the equal protection clause of the U.S. Constitution and federal law.

A VOICE: Time. Please wrap up your comment.

A VOICE: Furthermore, Section 15-57 of the Affordable Care Act prohibits discrimination on the basis of sex by any health program or activity receiving federal financial assistance.

Finally, shame on you all for proposing this rule.

(Applause.)

A VOICE: Jason, did you want to comment?

A VOICE: Just quickly, I would like to refer everyone to the Gapums report, in particular the numerous appendices that we attached to that report. There have been references to the numerous clinical organizations that have endorsed these procedures, and in particular, I would refer you to Dr. Canter's report, pages 27 through 28 -- I'm sorry, pages 32 through 42, which go through each

one of those organizations. Thank you.

A VOICE: Speaker Ed Wilson.

MR. WILSON: Ed Wilson. I've traveled here today to speak in support of Rule 59G-1.050 to ban Medicare funding from being used for transgender treatments and surgeries.

This rule will protect children who are not mature enough to be comfortable in their own body or to have sexual desires that they have not gone through puberty yet from making mistakes that will destroy their lives.

Children are being misguided into believing that they're transgender. Taxpayer money should never be used to destroy innocent lives.

Transgender treatments and surgeries never actually succeed in changing someone to the opposite sex, but do cause permanent harm to the people who undergo such treatments.

Health care professionals need to focus on healing the mind of confused and/or abused people, not mutilating their bodies. As Anthony already quoted, I'm going to skip part of the quote from the American College of Pediatrics, but it ends with, "The suppression of normal puberty, the use of disease-causing cross-sex hormones, and the

surgical mutilation and sterilization of children constitute atrocities to be banned, not health care.

Please take their advice. Ban these atrocities --

A VOICE: Thirty seconds.

MR. WILSON: -- and keep Medicaid about health care. Thank you very much.

(Applause.)

A VOICE: Speaker Suzanne Zimmerman.

MS. ZIMMERMAN: I'm Suzanne Zimmerman, and I am merely a mother, grandmother, great-grandmother, aunt, great-aunt, and specifically great great-aunt of a young child who is going through the throes of gender dysphoria from the age -- a young age. He is now 8 years old, and I pray that our state doesn't make it easy for her parents to be dissuaded toward gender change.

I listened to the young people here who have gone through this, and I think they speak volumes more than any of the rest of us could say because they've been through the difficulties and they've learned through the difficulties.

And my bottom line is God doesn't make mistakes. We're all created equal and different,

each in His image, and there are many, many different people in this world and we are to love them all. It's a commandment, it's God commandment, and He loves us all.

I urge you to support this ban to make it easy through Medicaid to have --

A VOICE: Thirty seconds.

MS. ZIMMERMAN: -- the surgery for children who are children with very young brains. Have a heart and please pass this ban. Thank you.

(Applause.)

A VOICE: Judy Hollerza, H-o-l-l-e-r-z-a.

MS. HOLLERIN: I'm Judy Hollerin, poor work -- poor penmanship apparently.

I support -- I support that we ban -- that we ban this. I -- every day, of course, we wake up seeing new things that we can't believe are happening to us today. And I support everything that's been said -- everything in support of that has been said today.

The idea that Medicaid should be doing -- should be supporting this or paying for it -- again, this expansion of us paying for these kinds of critical things without further thought. My, I -- I would like to look 20 years younger, but I

do not expect Medicaid to be paying for it. Enough said.

(Applause.)

A VOICE: Next speaker, Ezra Stone.

MR. STONE: Good afternoon. My name is Ezra Stone and I'm a licensed clinical social worker.

Social work is a profession with a long history of valuing human dignity and autonomy, and according to the values of my profession, I have an ethical obligation to support my clients in reaching their fullest potential, problem-solving barriers to treatment with them, and collaborating with other professionals.

Additionally, we have a professional obligation to provide evidence-based treatment, and there is significant research that medical transition is safe, effective at relieving symptoms of dysphoria, and improves mental health.

In my private therapy practice, my clients express tremendous relief at being able to access medical care, which decreases their anxiety and depression and increases their feelings of safety, comfort, and joy as their bodies and minds become more congruent. Understanding and being seen as their true selves creates a sense of belonging,

which is a fundamental human need.

On the other hand, the current political climate in the state is causing significant harm to transgender, nonbinary questioning and gender diverse Floridians. My clients report increases in anxiety with each proposed anti-LGBT measure the state takes, fear violence in their daily lives, and worry about their continued access to medical care.

These observations from my clinical practice support the research on the minority stress model, which demonstrates that expecting experiences of harm, marginalization, and rejection have a negative impact on people's mental health and overall well-being.

Passing this change to Medicaid --

A VOICE: Thirty seconds.

MR. STONE: -- will not only take away medically-necessary care from several thousand of the most vulnerable Floridians, but it will also further create a climate of fear for LGBT people and their health care providers across the state.

(Applause.)

A VOICE: Jason. Speaker Peggy Joseph.

MS. JOSEPH: Hello. I'm Peggy Joseph, and I

would just like to share some thoughts from an author and doctor, Ryan T. Anderson, who wrote about -- a book called, "When Harry Became Sally."

So in 2016, the Obama administration and the Center for Medicare and Medicaid Services revisited the question of whether sex reassignment surgery would have to be covered by Medicare plans. It refused on the grounds that we lack evidence that it benefits patients. They stated, "Based on a thorough review of the clinical evidence available, there is not enough evidence to determine whether gender reassignment surgery improves health outcomes."

There were conflicting study results, and the quality and strength of evidence were low. Many studies that reported positive outcomes were exploratory-type studies with no confirming follow-up. The author says, "The lack -- the lost of follow-up could be pointing to suicide."

The largest and most robust study, a study from Sweden, found a 19 times greater likelihood of death by suicide and a host of other poor outcomes.

To provide the best possible care serving the patient's interest requires an understanding of human --

A VOICE: Thirty seconds.

MS. JOSEPH: -- wholeness and well-being. The minimal standard of care should be with a standard of normality. Our brains and senses are designed to bring us into contact with reality. Thoughts that distort --

A VOICE: Fifteen seconds.

MS. JOSEPH: -- (inaudible) are misguided and cause harm. Okay.

(Applause.)

A VOICE: Next speaker, Jack Barton.

A VOICE: Actually, I have one comment with respect to that, so as a partial addendum to my earlier answer focusing on some of the clinical organizations in the United States, but I wanted to also mention because it has come up a couple times here, that the Gamus report on pages 35 and 36 also talks about international consensus as also talked about in Dr. James Canter's report on pages 42 through 45. So I would encourage people to look at that as well.

A VOICE: Go ahead.

MR. BARTON: My name is Jack Barton. I'm here with the Christian Family Coalition. I'm an Assembly of God pastor. The 37 years I have

counseled, among them I've counseled lesbians, gays, and bisexuals. I believe in First Corinthians 6:9, that people can escape from that life. Unfortunately for the transgender, they suffer. These young people have made that clear.

I believe that gender dysphoria should be labeled as child abuse, it is not something that should be happening to our children, and with the doctors that will participate in this, it's not so unlike the doctor who tears a child apart in abortion and calls it health care.

These are the issues: The puberty blockers, the hormone manipulations, that's not science. The only name that was left out before was Anthony Fauci. I kept waiting to hear them to say that.

Every -- any procedure like this should be labeled criminal. You have a child that at that age doesn't know if they like vanilla ice cream or if they like chocolate ice cream, and yet they're going to let them march in and either make that decision to be led down that path. Nearly 90 percent of those that escape from that life do it by the time they reach the end of puberty because they come back to their senses that they were created male and female by God.

Suicide that we talk about so much comes when a person has followed up on these things, has done it, and now they are confused because they still don't find the completion that they thought they felt.

Among those that go through these processes, many of it comes from child abuse that happened when they were kids, some who have wanted to have acceptance by others and were rejected. One man, his grandmother wanted a granddaughter. She dressed him like that, and so he adopted that life.

A VOICE: Thirty seconds.

MR. BARTON: I'll close with this. There are two genders, male and female. Women bear children, women breastfeed, women have menstrual cycles. Men do not. I would not provide the anorexic with food and I would not say give money to do something that would harm a child.

A VOICE: Fifteen seconds.

MR. BARTON: It's a terrible thing to do and I ask you to stand your ground.

(Applause.)

A VOICE: Jose Martin.

MR. MARTIN: Good afternoon. Thank you for letting me speak. I'm also with the Christian

Coalition, and I'm here to speak in support of Rule 59G-1.050. I am a father and a grandfather, and I am here to stand against mutilation that we all are asked to fund. The people we are talking about need counseling, not promotion to a destructive choice.

I also want to remind that one day we will all stand before a living God and give account for where we stand on this and other issues. And I also want to thank you brave people, who I think are more qualified than all the other experts that came up, because you are living and you lived through it and you know the results of that, and I thank you. Thank you very much.

(Applause.)

A VOICE: Folks, we have a number of speakers coming up from the same organization. We just ask that you be respectful of others' time. We've got a number of speakers to get through before 5:00 p.m., so if you could just be brief and support comments of others, if possible. Thank you.

Next speaker, Bob Johnson.

MR. JOHNSON: Good afternoon, Bob Johnson. I am a retired and recovering attorney, but I am -- and I'll be very brief.

I say thank you to the Florida Division of Medicaid for putting together this report. I've read the whole report. It's not my area of expertise, but I've had significant experience working with the development of agency rules, statements of need, and reasonableness as we call them in the state that I come from, and I just want to compliment the agency. I've read through it. I think the case is compelling for the rule change. I strongly support the rule change.

There is specifics in there again that's not an area that I studied, but in reading the report and looking how thorough that it was put together, the case has been made for the need to adopt this rule change, the case has been made for the reasonableness of what you're proposing. I just found it compelling the fact that the FDA does not approve any medication as clinically indicated for gender dysphoria. The fact that there's no randomized, controlled trials for the use of these puberty suppression, that's the gold standard, I know, in medical studies, and there are no randomized, controlled trials, and the fact that there's no long-term data. I just think there is so much concrete, substantial evidence that totally

justifies it, and I would just echo many of the others that have testified here today. I urge you to go forward, adopt these rules, changes --

A VOICE: Thirty seconds.

MR. JOHNSON: -- (inaudible) we need them, we need them in the state of Florida. Thank you.

(Applause.)

A VOICE: Next speaker, Sandy Westad, W-e-s-t-a-d, I believe.

MS. WESTAD: My name is Sandy Westad and I'm also here with CFC, Christian Family Coalition.

I -- I want to speak from the heart. I'm a mother, I'm a grandmother, I'm a sister, whatever, and my heart is breaking for what these kids are going through. It just seems to me that if the parents -- the parents need to stay in control. They need to stay in the authority of their children. They need to be able to speak to their kids about the sex and the transgender.

Kids play house. They pretend. You know, they do things in a play world, but they don't want to be or understand or even know what it is to change from one sex to another. They pretend. I remember my sons playing and pretending they were girls and sometimes they would pretend they were

boys, but they were boys and they grew up to be boys. They didn't want to be girls. They felt that that was what they were supposed to be. Jesus made them boys, and they were going to stay boys. But the thing is we -- we need to understand that children cannot make those kinds of decisions. They cannot --

A VOICE: Thirty seconds.

A VOICE: -- decide who they are. The parents need to be their guide, and the parents -- God gave children parents for a reason.

So I just support this bill, this rule, and I thank you so much for everyone that's here.

(Applause.)

A VOICE: Gail Carlins.

MS. CARLINS: Good afternoon. I'm Gail Carlins and I'm with CFC also. And I am in favor, I support this rule change here with not having the funds -- the Medicaid funds go to supporting these.

My beliefs are based on the Bible, and the Bible, I believe, is the only truth that there is. And the Bible says, as was mentioned a couple times, God created male and female. If you want to bring science into it, females have two X chromosomes, males have an X and a Y chromosome.

It's an impossibility to change from one to the other. That cannot be done. And so no matter what kind of mutilation or anything is done to a person, they can't change it.

So, again, I am in support of this bill and I thank you for your time.

(Applause.)

A VOICE: Dorothy Berring.

MS. BERRING: Good afternoon. My name is Dorothy Berring, also with the Christian Family Coalition. I also live in The Villages, Florida.

First of all, I would like to thank our brave governor once again for bringing this to the forefront. We are -- Florida definitely is going to make change, and thank you to these brave people and to Amber for not going along with what you were trying to be brainwashed into believing.

Again, it's strange, you know, they're definitely targeting our -- our youngest. We can't seem to find baby formula anywhere, but yet Medicaid can fund this nonsense.

Again, this has to be left up to the parents. Whatever you choose to practice in the privacy of your own home is your business. I'm not discriminating against any genders or whatever. I

just -- it needs to be taken out of the schools, and this doctor that was from UF or USF or whatever, it's shameful, shameful what you are trying to teach our students, and that's why we are in this bloody mess right now. Okay? And this needs to be changed --

A VOICE: Thirty seconds.

MS. BERRING: -- and you all need to listen.

And thank you, doctors, for being here and for giving us this forum. Thank you.

(Applause.)

A VOICE: We would ask that the comments be focused on the rule and be respectful of other speakers, please.

Troy Peterson.

MR. PETERSON: Good afternoon, Troy Peterson. I come supporting Anthony and Christian Family Coalition. I'm also the President of Warriors of Faith here in Florida. We brought a few people with us from the Tampa Bay area, and really we come representing thousands that stand in agreement with this rule.

And I want to thank you, doctors. I read the 40-page report. I'm not a doctor, I'm a pastor. But when I saw the evidence, I could clearly see

that we need this rule.

In the book of Genesis, in the beginning God created man in his own image, male and female, and then he said, "Be fruitful and multiply the earth." So that's why I'm here is because I'm opposed to even that doctor back there. And I appreciate you said that because if I had any authority in the medical field, I would have his license revoked.

The most thorough follow-up of sex reassigning people, which was conducted in Sweden, documented that 10 to 15 years --

A VOICE: Thirty seconds.

MR. PETERSON: -- of surgical reassessment, that the suicide rate is 20 times that of the comparable peers.

I also read in the medical evidence that 50 percent --

A VOICE: Fifteen seconds.

MR. PETERSON: -- of the gender identity-confused children have thoughts of suicide.

Thank you for your time.

(Applause.)

A VOICE: Janet Rath.

MS. RATH: Hi, my name is Janet Rath. I'm a

mother, a grandmother, and a new great-grandmother. And I think 50 years ago as parents, we were smarter than what is going on today. Parents are left out of their children's lives. Some of it is the parents' fault, and some of it's the teachers' faults.

I have a granddaughter that's a teacher who has said that if she has a child that comes in and identifies as a cat, she must have a litter box there and a bowl of water.

We are as a country going absolutely insane, absolutely insane. We all bought into Dr. Fauci, who was nothing but a money-grabbing liar -- pardon my French -- and we have been hoodwinked ever since. We have got to stop this.

Chinese children in third grade are learning advanced calculus. Our third graders are learning which bathroom to use. I'm sorry, but I do not want my great granddaughter growing up in this world if this is what it's going to turn into. We have got to change, and we had best do it now. Thank you.

(Applause.)

A VOICE: Gerald Loomer, L-o-o-m-e-r, Gerald.

MR. LOOMER: Good afternoon. My name is

Gerald Loomer. I drove three and a half hours from Lady Lake, Florida, to be here because I want to support Rule 59G-1.050. Especially I want to support the best governor in the United States, Ron DeSantis who also supports this.

(Applause.)

MR. LOOMER: But I'd like to share three quick stories with you. The first is the little girl who saw her brothers go fishing with their dad, out in the backyard playing catch with a football, says, "You know, I'd like to spend more time with Dad. If I were a boy, I could spend more time with Dad."

Or the boy who said, "You know, those girls, they're in the kitchen cooking with Mom, they go shopping with Mom, they're doing makeup with Mom. I want to spend more time with Mom. I think I should be a girl, then I can spend more time with Mom." Well, those things passed.

Remember the child who said, "Can I drive the car?" "Of course not, you're 13 years old." "Well, can I drink a beer?" "Of course not, you're 13 years old." "Can I smoke a cigarette?"

A VOICE: Thirty seconds.

MR. LOOMER: "Of course not, you're 13 years old." "Can I take hormones to block puberty?"

"No, you're 13 years old. Of course, you can. You know what you want." "Can I take cross-sex hormones?"

A VOICE: Fifteen seconds.

MR. LOOMER: "You're 13 years old. Of course, you can. You know what you want." "Can I have gender sterilizing surgery?" "You're 13 years old. Of course, you can, you know what you want." "Can I have body-mutilating surgery" --

A VOICE: Time. Please wrap up your comment.

MR. LOOMER: -- "that's going to alter my sex?" "Of course, you can, you's are 13 years old, you know what you want."

A VOICE: Sir, your time is up. Please wrap it up.

MR. LOOMER: How absurd is all of this? Continue to keep this resolution.

Thank you.

(Applause.)

A VOICE: Pastor Marta Marcano.

MS. MARCANO: Good afternoon. I'm Pastor Marta Marcano from (inaudible) Jacksonville, Florida. I'm a director of Protect our Children Project, Duval County chapter, and an organizer of the Christian Family Coalition in Jacksonville too.

I'm here to let you know that I'm support of the Rule 59G-1.050 to ban Medicaid funding for transgenders, surgeries, (inaudible) blockers, and other unnatural therapies.

Also, this rule protect taxpayers from being forced to subsidize the (inaudible) is driving by unethical pharmaceutical companies enriching themselves with the puberty blockers. That is an atrocity of children abuse.

World-renowned Swedish psychiatric, Dr. Christopher Gilbert, has said that pediatric confusion is possibly one of the greater --

A VOICE: Thirty seconds.

MS. MARCANO: -- scandal in medical history and call for an immediate moratorium.

As a pastor --

A VOICE: Fifteen seconds.

MS. MARCANO: -- I want to remind you that doc do not been a stumbling block for the little one, because Hebrews 10:31 said --

A VOICE: Time. Please complete your comment.

MS. MARCANO: -- "It's a fearful thing to fall into the hands of the living God."

Please protect our children. Thank you very much for this time.

(Applause.)

A VOICE: Paul Arrans.

MR. ARRANS: Good afternoon. My name is Paul Arrans. I'm a physician. In practice, I've had transgender patients, and I have transgender personal friends with whom I discuss their medical care at length.

With profound respect for the young people who testified earlier, I still oppose this amendment (inaudible) the preponderance of medical science and practice when we do irreparable harm to the health and well-being of thousands of transgender Floridians of all ages and their families.

The American Academy of Pediatrics and its Florida chapter representing thousands of board-certified pediatricians have directly reviewed many controversial assertions in your publication on gender dysphoria, and the Florida Department of Health's statement responded.

Contrary to an earlier comment, the Endocrine Society has stated, "Both medical intervention for transgender youth and adults, including puberty suppression, hormone therapy, and medically-indicated surgery has been established as the standard of care. Federal and private

insurance should cover such interventions as prescribed by a physician," end quote.

Gender dysphoria is very real. You can learn this for yourselves by meeting with transgender people. You will then realize that denial of appropriate gender-affirming care at any age would be inhumane and a violation of human rights. These medically-necessary treatments are the generally accepted professional medical standards, (inaudible) authoritative opposition to the proposed rule.

A VOICE: Thirty seconds.

MR. ARRANS: (Inaudible) to just rush this through, thereby putting the health and lives of trans people in danger.

It feels like Medicaid is crossing into a political lane by seeking to preempt provider/patient/family decision-making here, and I urge you to withdraw this proposal.

A VOICE: Fifteen seconds.

MR. ARRANS: This represents knowledge and practice regarding gender-affirming care. If you are still determined to address this topic, at least convene (inaudible) panels of experts, including transgender community members, who inform

yourselves and the public about the overwhelming evidence --

A VOICE: Time.

MR. ARRANS -- against denying coverage for gender-affirming care.

Thank you for the opportunity to testify.

(Applause.)

A VOICE: Thank you for that comment. I'm going to refer for further comment to Dr. Van. VANMOLE, VANMO, VENMO?

DR. V: I would encourage everybody just to read the Gaplins report, and particularly the attachment to it. A great deal of attention has been put in there into evaluating the science. And some of the studies that have been brought up, both pro and con, are involved -- they're specifically the flaws that are in so many of these studies. Specifically --

A VOICE: Hold on.

A VOICE: (Inaudible) while Dr. Vanmo speaks.

DR. V: Yeah, and by the way, I like the idea that everybody lets everybody speak. So it kinds of bothers me when I'm hearing speakers shout it down because they're saying something you don't like. How we treat other people with whom we

disagree is a reflection of our own character, not theirs. So, please, let -- due decorum.

First of all, the Endocrine Society's 2017 guidelines are guidelines, just that. And it states specifically page 3895 that they do not guarantee an outcome and they do not establish a standard of care. It's in black and white there.

I would refer you also, as is mentioned in the Gaplins report, the histories in the United Kingdom, Sweden, Finland, France, four nations that were leading this from quite some time, they did national-level reviews involving scientific organizations, divisions of governments, medical professionals. And mind you, these are nations that were leading it. And after review, they all came to the same conclusion, this should not be going on in minors at all under 16, and only between 16 and 18 under tightly-regulated studies, the kind of which we really don't see happening.

And they also came to the conclusion that strong psychological support is what's needed when we talk about evaluating kids for this. We have four decades of literature showing the overwhelming probability of mental health problems, adverse childhood events, neuropsychological problems like

autism spectrum disorder, and other things that need to be addressed. And, in fact, also for these nations, somebody strongly demonstrating psychologic instability -- quite specifically, you say you're suicidal -- blocks you from the transition pathway. They insist that those things be taken care of first because transition simply won't fix them. The underlying problems of a transgender youth become the underlying problems of an adult who identifies as transgender. That's what is going on here.

So, again, I'd refer you to the report and some of the other letter, complaints, that I've seen come in in the past 24 hours from the AAP, as well as from the Endocrine Society, what they're complaining about is actually addressed here, including some of the studies they bring up, and there too, it's a very well-researched document. The State of Florida put a lot of effort into this.

You're free to disagree, but please make sure you've read it and understand it before you do.

A VOICE: Just to be a little bit more specific with respect to the report, I'd refer you to Dr. Rigner (inaudible) Peterson's report, which is Attachment C to the Gaplins report, and also a

doctor named Paul Hruz, H-r-u-z. Title of his publication is, "Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria." He did not provide an expert report for purposes of this report, but he is published in medically reviewed literature, and I would encourage you to read that as well.

Thank you.

(Applause.)

A VOICE: January Littlejohn.

MS. LITTLEJOHN: My name is January Littlejohn. I am a mother of three children and a licensed mental health counselor.

In the spring of 2020, our 13-year-old daughter told us that she was experiencing distress over her sex and that she didn't feel like a girl. She had expressed no previous signs of gender confusion, and three of her friends at school had recently started identifying as transgender.

As we tried to understand our own observations and seek professional help, we discovered that her middle school had socially transitioned her without our knowledge or consent. Her mental health spiraled. We worked with a psychologist to help our daughter explore and resolve co-occurring

issues, including low self-esteem and anxiety. We also gave her more one-on-one time, in-person activities away from trans influences, limited her Internet use, and declined to affirm her newly-chosen name and pronouns. We set appropriate boundaries and allowed her to choose her hair style and clothing, but denied harmful requests such as breast binders, puberty blockers, cross-sex hormones, and surgeries.

It was clear from our conversations that our daughter was uncomfortable with her developing body and had an intense fear of being sexualized. She was filled with self-loathing and was in true emotional pain, but had been led by peers and influencers to believe that gender was the source of her pain.

What she really needed was for us to help her make sense of her confusion and remind her that hormones and surgeries could never change her sex or resolve her issues.

A VOICE: Thirty seconds.

MS. LITTLEJOHN: I shudder to think what could have happened if we had affirmed her false identity and consented to medical treatment as opposed to what we did, which was to lovingly affirm her as

she is: Beautifully unique and irreplaceable and undeniably female.

A VOICE: Fifteen seconds.

MS. LITTLEJOHN: Our daughter has desisted and is on a path to self-love, but, unfortunately, gender-dysphoric children are being encouraged through activism and peer pressure to disassociate from their bodies and to believe their body parts can be simply removed --

A VOICE: Time. Please finish your comment.

MS. LITTLEJOHN: -- modified, or replaced.

The irreversible consequences of medically transitioning, including loss of sexual and reproductive function, cannot be fully understood by children or teens who lack the necessary maturity or experience. These children need love and therapy, not hormones or surgery.

Thank you.

(Applause.)

A VOICE: Next up, Kendra Paris.

MS. PARIS: Hi there, my name is Kendra Paris. I still suffer from being an attorney. I'm a mental health attorney, and I wanted to follow up on the comment about the lack of peer-reviewed standards of care, because as an attorney, the lack

of peer-reviewed standards of care mean that a lot of people who are harmed or experience bad outcomes from these surgeries or other interventions have no ability to sue, and I find that problematic as an attorney. They've had decades to create peer-reviewed standards of care, and they have not. And I suspect some people don't want those standards of care because it would open them up to lawsuits for bad outcomes, which is not happening right now and it really frustrates me.

You all are so brave. I'm so proud of you for coming and telling your stories.

We just don't know, and I want to talk about a particularized thing that we don't know yet. When you put a female on testosterone, within about five years, she's going to have to have a hysterectomy, though you passed most recent standards of care, recommend hormone -- cross-sex hormone therapy for females at 14. So we're talking about a potential hysterectomy before she turns 20. We have known for a very long time that hysterectomies correlated with negative mental health outcomes and cognitive decline. And we know that the earlier a hysterectomy is performed, the worse mental health and cognitive decline is. Essentially, the earlier

you do the hysterectomy, the earlier the onset of dementia.

And so what I am very concerned about is in, I don't know, 10, 20, 30 years, we're going to have an absolute wave of young females, 40, 50 years old, with early-onset cognitive decline --

A VOICE: Thirty seconds.

MS. PARIS: -- or dementia in our assisted living facilities.

And in surveys and anecdotal experience is starting to indicate that some individuals who are trans and have dementia forget that they're trans. In a state like Florida, we have substituted judgment.

A VOICE: Fifteen seconds.

MS. PARIS: So if they don't have written documentation allowing for their medical proxy to allow for detransition, they might be cut off. And I really worry that we have not considered all of the implications of this.

So I appreciate the rulemaking and I thank you --

A VOICE: Time.

MS. PARIS: -- for your time. Thank you.

(Applause.)

A VOICE: Nathan (inaudible).

MR. BRUMER: My name is Nathan Brumer. I am Florida's LGBTQ consumer advocate as appointed by Commissioner of Agriculture Nikki Fried. One of FDACS' many critical roles here in the state includes serving as Florida's consumer protection agency.

On behalf of health care consumers, I provide the following comments in opposition to the proposed changes to Rule 59G-1.050: As a state agency, FDACS encourages all consumers to remain aware, vigilant, and act when necessary, but to do so, we know consumers must be provided with accurate information, education, choice, safety, representation, and redress.

Documented, well-researched standards of care have been established, are based on a wide range of evidence, and conclude gender-affirming medical care is medically necessary and safe and effective. In other words, gender-affirming care is the standard of care, and the proposed rule as it stands would deny health care consumers in the state of Florida access to the standard of care.

State agencies must serve and advocate for all Floridians. We should not deny any Floridian the

ability to thrive. We serve the public good and we must defend the rights of every Floridian, including transgender Floridians, and this includes the right to nondiscriminatory health care coverage. We must work to increase access to health care, not lessen it or remove it all together.

A VOICE: Thirty seconds.

MR. BRUMER: On a personal note, Florida is my home state. I am one of thousands, tens of thousands of transgender Floridians here in our state who have had the privilege to have access to gender-affirming health care --

A VOICE: Fifteen seconds.

MR. BRUMER -- for decades who are happy and successful and thriving. I'm an attorney, I'm an advocate, and I work for and very hard and I'm proud to serve the State of Florida. We are part of the fabric of this nation --

A VOICE: Time. Please wrap up your comment.

MR. BRUMER -- and of this great state, and we deserve the rights and benefits afforded to all.

(Applause.)

A VOICE: Nathan Bremmer.

MR. NEWELL: Hi, I'm Nathan Newell. I think

we got the Nathans mixed up. Here (inaudible) for support. Tell you a little bit, I have a son, I have four children. My son, 15, is -- doing everything we can to keep him straight. He doesn't make good decisions. One of the things lately, you know those little things on the side of the road that flashes and tells you your speed? Well, we had one of those near our house. So he decides to take his dirt bike in pitch black and with his friends out there and go 80 miles per hour down the road. We know this because of the ring. He was bragging to his friends, so we watched the ring and saw that.

Then a couple days ago, he was upset with us and said he was leaving. So we said, "Where are you going to go, Hunter?" He goes, "I'm going to St. Teresa, I got friends down there." "How are you going to get there, Hunter?" "I'm going to ride my bike." I said, "It's going to take you forever," and he goes, "It's going to take me four hours."

So, anyways, this 15-year-old, he's not making good decisions. And to sit here and to even think that these kids can make a decision on what they want that's going to be with them for the rest of

life is child abuse. These doctors are despicable. They need to have their license taken away. They are a disgrace to the human race. It's just despicable to think that these people are taking care of us and taking care of our children, and I appreciate what y'all are doing.

(Applause.)

A VOICE: We'd ask that you please be respectful to the other speakers.

A VOICE: Thank you for your comments. We respect your comment, we respect everybody's comments, including the doctors that you referenced.

A VOICE: Nathan Brumer.

Dotty McPherson.

MS. MCPHERSON: Hi there, I'm Dotty McPherson. I'm speaking as the District 2 representative for the Florida Federation of Republican Women.

The age of majority is 18, but even at 18, children don't have the maturity to handle certain responsibilities given them, like driving, alcohol. Even older adults don't.

Your agency's safety net programs include programs for abused and neglected children, but not gender decisions. Please prevent funding the

destruction of children's genitalia and hormonal balance.

Please consider unintended consequences of, No. 1, is taxpayer money that will need to be used for lawsuits by those whose lives are ruined from surgeries that got -- that they got while they were immature or too young to understand, also by parents whose parental rights were denied to protect their children's future.

I grew up in a low-income neighborhood on the low-income side of town. When I got to junior high school, I saw how rich kids were, and a lot of them were just real brainiacs, and I felt so inadequate. I had a terrible inferiority complex, but I got over it. I graduated with honors from FSU. I had a good job and made a good life for myself and my four children. Life isn't fair. We've got to stop giving in to the poor, pitiful me syndrome. People need to get their brains right and --

A VOICE: Thirty seconds.

MS. MCPHERSON: -- get straight. Government has no business funding these things. Our elected governor has authority to make this rule, which should be upheld. Please support our governor's rule. Thank you.

(Applause.)

A VOICE: I'm going to get this first name wrong, but I think it's Marjorie Caulkins.

MS. CAULKINS: Hello, my name is (inaudible) Caulkins and I am from Milton, Florida, and I came in support of the ban of Medicaid funding for transgender surgeries and treatments.

I believe that Floridians do not need our taxpayers' money to be spent in this funding of surgeries that are both unnecessarily and tremendously harmful.

As a mother of two, I believe there is a war on our children and we need to stand on the right side of this war and protect our children, support our Governor DeSantis. We are blessed with our governor, and I think we should be on the right side and support this rule and ban Medicaid funding for transgender surgeries.

Thank you so much, and thank you for your service.

(Applause.)

A VOICE: James Caulkins.

MR. CAULKINS: Hi. I'm James Caulkins from Milton, Florida, and I just want to say we really need this rule passed to support Rule 59G-1.050 to

ban Medicaid funding for transgender surgery and treatment.

We are in a battle in this country, and I'd like to thank all the people who showed up today, because your voice matters. Our state -- the people have spoken. They elected the greatest governor in the United States, Ron DeSantis. They put Republicans in office in this state to stand for what's right, and this rule change is what's right.

We don't need this stuff, this evil, this Medicaid funding for transgender surgery. We don't need this in our state of Florida. We need to lead in Florida, we need to lead the other states in Florida against this evil transgender surgeries.

So please pass this rule. Thank you all so much for your public service and God bless the state of Florida. Thank you.

(Applause.)

A VOICE: Tuana Aman.

MS. AMAN: Thank you for the opportunity for us to be here. I am in support of the ban to the Medicaid funding for transgender surgeries and treatments. And let me say that years ago, I was told that I needed to go on hormone therapy, and I

had one doctor tell me that it was the right thing to do, but as I did more and more surg- -- more and more study and research, I saw the risks involved to hormonal therapy. And when someone tries to tell you there isn't any risk to these kinds of procedures and these kinds of things that are happening to young people, to young kids -- I mean, I'm an adult who's fully developed, right, as a human being now, right, and they say 25 generally, look at these kids and their development, the process.

And what I think is even more sad is that they're born like the young girl with a certain amount of eggs that will be released every month from the time she starts puberty, and here we're trying to prevent those natural things from occurring and expect it not to have any problems.

I was watching Bill Mayer, which he's not a favorite of conservatives, right? And he came out a couple of weeks ago and was slammed by the LGBT community because he said, "Isn't it interesting" -- and this is him, right -- "Isn't it interesting that if you look at Los Angeles and New York and Miami and all these different hubs, that's where this transgender service -- these surgeries

are going on, the focus," and he got slammed. They said they wanted him off the air, and, I mean, he had -- they had a campaign against him --

A VOICE: Thirty seconds.

MS. AMAN: -- because it was focused on the fact that he was just saying, "Isn't there something ironic about the fact that you look at the rest of the country and these things aren't going on, and then you look at these hubs where social engineering is happening and where people are being influenced that I" --

A VOICE: Fifteen seconds.

MS. AMAN: -- "can't go out into the media and say anything against transgender, because what will happen? I will be criticized and condemned." It isn't fair. I think it's right to be here and have the opportunity to give our voices, but I believe that the government should not be involved in supporting any --

A VOICE: Time. Please wrap up your comment.

MS. AMAN: -- kind of procedure for these young kids. Thank you. Amen.

(Applause.)

A VOICE: Jason, do you have a follow up?

A VOICE: Just very quickly. We appreciate

your comments, just like we appreciate the comments of everyone in this room and all the people that have made comments on-line and otherwise.

I just wanted to make sure -- clear, just so we're crystal-clear about the purpose of this rule is that we're not talking about a ban of treatment for gender dysphoria. We're talking about not covering through reimbursement in the Florida Medicaid program for the services that are enumerated in the rule itself.

I also want to make clear that there are other comprehensive coverage of services for gender dysphoria currently in the Florida Medicaid program, and I just want to read a couple of those: "Community-based health services provided by an array of provider types; psychiatric services provided by a physician or other qualified health care practitioner in office settings, clinics, and hospitals; emergency services and inpatient services in hospital settings; behavioral health services provided in schools and by school districts."

So I just wanted to make sure that everyone was crystal-clear about the purpose of this rule. I very much appreciate your comment and the

comments of everybody else.

A VOICE: Thank you, everyone, for your participation in this hearing. We will accept written material or comments until 5:00 p.m. on Monday, July 11, 2022. Comments may be submitted by e-mail to medicaidrulecomments@ahca.myflorida.com.

That being our time, this hearing is now closed. Thank you.

(Whereupon, the hearing was concluded.)

C E R T I F I C A T E

STATE OF FLORIDA)

COUNTY OF LEON)

I hereby certify that the foregoing transcript is of a tape-recording taken down by the undersigned, and the contents thereof were reduced to typewriting under my direction;

That the foregoing pages 02 through 91 represent a true, correct, and complete transcript of the tape-recording;

And I further certify that I am not of kin or counsel to the parties in the case; am not in the regular employ of counsel for any of said parties; nor am I in anywise interested in the result of said case.

Dated this 19th day of July, 2022.

Clara C. Rotruck

CLARA C. ROTRUCK

Notary Public

State of Florida at Large

Commission Expires:

November 13, 2022

Commission NO.: GG 272880

From: Kumar, Vatsala (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC510606A9034939AC2EB2C237DD8CF3-KUMAR, VATS <Vatsala.Kumar@hhs.gov>
To: (b)(6) (b)(6) (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91-(b)(6) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care
Date: 2022/08/01 16:33:44
Priority: Normal
Type: Note

Updated version attached; (b)(5)

(b)(5)

Best,
Vatsala

From: Kumar, Vatsala (HHS/OCR)
Sent: Monday, August 1, 2022 3:39 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

No worries! (b)(5)

(b)(5)

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Monday, August 1, 2022 3:36 PM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi Vatsala,

(b)(5)

(b)(5)

Thank you!
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Sent: Friday, July 22, 2022 2:58 PM
To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Please find attached a memo about the Florida proposed rule. While the document is pretty long, note that the memo itself is only the first six pages, and the rest is a rundown of the public hearing that was held.

This focuses primarily on public and written comments I was able to find and some of the major issues that have come up therein, but I'm keeping an eye on the news to see if there are any other developments.
Please let me know if I can do any follow-up on this today or next week!

Have a great weekend!

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, July 20, 2022 11:15 AM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Yup!

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her)
Phone: (b)(6) (b)(6)
Email: (b)(6)

From: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Sent: Wednesday, July 20, 2022 11:14 AM

To: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Subject: RE: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi (b)(6)

Yes! Can do. Is Friday an okay timeline for this?

Best,
Vatsala

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Wednesday, July 20, 2022 11:12 AM
To: Kumar, Vatsala (HHS/OCR) <Vatsala.Kumar@hhs.gov>
Subject: FW: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Hi Vatsala,

We are meeting with CMS to discuss the below FL proposed rule next week; are you able to do some research to find out the latest? Maybe there is a transcript or recording of the public hearing as well?

If you can draft up the information as a briefing memo for the Director, that would be great. I have attached a sample for format of the header, and for the body you can include the headers of Background, Current Status, and maybe next steps? Also if there is any information about organizations working in FL on the issue that would be good to know.

Once we have a time, I'll send you the invite.

Thank you!
(b)(6)

From: (b) (b)(6) (b)(6) (HHS/OCR) (b)(6)
Sent: Tuesday, June 21, 2022 9:32 AM
To: Rainer, Melanie Fontes (OS/IOS) <Melanie.Rainer@hhs.gov>; Jee, Lauren (HHS/OCR) <Lauren.Jee1@hhs.gov>; Katch, Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>
Cc: Barron, Pamela (HHS/OCR) <Pamela.Barron@hhs.gov>
Subject: FL proposed rule - banning FL Medicaid coverage of gender-affirming care

Good morning all,

I am sure you have all seen the news, but I am flagging the State of Florida's proposed rule 59G-1.050, published in the Florida Administrative Record on Friday (6/17/2022), to prohibit Florida Medicaid coverage of the below services "for treatment of gender dysphoria": 1. Puberty blockers; 2. Hormones and hormone antagonists; 3. Sex reassignment surgeries; and 4. Any other procedures that alter primary or secondary sexual characteristics. Proposed 59G-1.050(7)(a). The proposed rule futher states that for the "purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical

necessity in accordance with Rule 59G-1.010, F.A.C. Proposed 59G-1.050(7)(b). I have attached the notice here for ease of reference.

There is a public hearing scheduled for July 8, 2022 from 3:00 – 5:00 p.m. in Tallahassee, FL.

I'm not sure if calls are already happening on this, but since they implicate both CMS and OCR equities it seems like coordination would be beneficial.

Best,
(b)(6)

(b)(6) (b)(6) (b) (b)(6) Esq., MSW (she/her) | Section Chief
Office for Civil Rights
U.S. Department of Health &Human Services
200 Independence Ave. S.W., Room 532E
Washington, D.C. 20201
Phone: (b)(6) (b)(6)
Email: (b)(6)

Please note I will be out of the office with no email access July 4 – 18, 2022.

Sender: Kumar, Vatsala (HHS/OCR) /O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FC510606A9034939AC2EB2C237DD8CF3-KUMAR, VATS <Vatsala.Kumar@hhs.gov>

Recipient: (b) (b)(6) (b)(6 (HHS/OCR) /o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=0bdec12ad0974eacababe032f2b37c91(b)(6) (b)(6)

Sent Date: 2022/08/01 16:33:12

Delivered Date: 2022/08/01 16:33:44

DELIBERATIVE

DATE: July 22, 2022 (updated August 1, 2022)

TO: Melanie Fontes Rainer, Director, Office for Civil Rights

CC: (b)(6) (b) (b)(6) Section Chief

FROM: Vatsala Kumar, Intern

SUBJECT: INFORMATION MEMO – Florida Proposed Rule 59G-1.050

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1. Background

In June 2022, the Florida Agency for Health Care Administration proposed amendments to Florida Administrative Code Rule 59G-1.050, the General Medicaid Policy. 48 Fla. Admin. Reg. 2461–62 (June 17, 2022). The proposed rule states that certain gender-affirming procedures are not covered under Florida Medicare. *Id.*

This memorandum will first detail the content and timeline of the proposed rule, as well as the report used to justify promulgation. It will then explore the current status of the proposed rule and developments since its original publication. It will also note the work of Florida organizations on this rule, before turning to next steps on the proposed rule.

a. Timeline and Contents

The Florida Agency for Health Care Administration proposed an amendment to the Florida General Medicaid Policy in June 2022. The proposed amendment adds the following text:

> (7) Gender Dysphoria
> (a) Florida Medicaid does not cover the following services for the treatment of gender dysphoria:
> 1. Puberty blockers;
> 2. Hormones and hormone antagonists;
> 3. Sex reassignment surgeries; and
> 4. Any other procedures that alter primary or secondary sexual characteristics.
> (b) For the purpose of determining medical necessity, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), the services listed in subparagraph (7)(a) do not meet the definition of medical necessity in accordance with Rule 59G-1.010, F.A.C.

48 Fla. Admin. Reg. 2461–62 (June 17, 2022). As rulemaking authority for promulgating this amendment, the agency cites Florida Statute § 409.919 and § 409.961, which some commenters have challenged as being insufficient for this proposal. *See infra* Appendix. Sections 409.919 and 409.961 both include the same language surrounding agency rulemaking. Both state that the agency "shall adopt any rules necessary to comply with or administer" Medicaid "and all rules necessary to comply with federal requirements." Fla. Stat. § 409.919 (2021); Fla. Stat. § 409.961

(2021).

The Florida Agency for Health Care Administration held a hearing on this proposed rule on July 8, 2022. Written comments were due to the agency on July 11, 2022, and they reportedly received approximately 1,200 total public comments. Forrest Saunders, *Agency for Health Care Administration Set to Decide on Medicaid Coverage of Gender Dysphoria Therapies*, WPTV (July 11, 2022). No further developments have yet ensued on the rule.

b. Florida Medicaid Report

In order for services to be covered under Florida Medicaid, they must be "medically necessary." Agency for Health Care Admin., *Florida Medicaid: Definitions Policy* 7 (2017). Part of this definition includes being "consistent with generally accepted professional medical standards" and not being "experimental or investigational." *Id.*

Shortly before the proposed rule was published, the Division of Florida Medicaid issued a report ("Florida Medicaid Report") concluding that gender-affirming care is not medically necessary because it is not "consistent with generally accepted professional medical standards" and it is "experimental or investigational." *See* Div. of Fla. Medicaid, *Florida Medicaid: Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria* (June 2022). In making this conclusion, the report opened the door for the Medicaid exclusion. The Florida Medicaid Report incorporates literature reviews on the etiology of gender dysphoria, desistance of gender dysphoria and puberty suppression, cross-sex hormones as a treatment for gender dysphoria, sex reassignment surgery, and the quality of available evidence and bioethical questions. *Id.* at 1. It also explores coverage policies domestically and in western Europe, and includes several attachments, including articles in support. *Id.* at 1–2.

The Florida Medicaid Report claims that "[a]vailable medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria" and that studies focusing on the benefits "are either low or very low quality and rely on unreliable methods." *Id.* at 2. It claims that current evidence around gender-affirming care shows that it "cause[s] irreversible physical changes and side effects that can affect long-term health." *Id.* From the literature reviews conducted, the report states that "Florida Medicaid has determined that the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety." *Id.* at 3.

Numerous critiques have been levied against the Florida Medicaid Report, both in public comments as described *infra* Part 2 and in external documents. Most comprehensively, faculty members from Yale and other universities[1] drafted a report reviewing the Florida Medicaid Report ("Critical Review"). *See* Meredithe McNamara et al., *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022). The Critical Review states that the Florida Medicaid Report "purports to be a review of the scientific

[1] Faculty members were from Yale Law School, Yale School of Medicine Child Study Center, Yale School of Medicine Department of Psychiatry, Yale School of Medicine Department of Pediatrics, University of Texas Southwestern, and University of Alabama at Birmingham. *See* Meredithe McNamara et al., *A Critical Review of the June 2022 Florida Medicaid Report on the Medical Treatment of Gender Dysphoria* (July 8, 2022).

and medical evidence but is, in fact, fundamentally unscientific" as it "makes false statements and contains glaring errors regarding science, statistical methods, and medicine." *Id.* at 2. The Critical Review is structured in five parts. It argues that "medical care for gender dysphoria is supported by a robust scientific consensus, meets generally accepted professional medical standards, and is neither experimental nor investigational"; that the Florida Medicaid Report is "a flawed analysis that ignores the scientific evidence and relies instead on pseudo-science" including experts who have been disqualified in court; that the Florida Medicaid Report "makes unfounded criticisms of robust and well-regarded clinical research and . . . cites sources with little or no scientific merit"; that the Florida Medicaid Report's "linchpin" is an analysis which is "extremely narrow in scope, inexpert, and so flawed it merits no scientific weight at all"; and that the Florida Medicaid Report "erroneously dismisses solid studies as 'low quality,'" which if followed regularly would mean that widely-used medications and common medical procedures would also have to be denied coverage. *Id.* at 3.

The Florida Agency for Health Care Administration responded to the Critical Review, stating that it is "another example of the left-wing academia propaganda machine arrogantly demanding you follow their words and not the clear evidence-based science sitting right in front of you" and that it is a "hodgepodge of baseless claims" without authority or credibility. Dara Kam, *Expert Report Condemns Florida's Plan to Ban Medicaid Coverage for Transgender Care*, Palm Coast Observer (July 17, 2022).

2. Current Status

While no further actions have yet been taken on the proposed rule, several other developments have ensued. First, the Florida Agency for Health Care Administration held a public hearing and accepted public comments on the proposed rule, both of which are discussed below and in the Appendix.

Additionally, the Florida Department of Health submitted a petition to the Florida Board of Medicine, urging them to bar physicians from providing gender-affirming care to minors. *See Florida Medical Board to Weigh Blocking Treatments for Transgender Youth*, CBS Miami (Aug. 1, 2022). The change would create a standard of care prohibiting individuals under the age of eighteen from receiving gender-affirming surgeries and hormones; it would also mandate a consent form and waiting period for older individuals. *Id.* The petition relied on guidance issued by the Florida Department of Health which stated that gender-affirming care should not be a treatment option for minors, Off. of State Surgeon Gen., Fla. Dep't of Health, Treatment of Gender Dysphoria for Children and Adolescents (Apr. 20, 2022), as well as the Florida Medicaid Report discussed *supra* Part 1-b. *Florida Medical Board to Weigh Blocking Treatments for Transgender Youth*, CBS Miami (Aug. 1, 2022). The next steps in this process are for the Board of Medicine to draft a proposed rule and take public comment. *Id.*

a. July 8, 2022 Hearing

The Florida Agency for Health Care Administration held a lively public hearing on July 8, 2022 on the proposed rule. The hearing consisted mostly of public comments, a comprehensive summary of which is attached in the Appendix. The full hearing can be viewed online. 7/8/22

Agency for Health Care Administration Hearing on General Medicaid Policy Rule, Fla. Channel (July 8, 2022).

The hearing included a "panel of experts" consisting of Dr. Andre Van Mol, Dr. Quentin Van Meter, and Dr. Miriam Grossman. Dr. Van Meter has been found by a court unqualified to be an expert on the subject of gender-affirming care. *See* Stephen Caruso, *A Texas Judge Ruled This Doctor was Not an Expert. A Pennsylvania Republican Invited Him to Testify on Trans Health Care*, Penn. Capital-Star (Sept. 15, 2020). He is also the president of the American College of Pediatricians, an advocacy group whose primary focus is to advocate for conservative policies in medicine, which has been categorized by the Southern Poverty Law Center as a hate group. *See American College of Pediatricians*, Southern Poverty L. Ctr., (last visited July 22, 2022). Dr. Van Mol is also a member. *Andre Van Mol*, Pub. Discourse, (last visited July 22, 2022). The panelists spoke at several times during the hearing, primarily to point the audience towards the Florida Medicaid Report. *See* Appendix.

Over the two-hour hearing period, fifty public commenters spoke. Forty-two of those commenters supported the proposed rule and eight opposed it. Of the forty-two in support, two formerly identified as transgender but have since detransitioned, eight were representatives of the Christian Family Coalition, and at least ten mentioned God or the Bible as part of their rationale. Many supporters also raised concerns that children and teenagers are not mature or knowledgeable enough to choose these procedures, or that they are being unduly influenced by their peers and may later regret transitioning. Notably, the proposed rule would apply to gender-affirming care for individuals of all ages, not only youth. 48 Fla. Admin. Reg. 2461–62 (June 17, 2022). Several supporters also cited the Florida Medicaid Report as being well-researched and providing a strong basis for the rule; some opponents of the rule noted criticisms of the report including those raised by the Critical Review.

b. Florida Organizations and Individuals

The university faculty who wrote the Critical Review also wrote a significant public comment on the proposed rule. *See* Letter from Anne L. Alstott et al. to Simone Marstiller & Tom Wallace re Rule No. 59G-1.050: General Medicaid Policy (July 8, 2022). The letter highlights similar concerns, noting that the "complete absence of scientific foundation for the Proposed Rule renders it an arbitrary and capricious use of rulemaking power" and that it "cannot [be] characterize[d] . . . as a valid interpretation of the existing Florida regulations on generally accepted professional medical standards, because the [Florida Medicaid] Report fails to satisfy Florida's own regulatory requirements for scientific review." *Id.* at 2. It reiterates concerns about the Florida Medicaid Report, including the cited experts' bias and lack of expertise, errors about scientific research and medical regulation, and lack of scientific weight. *Id.* passim, 20.

Disability Rights Florida submitted a comment also opposing the proposed rule. *See* Letter from Peter P. Sleasman to Simone Marstiller re Proposed Amendments to Rule 59G-1.050. The letter focuses primarily on how this proposed rule "will cause unnecessary and disproportionate harm to individuals with disabilities living in Florida," especially those who are low-income. *Id.* at 1. It notes that transgender individuals "are more than twice as likely as the general population to live in poverty," and transgender individuals with disabilities are four times as likely. *Id.* at 2.

Disability Rights Florida goes on to raise concerns about the agency's "apparent failure to take even minimal steps to ensure that the rulemaking workshop . . . is accessible to the very people with disabilities it will directly impact," citing to the lack of accommodations, contact information for seeking accommodations, and response regarding livestreaming. *Id.* at 3.

As did the Endocrine Society. *See* Letter from Ursula Kaiser to Agency for Health Care Administration re 59G-1.050: General Medicaid Policy (July 8, 2022). They note that their guidelines, "while not standards of care that clinicians are legally bound to follow, . . . provide a framework for best practices, and deviations must be justified." *Id.* at 1–2. They expound on how their guidelines were developed—using a "robust and rigorous process that adheres to the highest standards of trustworthiness and transparency" and with a "systematic review of the evidence that supports [clinical] questions"—in contrast to the Florida Medicaid Report, which "did not include endocrinologists with expertise in transgender medicine," "makes sweeping statements against gender affirming medical care that are not supported by evidence or references provided," and "does not acknowledge the data showing harm reduction and improvements in behavioral health issues" that result from gender affirming care. *Id.* at 2–3. The letter goes on to state that this proposed rule would cause irreparable harm to transgender youth, including putting their lives at risk. *Id.* at 6.

Equality Florida advocated against the rule as well. Equality Florida, Press Release, Equality Florida Decries Proposed Rule to Eliminate Medicaid Coverage for Gender Affirming Care (June 17, 2022). They note that this will affect approximately 9,000 transgender Floridians insured with Medicaid, and that "major medical and mental health associations recognize the critical importance of gender affirming care." *Id.*

The Florida Coalition for Trans Liberation has also put together a short policy brief around the proposed rule. *See* Fla. Coal. for Trans Liberation, *Stop Rule 59G-1.050* (2022). They note that this proposed rule contravenes all major medical advice, pushes a political agenda, and can be life-threatening. *Id.*

Florida Policy Institute also submitted a comment. *See* Letter from Anne Swerlick to Thomas Wallace re Proposed Rule 59G-1.050, Florida Administrative Code (July 7, 2022). They note that the proposed rule would "bar transgender patients from accessing essential care and reverse current Medicaid policies which have been in effect for years. *Id.* at 1. They also point out that this is counter to established standards of care, inconsistent with antidiscrimination laws, and exacerbates the challenges that transgender individuals already face. *Id.* It closes by noting that this rule seems to be "weaponiz[ing] [the Medicare program] as a tool for promoting a particular political agenda." *Id.*

While the majority of public comments during the July 8 hearing were in support of the rule, few comments posted online seem to be, and Florida Medicaid has not made all of the comments publicly available. Christian Family Coalition, who was also heavily represented at the July 8 hearing, did make a public statement, stating that this rule was "important and necessary" to protect Floridians, "especially minors, from harmful transgender surgeries, hormone blockers, and other unnatural therapies." *CFC Florida to Testify in Support of DeSantis Administration Rule Banning Medicaid Funding for Transgender Surgeries and Puberty Blockers*, Best Things

Fla. (July 8, 2022).

3. Next Steps

Several nonprofit groups in Florida are prepared to push back against the proposed rule. Lambda Legal, the National Health Law Program, the Florida Health Justice Project, and Southern Legal Counsel issued a statement criticizing the Florida Medicaid Report and stating that they "stand ready to defend the rights of transgender people in Florida." *LGBTQ Groups to Fight Florida Over Medicaid Ban for Trans Treatments*, CBS Miami (June 6, 2022).

One potential avenue for doing so may be seeking an administrative determination. Florida law says that any person "substantially affected by a . . . proposed rule may seek an administrative determination of the invalidity of the rule on the ground that the rule is an invalid exercise of delegated legislative authority. Fla. Stat. § 120.56 (2022). If a complaint is properly filed, the state must assign an administrative law judge (ALJ) to conduct a hearing within thirty days. *Id.* at (1)(c). The ALJ may declare the proposed rule wholly or partially invalid, and the rule then may not be adopted unless the judgment is reversed on appeal. *Id.* at (2)(b).

Appendix: Summary from July 8, 2022 Hearing

This appendix will detail the public comments made at the July 8 hearing regarding the proposed changes to 59G-1.050. There is no readily available transcript of the proceedings, so please note that names below may be missing or misspelled. Each speaker was met with audience applause at the end of their remarks, but any audience reactions during remarks are noted below.

The meeting opened with introductions of the panelists and representatives and a brief summary of the rule before opening the floor for public comments. Public commenters were asked to state their name and organization and to limit comments to two minutes, focusing only on the proposed rule language. The agency also noted that comments could be submitted via email.

The first speaker was Chloe Cole, a 17-year-old detransitioner from California. Cole began medical transition at the age of 13. In retrospect, she states that she was not becoming a man, but was just "fleeing from the uncomfortable feeling of being [a] wom[a]n." Chloe states that she "really didn't understand all of the ramifications of any of the medical decisions that [she] was making" when she chose to undergo a double mastectomy at the age of 15. She lamented that she will never be able to breastfeed, has blood clots in her urine, cannot fully empty her bladder, and does not know if she can ever give birth.[2]

The next speaker was Sophia Galvin, also a detransitioner. She states that she had a history of mental illness, including self-harm and suicidal ideation, and that her desire to transition was "all in an effort to escape the fear of being a woman in this society." Galvin stated that she had no support when she chose to detransition; her doctor told her to stop taking hormones but she did not see a mental health counselor. She said that "this is not good for children" and she "was harmed by this, and it should not be covered under Medicaid."

Next, the mother of a transgender boy spoke. She said that a physician gave her son testosterone at the age of 16 without her consent or knowledge, and that Medicaid covered her son's double mastectomy, hysterectomy, and vaginoplasty. She states that her son had private insurance but it was bypassed. She said that it is "impossible to change one's biological sex" and that doctors should not be affirming the "lie that biological sex is changeable." She characterized these lies as "child abuse," at which point the crowd began to applaud, and said that "amputating the healthy body parts of a child whose brain has not reached full decision-making maturity is simply criminal." This lead to more applause. She further characterized gender-affirming care as a "medical experiment."

The next speaker, Jeanette Cooper, spoke on behalf of Partners for Ethical Care. Cooper stated that "we need to make space in the public sphere for ethical therapists by removing the medical treatment option" and characterized gender identity affirmation as a "poisoned bandage on the

[2] Several news sources also reported on Chloe and her testimony. *See, e.g.*, Tyler O'Neil, *California Ex-Trans Teen Backs Florida Ban on Medicaid Funds for Transgender Medical Interventions*, Fox News (July 10, 2022), https://www.foxnews.com/health/california-ex-trans-teen-backs-florida-ban-medicaid-funds-transgender-medical-interventions. In one article, she urged individuals to "wait until you are a fully developed adult" prior to transitioning. *Id.* Notably, the Florida proposed rule is not only a prohibition on gender-affirming procedures for minors, but prohibits Medicaid funding for any gender-affirming procedures regardless of age.

skin of children causing permanent psychological and physical harm." The audience applauded when Cooper said "everyone knows what a woman is, but some people are afraid to say it." Cooper went on to state that "the state has no business using taxpayer funding to turn children into permanent medical patients" and "assisting doctors in selling disabilities to vulnerable suffering children." She further said that gender-affirming care is "not real healthcare" and that the state should instead fund "legitimate care" that addresses trans children's "actual needs." She likened the satisfaction children get from gender-affirming care to "a street drug that needs to be injected every day." Cooper closed by stating that the medical is "failing these families" and that her organization supports the proposed rule.

Donna Lambert, on behalf of Concerned Parents, also supported the rule. She said that "the healthcare professionals are presenting many [parents] with a false and painful choice: accept what we know will permanently harm our children, or lose them to suicide." She stated that "there is no data to prove that medically transitioning minors prevents suicide" and that parents lose their children down this "dangerous medical path permanently harming their healthy bodies with off-label drugs and experimental surgeries." Lambert said that transgender children "become angry and hostile and resentful; they begin lashing out at anyone who will not agree with their newfound identity." She described this as a "destructive social phenomenon" which "cuts parents out of the equation."

A Christian pastor spoke next, stating that the Bible teaches that "God makes people made and female" and to try and transition people "is a sin" and "should be a criminal abuse of children, especially when they're not at the age when they can properly process what they're doing to themselves." He said that the "one goal" of doctors who provide gender-affirming care is to "cut[ ] back on the birth rate." He supported the proposed rule and said Florida should "go further" and classify aiding in this case as "extreme child abuse."

Brandy Hendricks stated that gender-affirming procedures "have been shown to be extremely harmful, especially to minors." She lamented that children are being allowed to "change their genders before they've even reached puberty or shortly after." She said that pharmaceutical companies are advertising puberty blockers to children and unethically enriching themselves. She too characterized gender-affirming care as "child abuse" and as "experimental."

Sabrina Hartsfield, an alumna of Florida State University and a born-again Christian, spoke against the rule. Hartsfield said that "without gender-affirming healthcare, transgender and gender nonconforming individuals will die." She said that, "according to every major legitimate medical organization, gender-affirming care is the treatment for gender dysphoria." She said gender affirming care is "medically necessary and lifesaving treatment" that should not be decided by big government overreach. An audience member shouted something indiscernible at this point in Hartsfield's comment. Hartsfield went on to state that the proposed rule violates the Affordable Care Act and Medicaid Act's nondiscrimination provisions. She noted that denying gender-affirming care can be life-threatening.

Simone Chris, an attorney and the director of the Transgender Rights Initiative at Southern Legal Council, "vehemently oppose[d]" the proposed rule. She stated that her organization's experience working with hundreds of transgender individuals has evinced "the tremendous

benefits that access to [gender-affirming] care provides." Chris went on to state that "the insidiousness of this rule is exacerbated by the fact that it places in its crosshairs the individuals in our state who are already disproportionately likely" to face poverty, homelessness, poor health outcomes, and limited access to healthcare. She noted that every major medical association supports gender-affirming care, and that the proposed changes would "cause significant harm" by depriving individuals of "critical, lifesaving medical care." Chris went on to state that the changes to the rule substitute the state's judgment for that of the patient and their doctor, and that it is a "shameful waste of state resources." She cited to nationwide litigation which has struck down similar laws as inconsistent with the guarantees provided by the Medicaid Act, the Equal Protection Clause of the Fourteenth Amendment, and the Affordable Care Act, and noted that Florida will undoubtedly face similar challenges, wasting taxpayer money.

The next speaker, Matthew Benson, a pediatrician and pediatric endocrinologist, agreed with the proposed changes, stating that the data used to support gender-affirming care "is not scientific." He cited to a Swedish study from 2016 which found that the mortality rates of transgender individuals who received gender-affirming care were three times that of the general population, and that they attempted suicide five times more often than the general population. He also cited a similar study from Denmark wherein 10 percent of the study population died over the 20-year study period. Benson said we need better data and longer-term trials "to justify these kinds of very aggressive therapies."

Karen Schoen, a former teacher, spoke on behalf of Florida Citizens Alliance. She opened by stating that she would like to know "why 0.03 percent of the population is dictating to 99.97 percent of the population" that their elective surgeries should be paid for. This was met with audience applause. Schoen said that "kids change their minds" and that they become fearful of maturing. She lamented that thirteen-year-olds cannot drive a car, have a drink, or shoot a gun, but are "in charge" when it comes to changing their gender. This was met with audience laughter and applause.

The next speaker was Bill Snyder. Snyder first told a story about "reality disease," stating that "the further we move from reality, the further we move from morality" and that "the further we move from virtue, the more secular we become." Secularity leads to less freedom, he said, and then urged Florida to approve the changes to the rule.

Avery Fork with Christian Family Coalition, a college counselor, also spoke in support of the proposed rule. She characterized gender-affirming procedures as "unnatural therapies being promoted by radical gender ideals and with no basis in science." She said the proposed rule would prevent taxpayers from having to pay for "highly unethical and dangerous procedures."

Richard Carlins also spoke in support of the rule. He said that our Constitution was founded on "biblical principles." Carlins said children are being indoctrinated through commercials, Disney World, Coca-Cola commercials, and restaurants, and that gender-affirming procedures are a "horrendous evil." He said that "God raises up nations and he brings down nations," which was met with audience vocal support, and that this is a recent phenomenon. He said we've been "living in Judeo Christian principles" for 1500 years, and "it's just recently that we're throwing any mention of God [or] the Bible under the bus."

Amber Hand with the Body of Christ grew up with two queer parents. She said she had been considering gender transition for most of her life, but that "we have to teach these kids right from wrong" and that it is wrong to teach children they can make these decisions. Hand said that she is glad she never transitioned because she recently realized she wanted children. She went on to quote the Bible and that it's "not okay to change your identity."

The next speaker, Ms. Hazen, also supported the rule. She said that children are being pressured at a young age to identify as transgender, and that much of the pressure comes from the internet. She cited a follow-up study of individuals who transitioned, which found that the suicide rate in those individuals was twenty times the general population. She said that this evinces the "deep regret" they face after "mutilating" their bodies. She said that children "don't understand that they will never be able to procreate ever again" when we "mutilate these children's bodies at an early age."

Leonard Lord also spoke in favor of the proposed changes. He said that he was also uncomfortable in his body as a child but was able to get comfortable by becoming closer with God. The audience murmured in approval. He said that "either we're playing games, or we really believe there's a God and the Bible is true," and that this "problem" happens because we don't believe in God. Lord said that, with regard to mental health issues, "God's spirit is the answer to what's missing in their lives," again leading to audience applause and cheers. He said that by taking God, the Bible, and prayer out of schools, we are removing ourselves of power, love, and a sound mind. The audience again applauded. He said the "devil is the author of confusion" (the audience cheered) and that "if you spend your life trying to figure out if you're a man or a woman you'll never know why you're here" (again, audience applause).

The next speaker, Pam, also supported "stopping Medicaid from paying for children and teenagers to have such changes." She said that children are "confused" and likened gender-affirming procedures to "paying for [children] to have furry animal body parts," to which the audience cheered. She said she is thankful that Florida will "stop the madness" for "the sake of the children."

Jon Harris Maurer, the public policy director for Equality Florida, spoke next against the proposed rule. Maurer said that the proposed changes are without scientific or legal basis and are "clearly discriminatory." He cited to numerous experts and organizations who endorse gender-affirming care. Maurer also said that the agency "lacks the specific delegated rule-making authority to adopt the proposed rule" and that the statute cited "grants no authority" for the agency to usurp the role of healthcare providers. He said the rule is discriminatory and targets the transgender community, and that it would harm the 9,000 transgender Floridians on Medicaid. An audience member began to shout, and the audience began to speak over Maurer. He said that the proposed rule is politically calculated and urged them to reject the rule.

Anthony Verdugo spoke on behalf of the Christian Family Coalition as the Executive Director. Verdugo supported the rule. He said that "they call it gender-affirming care" but "they don't care, and it's not affirming." He called Chloe Cole and Sophia Galvin "heroes," and said that this is a "war on children and this is a crime against humanity." Verdugo said that "groomers" are pressuring children to undergo gender-affirming procedures. He cites to the warning label on a

package of hormones which states that emotional instability is a side effect. He said that the organizations Maurer listed "have been discredited" and cited to "more renowned" organizations who believe that "the suppression of normal puberty, the use of disease-causing cross sex hormones, and the surgical mutilation and sterilization of children" are "atrocities" and "not health care."

The next speaker, a veteran and police officer, said that doctors, parents, teachers, and scientists have been wrong before, but that detransitioners are the "evidence" we need. He said we need to "stop being ignorant" and that churches are bigger than any organization and in support of the proposed change. The audience met this with cheers and applause throughout.

Michael Haller, a doctor and professor of medicine at the University of Florida, spoke on his own behalf. After establishing himself as an expert, he said that this proposed rule makes "numerous false claims, uses biased reviews of the literature, and relies on more so-called experts who actually lack actual expertise" in caring for transgender youth. He said that the state's assertion that gender-affirming care is not safe or effective is "patently false" and that nearly every major medical organization supports this care. He says the state is "either unwilling or willfully chooses to ignore the totality of evidence for gender-affirming care." He said that the state's experts are unqualified. Haller noted that the proposal is "poorly-conceived," likely to cause harm, and should be rejected.

At this point, a member of the panel, Dr. Van Meter, made a comment. He said that the Endocrine Society guidelines are not standards of care, but merely guidelines, drafted by "ideologues" from the World Professional Association for Transgender Health. He said that this group excluded "world renowned experts in the field" and did not include their input "on purpose." He said that we "have to stop using the term 'standards of care' when there are absolutely no standards of care in this instance that have been addressed."

Robert Youelis spoke next, lamenting that gender-affirming care was not on anyone's radar even five years ago. He said that this is man "proclaim[ing] himself as God" and that there is only one truth. Youelis said we are "philosophically and morally" going down a slippery slope when we start considering gender-affirming care. He said that brains are not fully developed until the age of twenty-five, and children cannot make other decisions in life, so we should not be educating anyone about gender identities until they are in twelfth grade.

The next speaker, Keith Claw of Florida Citizens Alliance, spoke next. He said that children in public schools are "purposefully confused, desensitized, and even pressured into abnormal sexual behavior" and that "gender idealogues are coaching kids to be into this dysphoria." He said that there is ongoing debate as to whether gender dysphoria is biological or psychological. He said that taxpayers should not have to pay for gender-affirming care.

Robert Roper spoke next, also in support of the rule. He said that it "serves to protect the children." He said "gender confusion is the only disorder that comes with a false assertion that a child can be born in the wrong body" and that it is "impossible" to become the opposite gender. He went on to say that gender dysphoria is the only "disorder [where] the body is mangled to conform to the thoughts of the mind" and where "the child actually dictates his or her medical

care . . . instead of the other way around." He called this a "social media epidemic manufactured by social media influencers making a lot of money off the very vulnerable element of our society." He likened gender-affirming procedures to giving drugs to a drug addict or alcohol to an alcoholic and cited to a Reddit post where 35,000 individuals expressed regret of transitioning.

Karl Charles of Lambda Legal spoke against the proposed rule. He said that this care is "essential and in some cases lifesaving," "clinically effective," "evidence based," and "widely accepted." Charles said that exclusions such as this one cause "serious immediate and irreparable harm" to those who already experience "well-documented and pervasive stigma" and barriers to healthcare. He said that he is particularly concerned by the agency's characterization of this care as "experimental and ineffective," and that this is contrary to available medical evidence and misrepresents studies. He notes that the so-called experts relied on have been discredited and do not treat transgender patients. He noted that no one on the panel was a transgender Medicaid recipient in Florida, and that singling out transgender Medicaid participants violates Equal Protection and ACA § 1557.

A panelist at this point referred everyone to the appendices to the Florida Medicaid Report, including Dr. Cantor's reports cited to on page thirty-nine, which discusses each organization that has supported gender-affirming care.

Ed Wilson spoke in support of the proposed rule, saying that it would "protect children who are not mature enough to be comfortable in their own bodies" from "making mistakes that will destroy their lives." He said that taxpayer money should "never be used to destroy innocent lives" and that gender-affirming care "never actually succeed[s]" but does cause harm. He characterized it as "mutilation" and an "atrocit[y]" to be banned, "not healthcare."

Suzanne Zimmerman, a relative of a gender dysphoric youth, spoke next. She "pray[ed]" that the state "not make it easy" for this youth's parents to be persuaded towards gender-affirming care. She pointed to the testimony of detransitioners to state that "God doesn't make mistakes" (the audience said "amen"). She urged them to support the changes.

Jean Halloran also supports the changes. She said that Medicaid should not be supporting or paying for gender-affirming care. She likened gender-affirming care to cosmetic changes to make her look younger, receiving audience applause and laughter.

Ezra Stone, a clinical social worker, pointed to research that medical transition is safe and effective. They pointed to clients who have "expressed tremendous relief" and an increased sense of safety when they are able to access medical care. They said that "understanding and being seen as [one's] true sel[f] creates a sense of belonging, which is a fundamental human need." They pointed to the political climate in Florida as causing harm and anxiety to "transgender, nonbinary, questioning, and gender-diverse Floridians." Their patients "worry about their access to medical care" and experience fear of violence daily, which supports the minority stress model that says that expecting harm and violence has a negative impact on mental health and well-being. They said that this proposed change will create an atmosphere of fear and take away medically necessary care.

Peggy Joseph shared the thoughts of Ryan T. Anderson, author of *When Harry Became Sally*. She cited to the Obama Administration's refusal to mandate coverage of gender-affirming surgeries under Medicaid, which said that there was "not enough evidence" to determine whether it improved health outcomes. She said that studies with positive outcomes were exploratory, without follow-up, which "could be pointing to suicide." She cited to the Swedish study regarding suicide rates, as well. She said the "minimal standard of care should be with a standard of normality" and that gender dysphoric thoughts are "misguided and cause harm."

A panelist again interjected to note that the report on pages 35–36 and 42–45 discusses the international consensus.

Jack Walton with the Christian Family Coalition is a pastor. He said he has counseled queer individuals for thirty-seven years. He believes that "gender dysphoria should be labeled as child abuse" and the doctors who prescribe gender-affirming care are "tear[ing] the child apart and call[ing] it health care." Walton says that gender-affirming care is "not science" and that any such procedures "should be labeled criminal." He said that "nearly 90 percent of those that escape from that life do it by the time they reach the end of puberty because they come back to their senses that they were created male and female by God." Walton expressed that suicide happens when a transgender person transitions but "still do[es]n't find the completion that they thought they felt." He said that many individuals transition because of child abuse they faced as children or because they were not accepted by others. He closed by saying there are "two genders, male and female; women bear children, women breastfeed, women have menstrual cycles, men do not." He said he "would not provide the anorexic with food and [he] would not say give money to do something that would harm a child."

Another member of the Christian Family Coalition, Jose, also supported the changes. He characterized gender-affirming care as "mutilation" and said that transgender individuals need "counseling" and should not be given a "destructive choice." He said that everyone will have to "stand before our living God and give account for where we stand on this and other issues." He thanked Chloe Cole and Sophia Galvin for their testimonies.

The panel then asked that members of the same organization be mindful of their time.

Bob Johnson, an attorney, spoke next. He thanked the agency for putting together the report, noting that it is "thorough," and said the "case is compelling." He strongly supports the rule change, and this is in large part due to the report making the case. He noted that the "FDA does not approve any medication as clinically indicated for gender dysphoria" and lamented the lack of randomized controlled trials and long-term data for puberty suppression medication.

Sandy Westad also spoke on behalf of Christian Family Coalition. She said that her heart is "breaking for what these kids are going through" and that "the parents need to stay in control." She said that kids "play house" and "pretend," but they "don't want to be or understand or even know what it is to change from one sex to another." She said, "children cannot make those kinds of decisions" and "cannot decide who they are."

Gayle Carlins also spoke from Christian Family Coalition. She said her beliefs are based on the

Bible, which is "the only truth that there is," and which says that "God created male and female." She went on to "bring science into it," stating that females have two X chromosomes and males have an X and a Y chromosome, and that "it's an impossibility to change from one to the other" "no matter what kind of mutilation or anything is done to a person."

Dorothy Barron spoke next, also from Christian Family Coalition. She first thanked Florida's "great governor," eliciting audience cheers and applause, and thanked Chloe Cole and Sophia Galvin for not "going along with what you were trying to be brainwashed into" (also eliciting audience cheers and applause). She said "they're definitely targeting our youngest," and lamented that "we can't seem to find baby formula anywhere but yet Medicaid can fund this nonsense." Barron said it "has to be left up to the parents," and that "whatever you choose to practice in the privacy of your own home is your business"; she is "not discriminating against any genders or whatever." She said that it needs to be "taken out of the schools." She said Michael Haller's testimony was "shameful" and is "why we're in this bloody mess right now," to which the audience also cheered and applauded.

The panel reminded the public to be focused on the rule and respectful of other speakers.

Troy Peterson, the president of Warriors of Faith, supported Christian Family Coalition, and came from the Tampa Bay area. He said that he represents "thousands that stand in agreement" with the proposed change. He thanked the doctors for the report and said that "when [he] saw the evidence, [he] could clearly see that we need this rule." He quoted from Genesis and said that God created male and female, and he is opposed to Michael Haller as well. He said that "if [he] had any authority in the medical field, [he] would have [Michael Haller's] license revoked." The audience whistled and verbally approved. He said that the most thorough follow-up of transgender individuals in Sweden said that "the suicide rate is twenty times that of the comparable peers" and that "50 percent of the gender identity confused children have thoughts of suicide."

Janet Rath spoke next. She said that "fifty years ago, as parents, we were smarter than what's going on today," and that parents are being left out of their children's lives. She said some of this is the fault of parents and some is the fault of teachers. She said her granddaughter, a teacher, has told her that "if she has a child that comes in and identifies as a cat, she must have a litterbox there and a bowl of water." Rath said that our country is going "absolutely insane," and the audience murmured in agreement. She said that Dr. Fauci is "nothing but a money-grabbing liar" and "we have been hoodwinked ever since." Rath went on to say that "Chinese children in third grade are learning advanced calculus" but "our third graders are learning which bathroom to use."

Gerald Lomer drove 3.5 hours to attend the hearing. He supported the proposed rule and "the best governor in the United States," to which the audience cheered and applauded. He told "stories" of a girl who wanted to spend more time with her father and thought that being a boy was the best way to do so and a boy who wanted to spend more time with his mother and thought that being a girl was the best way to do so. He said that thirteen-year-olds cannot drive a car, drink a beer, or smoke a cigarette, but are able to take hormones and obtain surgeries for gender-affirming care. He characterized gender-affirming surgeries as "mutilating."

A pastor from Florida spoke next on behalf of Protect Our Children Project, Duval Country Charter House, and Christian Family Coalition. She supported the rule prohibiting funding for "unnatural therapies" and does not want taxpayers to subsidize transgender care. She said that "transgenderism is driven by unethical pharmaceutical companies enriching themselves with puberty blockers" and that this is child abuse. She cited to Swedish psychiatrist Dr. Christopher Gillberg, who has said that "pediatric transition is possibly one of the greatest scandals in medical history."

Paul Aarons, a physician, spoke next. He said he has transgender patients and friends. He said that he opposes the proposed change, because it "conflicts with the preponderance of medical science and practice and would do irreparable harm" to transgender Floridians of all ages. He said that the American Academy of Pediatrics and its Florida chapter have directly refuted the agency's report. Aarons said that, "contrary to an earlier comment, the Endocrine Society has stated, 'medical intervention for transgender youth and adults, including puberty suppression hormone therapy, and medically indicated surgery, has been established as their standard of care. Federal and private insurers should cover such interventions as prescribed by a physician.'" He said gender dysphoria is "very real" and that people should meet and speak to transgender individuals, which will help them realize that denial of care "at any age would be inhumane and a violation of human rights." He said that gender-affirming care is "generally accepted professional medical standards" and that this rule would put the health and lives of transgender people in danger. He said that "it feels like Medicaid is crossing into a political lane by seeking to preempt provider/patient/family decision-making." He said that, if the agency still wants to address this topic, they should "at least convene an appropriate panel of experts including transgender community members to inform yourselves and the public about the overwhelming evidence against denying coverage for gender affirming care."

A doctor on the panel then encouraged everyone to read the report and its attachments. He said that the report focuses on studies which have been brought up, and "specifically the flaws" in those studies. He also encouraged audience members not to interrupt when others are speaking. He went on to say that the Endocrine Society's 2017 guidelines "are guidelines, just that," and they "do not guarantee an outcome" and "do not establish a standard of care." He also referred to international reviews which "all came to the same conclusion" that "this should not be going on in minors at all," to which the audience applauded. He said that children need "strong psychological support" and that four decades of literature point to the "overwhelming probability of mental health problems after these childhood events" and "problems like autism spectrum disorder." He said that in other nations, having "psychological instability . . . blocks you from the transition pathway" and that "those things be taken care of first because transition simply won't fix them." He said that the report is a "very well-researched document" and addresses a lot of the concerns raised in comment letters.

Another panelist then referred everyone to Attachment C of the report and Dr. Hruz's *Deficiencies in Scientific Evidence for Medical Management of Gender Dysphoria*.

January Littlejohn, a mental health counselor, spoke next. Her child expressed that they were experiencing gender dysphoria in 2020, shortly after three of their friends had started identifying as transgender. She said that the middle school had "socially transitioned [her child] without

their knowledge or consent"[3] and that her child's "mental health spiraled." She said that she has worked with a psychologist to help address her child's low self-esteem and anxiety, and has "given [her child] more one-on-one time, in-person activities away from trans influences, limited [her child's] internet use, and declined to affirm [her child's] newly-chosen name and pronouns." She said that they set "appropriate boundaries" and allowed her child to choose hairstyle and clothing but "denied harmful requests such as breast binders, puberty blockers, cross-sex hormones, and surgeries." She said it was "clear from [their] conversations" that her child was uncomfortable with their developing body and had "an intense fear of being sexualized." Littlejohn said that her child was "filled with self-loathing and was in true emotional pain," but "had been led by peers and influencers to believe that gender was the source of [their] pain." She said that her child needed to be "remind[ed] that hormones and surgeries can never change [their] sex or resolve [their] issues." She said that she "shudder[s] to think what could have happened if [they] had affirmed [her child's] false identity and consented to medical treatment" as opposed to "lovingly affirm [her child] as [they are], beautifully unique and irreplaceable and undeniably female." She said that her child has "desisted and is on a path to self-love" but unfortunately gender dysphoric children are "being encouraged to activism peer pressure to disassociate from their bodies and to believe their body parts can be simply removed, modified, or replaced." Littlejohn said that "the irreversible consequences of medically transitioning, including loss of sexual and reproductive function, cannot be fully understood by children or teens who lack the necessary maturity or experience."

Kendra Barris, a mental health attorney, spoke next. She first addressed the comment about the lack of peer-reviewed standards of care, saying that this lack means that "a lot of people who are harmed or experience bad outcomes from these surgeries or other interventions have no ability to sue." She said that "they have had decades to create peer-reviewed standards of care and they have not," and she suspects that some people do not want to standards because it would open them up to lawsuits, which is not currently happening. She went on to say that "when you put a female on testosterone, within about five years [they are] going to have to have a hysterectomy," which for teens could mean a potential hysterectomy before the age of twenty. She said that "hysterectomy is correlated with negative mental health outcomes and cognitive decline" and that this is worse the earlier a hysterectomy is performed. She said that "essentially, the earlier you do the hysterectomy, the earlier the onset of dementia." She is "very concerned about" how in a few decades "we're going to have an absolute wave of young females, 40–50 years old, with early-onset cognitive decline" in assisted-living facilities. She said that "some people who are trans and have dementia forget that they're trans" and if they don't have written consent to continue their transition, they "might be cut off." She worries that "we have not considered all of the implications of this."

The next speaker was Nathan Bruemmer, Florida's LGBTQ Consumer Advocate. He opposed the proposed rule "on behalf of healthcare consumers," saying that consumers "must be provided with accurate information, education, choice, safety, representation, and regress." He said that

[3] Note that news organizations have reported that Ms. Littlejohn was aware of her child's choice to change names and pronouns at school and told the school she would not stop them from doing so. She later filed a lawsuit against the school. *See, e.g.*, Leyla Santiago, *Fact Check: Emails Show One of Desantis's Stories Backing the Rationale for So-Called 'Don't Say Gay' Law Didn't Happen as the Governor Says*, CNN Politics (Apr. 6, 2022), https://www.cnn.com/2022/04/06/politics/fact-check-desantis-dont-say-gay-family-narrative/index.html.

"documented, well-researched standards of care have been established, are based on a wide range of evidence, and conclude that gender-affirming medical care is medically necessary and safe and effective." In other words, "gender-affirming care *is* the standard of care." Bruemmer said that the proposed rule would "deny health care consumers . . . access to the standard of care." He said that agencies must defend the rights of all Floridians, including transgender Floridians, and that this includes the right to non-discriminatory healthcare coverage. He said we should work to increase access to healthcare, not lessen or remove it. Bruemmer said that he is "one of . . . tens of thousands of transgender Floridians" who have had access to gender-affirming care, and who are "happy, and successful, and thriving." He said that transgender Floridians "deserve the rights and benefits afforded to all."

The next speaker's name was inaudible, but he also spoke in support of the proposed rule. He told examples of his fifteen-year-old son making bad decisions, including speeding on his dirt bike and wanting to leave home, as proof that "these kids can['t] make a decision on what they want that's going to be with them for the rest of life." He said that the doctors who spoke previously "are despicable," "need to have their licenses taken away," and "are a disgrace to the human race."

A panelist thanked him for his comment and said, "we respect everybody's comments, including the doctors that you referenced."

Dottie McPherson spoke next on behalf of the Florida Federation of Republican Women. She said that even at the age of eighteen "children don't have the maturity to handle certain responsibilities given them" like driving and alcohol, and that "even older adults don't." She said that state programs include "programs for abused and neglected children, but not gender decisions." She urged the panel to "prevent funding the destruction of children's genitalia and hormonal balance." McPherson urged the panel to consider unintended consequences, such as "taxpayer money that will need to be used for lawsuits by those whose lives were ruined from surgeries that they got while they were immature or too young to understand," parents whose "parental rights were denied to protect their children's future." She said that "life isn't fair" and we have to "stop giving in to the 'poor pitiful me' syndrome." McPherson said that government "has no business funding these things."

Maria Caulkins spoke next in support of the proposed rule. She said that taxpayer money should not be spent on funding surgeries that are "unnecessarily and tremendously harmful." She said that there is "a war on our children" and that we need to "protect our children" and "support our governor" by being on the "right side" of this war.

James Caulkins also spoke in support of the rule, saying that we're "in a battle in this country." He said that the people of Florida "have spoken" by electing "the greatest governor in the United States," to which the audience cheered and applauded. Caulkins said that we "don't need this stuff, this evil, this Medicaid funding for transgender surgery" and that Florida should lead other states against "this evil."

The final speaker, whose name was also inaudible, spoke in support of the proposed rule. She said that, years ago, she was told by a doctor that she needed to undergo hormone therapy, but

she "saw the risks involved." She said that hormone therapy is an attempt to "prevent . . . natural things from occurring," such as menstruation, and we can't expect it not to have any problems. She cited to Bill Maher, who pointed out that transgender procedures were only occurring in major cities where "social engineering is happening and where people are being influenced" but not in the rest of the country. She lamented that she can't go to the media and say anything against transgender individuals because it will be "criticized and condemned" which "isn't fair." She said that "the government should not be involved in supporting any kind of procedure to these young kids."

A panelist thanked everyone for their comments and then clarified the purpose of the rule. He said that it is *not* "a ban on treatment for gender dysphoria," but rather lack of Medicaid coverage for services mentioned in the proposed rule. He also said that "there are other comprehensive coverage of services for gender dysphoria currently in the Florida Medicaid program" before reading some of those services (community-based services, psychiatric services, emergency services and inpatient services, and behavioral health services in schools).

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

THE STATE OF TEXAS,

Plaintiff,

v.

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, *et al.*,

Defendants.

Case No. 2:21-cv-00194-Z

PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL MOTION TO DISMISS THE FIRST AMENDED COMPLAINT

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INTRODUCTION

In February 2022, Governor Greg Abbott wrote to Jaime Masters, Commissioner of the Texas Department of Family and Protective Services, attaching an opinion from Attorney General Ken Paxton. In that letter, Governor Abbott directed DFPS "to conduct a prompt and thorough investigation of any reported instances" of "so-called 'sex change' procedures" conducted on minors that Texas law recognizes as child abuse. Supp.App.013. He issued that direction because "DFPS and all other state agencies must follow the law as explained in" the attached Attorney General Opinion. *Id.* That opinion had concluded that "it is already against the law to subject Texas children to a wide variety of elective procedures for gender transitioning, including reassignment surgeries that can cause sterilization, mastectomies, removals of otherwise healthy body parts, and administration of puberty-blocking drugs or supraphysiologic doses of testosterone or estrogen." *See* Supp.App.015–027.

On March 2, 2022, HHS's Office of Civil Rights ("OCR") issued the HHS Rule, which it termed "additional information on federal civil rights protections . . . that apply to gender affirming care." Supp.App.001–004. It was neither published in the Federal Register nor promulgated subject to notice-and-comment procedures that apply to the issuance of substantive rules. A press release from HHS Secretary Xavier Becerra accompanied the guidance. In that press release, Becerra stated that OCR had issued the guidance in direct response to "a gubernatorial order in Texas" and that it was "intended to remind Texas and others of the federal protections that exist" under HHS's erroneous interpretation of the Affordable Care Act, the Rehabilitation Act, and the Americans with Disabilities Act. Supp.App.006–008. In bolded, inflated-size type, the HHS Rule invited "[p]arents and caregivers who believe their child has been denied health care, including gender affirming care, on the basis of that child's gender identity" and "[h]ealth care providers who believe that they are or have been unlawfully restricted from providing health care to a patient on the basis of that patient's gender identity" to "file a complaint with OCR." Supp.App.002.

Section 1557 of the Affordable Care Act makes it illegal for an entity receiving funds for a program under that law to discriminate against a person's participation in or receipt of benefits under such a program based on, among other things, the person's sex. *See* 42 U.S.C. § 18116 (incorporating 20 U.S.C. § 1681 (Title IX)). The HHS Rule purported to "remind" the public that that "federally-funded [sic] covered entities restricting an individual's ability to receive medically necessary care, including gender-affirming care, from their [sic] health care provider solely on the basis of their sex assigned at birth or gender identity likely violates Section 1557." Supp.App.003. Section 1557, however, does no such thing, mentioning the concept of gender identity not at all. Instead, HHS Rule adopted a new interpretation of Section 1557, relying on an erroneous interpretation of *Bostock v. Clayton County*—which proceeds directly on the assumption that "'sex' . . . refer[s] only to biological distinctions between male and female"—to do so. 140 S. Ct. 1731, 1739 (2020). The HHS Rule purports to empower HHS to withhold federal funding from entities, such as the State of Texas, that do not adhere to that misinterpretation. Specifically, it states—incorrectly—that doctors and other staff members at facilities that receive federal funds who comply with obligations to report suspected child abuse to State authorities may have violated federal law. Supp.App.003.

The HHS Rule further states that "Section 504 [of the Rehabilitation Act] protects qualified individuals with disabilities from discrimination in programs and activities receiving federal financial assistance" and that "[g]ender dysphoria may, in some cases, qualify as a disability under" that law. Supp.App.003. It concludes on that basis that "[r]estrictions that prevent otherwise qualified individuals from receiving medically necessary care on the basis of their gender dysphoria . . . may, therefore, also violate Section 504[.]" *Id.* Congress, however, has explicitly exempted gender dysphoria

from the definition of "disability" under Section 504 and the Americans with Disabilities Act except when that condition itself results from a physical impairment. See 42 U.S.C. § 12211(b).[1]

Texas sued the Defendants to have the HHS Rule and its erroneous interpretation of the law set aside. ECF No. 31. It identified billions of dollars of funding it received from the federal government each year, particularly its Department of State Health Services and its Health and Human Services Commission. *Id.* ¶ 59. It noted that HHS's threat to withhold federal funding from it based on its enforcement of its child-abuse laws, which conflict with HHS's erroneous interpretation of the law, threatened those billions of dollars in funding and that this threat—to change its laws or risk losing funds critical to the operation of its healthcare system—threatened its sovereign right to develop and enforce a legal code and threatened it with the burden of defending itself against frivolous investigations. *Id.* ¶¶ 60–62. It charged the Defendants with violating the Administrative Procedure Act by failing to use notice-and-comment procedures before promulgating the HHS Rule, *id.* ¶¶ 90–92; by adopting an unreasoned rule that did not consider all relevant factors, *id.* ¶¶ 111–118; and by adopting a rule not in accordance with the law, *id.* ¶¶ 119–123. It also challenged the HHS Rule as *ultra vires*, *id.* ¶¶ 124–127, and invalid as having not been published in the Federal Register, *id.* at 102–105.

The Defendants have moved to dismiss those claims. ECF No. 37. Texas now responds in opposition, demonstrating why dismissal is improper. Because the Defendants' claims in their Supplemental Motion to Dismiss largely parallel the arguments they raised in their Motion to Dismiss similar claims against Defendants EEOC and Charlotte Burrows, Texas incorporates by reference the legal bases for opposing dismissal that it raised in its Opposition to that motion, ECF No. 18, and uses this opposition to address only the facts and particular arguments relevant to the claims against the HHS Defendants.

[1] Consistent with this narrow exception, Texas's child abuse laws recognize "rare circumstances" of medical necessity for "children [who] have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female." Supp.App.016.

ARGUMENT

A. The HHS Rule is final agency action.

Texas has previously explained in detail why the EEOC Rule constituted final agency action. ECF No. 18 at 19–29. This section will explain why that analysis also applies to the HHS Rule.

Defendants do not contest that the HHS Rule satisfies the first prong of finality, that "it marks the consummation of the agency's decisionmaking process and is not of a merely tentative or interlocutory nature." *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (cleaned up). Their argument is limited to the second prong of the finality analysis, contending that the HHS Rule "does not determine Plaintiff's rights or obligations." Supp. MTD at 19. This misunderstands the nature of the finality analysis—Texas does not need to demonstrate that that the HHS Rule determines "*Plaintiff's* rights or obligations," only that it affects the rights or obligations of *someone*, including regulated parties or HHS staff. *See Texas v. EEOC*, 933 F.3d 433, 444 (5th Cir. 2019) ("Finality, however, cannot vary depending on who sued the agency; it depends on the rule itself.").

Defendants argue that the HHS Rule isn't determinative because some court "in enforcement proceedings" might find the HHS Rule's interpretation of the law to be mistaken. Supp. MTD at 20. But "reliance on formalistic criteria, such as whether the agency decision itself imposes penalties or is binding on a court" is inconsistent with the Supreme Court's emphasis on a "'pragmatic approach' to assessing whether APA review is appropriate." *Texas v. EEOC*, 827 F.3d 372, 384 (5th Cir. 2016), *opn. withdrawn on reh'g*, 838 F.3d 511 (5th Cir. 2016). "The possibility that the agency might not bring an action for penalties or, if it did, might not succeed in establishing the underlying violation [does] not rob the administrative order . . . of its legal consequences. . . ." *Rhea Lana, Inc. v. Dept. of Labor*, 824 F.3d 1023, 1032 (D.C. Cir. 2016).

Defendants also believe that if the HHS Rule is categorized as "[a]n interpretive rule and general statement of policy," it could not constitute final agency action. Supp. MTD at 19. But as

Texas already explained, even policy statements or interpretive rules may be final agency actions due to their effects. ECF No. 18 at 23. Several effects serve to make the HHS Rule final agency action.

First, the OCR document, Supp.App.001–004, is not the entirety of the HHS Rule. A challenged agency action with a "skeletal" explanation may be supplemented by reasons given in "accompanying explanatory correspondence" from the agency. *Alaska Dept. of Envtl. Conservation v. EPA*, 540 U.S. 461, 497 (2004). "Final agency action may result from a series of agency pronouncements rather than a single edict." *Barrick Goldstrike Mines Inc. v. Browner*, 215 F.3d 45, 48–49 (D.C. Cir. 2000) (cleaned up). "Hence, a preamble plus a guidance plus an enforcement letter from [an agency] could crystallize an agency position into final agency action." *Id.*; *see also Ciba–Geigy Corp. v. EPA*, 801 F.2d 430, 436 n.8 (D.C. Cir. 1986) (final agency action consisted of a "series of steps taken by EPA" culminating in a letter from an EPA official clarifying the agency's position). This is consistent with the "flexible and pragmatic way" in which courts apply the finality requirement. *Her Majesty the Queen in Right of Ontario v. EPA*, 912 F.2d 1525, 1531 (D.C. Cir. 1990).

An agency may not avoid judicial review "merely by choosing the form of a letter to express its definitive position on a general question of statutory interpretation." *Ciba–Geigy*, 801 F.2d at 438 n. 9. Secretary Becerra's statement "clearly and unequivocally" declared Texas's child abuse laws to be unlawful. *Her Majesty*, 912 F.2d at 1531. The challenged agency action—the HHS Rule—is the decision to mandate accommodations based on gender identity in Section 1557 and Section 504 of the Rehabilitation Act, and it is "simply *explained*" by the OCR document and Secretary Becerra's statement that accompanied it. *Texas v. Biden ("Texas MPP")*, 20 F.4th 928, 950–51 (5th Cir. 2021) (emphasis in original).

1. The HHS Rule is a legislative—or "substantive"—rule.

Texas previously explained in detail why the EEOC Rule contradicts Title VII—as interpreted in *Bostock*—because it did not merely forbid discrimination based on transgender status, but attempted

to protect conduct associated with transgenderism and to mandate accommodations for transgender persons from concededly lawful rules. ECF No. 18 at 2–17.

The same reasoning applies to the HHS Rule, which targets state child-abuse laws not on the basis that they discriminate against anyone based on their "internalized, felt sense of who they are as male or female," *Doe 2 v. Shanahan*, 917 F.3d 694, 708 (D.C. Cir. 2019) (Williams, J., concurring in the result), but because the targeted laws refuse to make exceptions from their generally applicable language—that is, make accommodations—based on gender identity. The child-abuse laws the HHS Rule purports to target do not discriminate based on the concept of gender identity; they disregard that concept altogether, as *Bostock* requires. *See Bostock*, 140 S. Ct. at 1741 ("[homosexuality or transgender status is not relevant to" decisions governed by a prohibition on sex discrimination). For example, Texas's child abuse laws forbid sterilization, genital mutilation, and unnecessary medical interventions for minors regardless of the minor's subjective gender identity. Supp.App.013–027.

For the same reasons that the EEOC Rule constituted a legislative rule, ECF No. 18 at 22–24, the HHS Rule is a legislative rule: neither Title IX, its implementing regulations, nor *Bostock* "compels or logically justifies" it. *Natl. Council for Adoption v. Blinken*, 4 F.4th 106, 113 (D.C. Cir. 2021). As the Fifth Circuit phrased it in rejecting a different attempt by the federal government to excuse a rule from review, "the [HHS Rule] does not simply repeat the relevant provisions of Title [IX or the other provisions it cites]. Instead, the [HHS Rule] purports to interpret authoritatively [those statutory requirements]. This court has always considered such a distinction important when deciding whether agency action is 'final' under the APA." *EEOC*, 827 F.3d at 385–86. In addition to the reasons Texas previously explained, ECF No. 18 at 2–17, the HHS Rule exceeds the outer reaches of *Bostock* because that decision did not purport to eliminate the permissibility of a distinction between legal adults and minors for irreversible medical procedures.

Defendants also maintain that the HHS Rule is "not a new interpretation of law" because it previously issued a rule explaining that "[c]ategorically refusing to provide treatment" based on gender identity is prohibited discrimination under Section 1557. Supp. MTD at 19; *see also* Supp.App.003. But nothing in that prior rule mentions the accommodation interpretation that HHS advances by requiring exemptions for transgender persons from concededly lawful policies. Supp.App.010–011. The HHS Rule therefore *is* a new interpretation of law, not only because no previous rule articulated an accommodation requirement, but also because none construed Section 1557 to require state child-abuse laws to fall silent if someone claims a transgender identity.

Furthermore, Defendants cite no prior HHS interpretation that Section 504 of the Rehabilitation Act protects as a disability "some cases" of gender dysphoria, as the OCR document asserts. Supp.App.003. The Rehabilitation Act expressly excludes "transvestism, transsexualism . . . [and] gender identity disorders not resulting from physical impairments" from its definition of disability. 29 U.S.C. § 705(20)(F)(i). And "[g]ender dysphoria, as a gender identity disorder, is specifically exempted as a disability by the Rehabilitation Act." *Michaels v. Akal Sec., Inc.*, 2010 WL 2573988, at *6 (D. Colo. June 24, 2010). *See also Parker v. Strawser Constr., Inc.*, 307 F. Supp. 3d 744, 753-54 (S.D. Ohio 2018);; *Gulley-Fernandez v. Wis. Dept. of Corr.*, 2015 WL 7777997, at *2 (E.D. Wis. Dec. 1, 2015) ("gender identity disorder is not a 'disability' under the Americans with Disabilities Act or the Rehabilitation Act."); *Mitchell v. Wall*, 2015 WL 10936775, at *1 (W.D. Wis. Aug. 6, 2015) (gender identity disorders expressly excluded from coverage under the ADA); *Kastl v. Maricopa Cnty. Cmty. Coll. Dist.*, 2004 WL 2008954, at *4 & n. 2 (D. Ariz. June 3, 2004) (equating "gender identity disorder" and "gender dysphoria" and holding them to be expressly excluded from definition of "disability"). The HHS Rule is therefore also a legislative rule on this basis.

All legislative rules are, "by definition, final agency action," *EEOC*, 933 F.3d at 441. Because neither Title VII, the Rehabilitation Act, nor *Bostock* "compels or logically justifies" the HHS Rule, it

is a legislative rule issued in violation of the APA's notice-and-comment requirements. *See NRDC v. Wheeler*, 955 F.3d 68, 84 (D.C. Cir. 2020) (because EPA "treated [a judicial decision] as having a legal effect—full vacatur—that the decision disclaimed[,] [it was] a legislative rule").

2. The HHS Rule binds EEOC.

Defendants do not address the binding nature of the HHS Rule on the agency—a fatal omission, as binding agency staff, as Texas previously explained, affects rights or obligations and indicates a legislative rule. ECF No. 18 at 22–26.

The Fifth Circuit has held EEOC guidance "broadly condemning" an employment practice "leaves no room for EEOC staff *not* to issue referrals to the Attorney General when an employer" implements that practice. *EEOC*, 933 F.3d at 443. The same reasoning applies here. OCR's document explaining the HHS Rule appeared to hedge the certainty of its guidance. *See, e.g.*, Supp.App.003 ("For example, if a parent and their child visit a doctor for a consultation regarding or to receive gender affirming care, and the doctor or other staff at the facility reports the parent to state authorities for seeking such care, that reporting may constitute violation of Section 1557 if the doctor or facility receives federal financial assistance. Restricting a health care provider's ability to provide or prescribe such care may also violate Section 1557."). But the HHS Rule was accompanied by the imprimatur of Secretary Becerra himself who hedged not at all. Becerra, indeed, indicated that he had already concluded that Texas's interpretation of its own child-abuse laws was "discriminatory and unconscionable," referring to "a discriminatory gubernatorial order in Texas," explaining that he had "directed [his] team to evaluate the tools at [its] disposal" to interfere with that interpretation, and inviting "[a]ny individual or family in Texas who is being targeted by a child welfare investigation because of this discriminatory gubernatorial order . . . to contact our Office for Civil Rights" to pursue that interference. Supp.App.006.

The Secretary of Health and Human Services himself has announced the Department's conclusion that Texas has violated federal law. What agency staffer has discretion to countermand him? *Cf. Profls. & Patients for Customized Care v. Shalala*, 56 F.3d 592, 599 (5th Cir. 1995) ("We would expect agency employees to consider all sources of pertinent information in performing [their] task[s], whether the information be contained in a substantive rule, an interpretive rule, or a statement of policy. Indeed, what purpose would an agency's statement of policy serve if agency employees could not refer to it for guidance?"). "Such an approach would flout the Supreme Court's repeated instruction to approach finality flexibly and pragmatically." *EEOC*, 933 F.3d at 445. The HHS Rule constitutes final agency action.

3. The HHS Rule widens the field of potential plaintiffs and sets norms or safe harbors for regulated parties.

Just like the EEOC Rule, the HHS Rule is "binding as a practical matter because private parties can rely on it as a norm or safe harbor by which to shape their actions." *See* ECF No. 18 at 26–29 (citing *EEOC*, 933 F.3d at 444 (cleaned up)). As in *EEOC*, the HHS Rule also "encourages" "[a]ny individual or family in Texas who is being targeted by a child welfare investigation because of this discriminatory gubernatorial order . . . to contact" the agency, Supp.App.006, "thus opening the field of potential plaintiffs." *EEOC*, 933 F.3d at 444 (citation omitted); *see also* Supp.App.002 (inviting "[p]arents or caregivers who believe their child has been denied" "gender affirming care" to "file a complaint with OCR").

The HHS Rule contains a norm or safe harbor on which HHS expects funding recipients to rely in shaping their behavior: "gender[-]affirming care for minors" must not be considered "abuse." Supp.App.002. *See also* Supp.App.003 (stating it "likely violates Section 1557" if "gender-affirming care" is reported as child abuse). Indeed, the HHS Rule, as Becerra announced, has a norm or safe harbor *specific to Texas*: to avoid loss of federal health care funding, change your child abuse laws. Supp.App.006. That this "safe harbor" is phrased in the negative ("don't do this, or you will lose

funding") rather than in the affirmative ("do this and you will avoid the loss of funding") is of no consequence. *See EEOC*, 933 F.3d at 442 (discussing "affirmative" versus "negative" jurisdictional determinations as safe harbors in *Hawkes*, 578 U.S. at 598–99).

4. The HHS Rule is also reviewable under the Court's inherent equitable power.

"The ability to sue to enjoin [illegal] actions by state and federal officers is the creation of courts of equity, and reflects a long history of judicial review of illegal executive action, tracing back to England." *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 327 (2015) (citing Jaffe & Henderson, *Judicial Review and the Rule of Law: Historical Origins*, 72 L.Q. REV. 345 (1956)). An *ultra vires* claim to enjoin operation of an illegally promulgated policy and actions premised on an illegal policy is just such a claim, neither preempted by the APA nor requiring Texas to wait until the federal government makes good on its promise to act against it.

As an initial matter, even if the Defendants were correct that *ultra vires* review represents only an exception to the APA's requirement of final agency action, that would not require dismissal of Texas's claim. A plaintiff is allowed to plead in the alternative, Fed. R. Civ. P. 8(d)(2)–(3), and pleading both that the HHS Rule is a violation of the APA and that it is *ultra vires* action does not require that one of those claims be dismissed.

And more, even if the Defendants were correct that Texas needed to satisfy a two-part test to defeat their motion to dismiss, Texas does so. For one, were this suit dismissed, Texas would not have a meaningful opportunity for review before it is injured. *See Bd. of Govrs. of Fed. Reserve Sys. v. MCorp Fin., Inc.*, 502 U.S. 32, 43–44 (1991) (citing *Leedom v. Kyne*, 358 U.S. 184, 190 (1958)). It suffers from the increased regulatory burden that the HHS Rule places on it, and it suffers the pressure to change state law that violates its sovereign interest in its power to create and enforce a legal code. *Texas v. EEOC*, 933 F.3d 433, 446–47 (5th Cir. 2019) (citing *Texas v. United States*, 787 F.3d 733, 749 (5th Cir. 2015)). Without the Court's intervention, those injuries cannot be remedied. For two, there is no clear

and direct preclusion of judicial review at issue here. *Cf. MCorp*, 502 U.S. at 44 (citing *Kyne*, 358 U.S. at 190, and *Abbott Labs. v. Gardner*, 387 U.S. 136, 141 (1967)). Indeed, the Defendants' only argument is that the APA requires that judicial review come later instead of now—a rehash of their incorrect argument that the HHS Rule is not final agency action. ECF 37 at 22–23.

5. Texas has no adequate alternative remedy precluding review under the APA.

For the same reasons it did not have an adequate alternative remedy against the EEOC Rule, *see* ECF No. 18 at 30–31, Texas has no adequate remedy against the HHS Rule.

As they did in their motion to dismiss, Defendants maintain that Texas's adequate remedy is to defend itself against an enforcement action. Supp. MTD at 15. But Texas cannot "initiate that process" and instead has to "wait for the Agency to drop the hammer." *Sackett v. EPA*, 566 U.S. 120, 127, 131 (2012). A pre-enforcement challenge under the APA is therefore the only "adequate remedy," even though "judicial review ordinarily comes by way of a civil action brought by the [enforcement agency]." *Id.* at 127. The cases cited by Defendants involve plaintiffs who file lawsuits to attempt to evade already-underway administrative proceedings. *See, e.g., Hinojosa v. Horn*, 896 F.3d 305 (5th Cir. 2018); *Garcia v. Vilsack*, 563 F.3d 519 (D.C. Cir. 2009); *El Rio Santa Cruz Neighborhood Health Ctr. v. U.S. Dept. of Health and Hum. Servs.*, 396 F.3d 1265 (D.C. Cir. 2005); *Temple Univ. v. Brown*, No. 00-cv-1063, 2001 WL 185535 (E.D. Pa. Feb. 23, 2001); *N.J. Hosp. Assn. v. United States*, 23 F. Supp. 2d 497 (D.N.J. 1998); *Assn. Am. Med. Colls. v. United States*, 34 F. Supp. 2d 1187 (C.D. Cal. 1998); *U.S. Steel Corp. v. Fri*, 364 F. Supp. 1013 (N.D. Ind. 1973); *Bd. of Educ of the Highland Loc. Sch. Dist. v. U.S. Dept. of Educ.*, 208 F. Supp. 3d 850 (S.D. Ohio 2016); *Elgin v. Dept. of Treas.*, 567 U.S. 1 (2012).

Here, Plaintiff is not challenging a specific agency action against it—in APA parlance, an "order"—but a generally applicable "rule." *See Texas MPP*, 20 F.4th at 982–83 (explaining the distinction). Defendants' cited cases are not on point; there is no ongoing administrative action regarding the issuance of the HHS Rule—it is complete and there is nothing that a court could

interfere with. *See Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 213 (1994) (distinguishing between statutory preclusions of individual determinations by the agency as opposed to "broad 'pattern and practice' challenges to the program" that may be challenged through the APA).

The Defendants argue to the contrary, that is, that Texas cannot seek review because the governing statute postpones judicial review until an individual determination has been made. *See Thunder Basin*, 510 U.S. at 207 (pre-enforcement challenges are prohibited if such an "intend is 'fairly discernible in the statutory scheme.'") (quoting *Block v. Cmty. Nutrition Inst.*, 467 U.S. 340, 351 (1984)). That statute here does no such thing. The only language in Title IX that addresses judicial review states:

> Any department or agency action taken pursuant to section 1682 of this title *shall be subject to such judicial review as may otherwise be provided by law for similar action* taken by such department or agency on other grounds. In the case of action, not otherwise subject to judicial review, terminating or refusing to grant or to continue financial assistance upon a finding of failure to comply with any requirement imposed pursuant to section 1682 of this title, any person aggrieved (including any State or political subdivision thereof and any agency of either) *may obtain judicial review of such action in accordance with chapter 7 of Title 5* . . . .

20 U.S.C. § 1683 (emphasis added). Section 1682 in turn describes two types of agency action, "issuing rules, regulation or orders of general applicability" and "termination of or refusal to grant or to continue assistance . . . for failure to comply" with a requirement so adopted. *Id.* The agency action that Texas is challenging is not a withholding of funds—that is, an individual determination. It is the issuance of "rules, regulations, or orders of general applicability," which is "subject to judicial review as . . . provided by law for similar action[.]" 20 U.S.C. § 1682. That law is the APA, which allows for pre-enforcement review. The Fifth Circuit permitted a pre-enforcement challenge to just such "guidance" in *Texas v. EEOC*:

> Texas is not, however, simply challenging the prospect of an investigation by the EEOC. Instead, it is challenging the Enforcement Guidance itself, which

> represents the legal standards that the EEOC applies when deciding when and how to conduct such an investigation, and what practices may require charges. The Guidance is an agency determination in its final form and is applicable to all employers nation-wide; it is not an intermediate step in a specific enforcement action that may or may not lead to concrete injury.

EEOC, 827 F.3d at 387 (finding final agency action).

This is the same conclusion Judge O'Connor reached in *Texas v. United States* when evaluating the enforcement mechanisms at issue here. 201 F. Supp. 3d 810, 826–27 (N.D. Tex. 2016). As he held there, "Title IX [does not] present[] [a] statutory scheme[] that would preclude Plaintiffs from bringing these claims in federal district court. Indeed, the Supreme Court has held that Title IX's enforcement provisions, codified at Title 20 U.S.C. §§ 1681–1683, do[] not provide the exclusive statutory remedy for violations." *Id.* at 826 (citing *Cannon v. Univ. of Chicago*, 441 U.S. 677 (1979)). He similarly rejected in another case the argument that a "comprehensive scheme of administrative and judicial review" precluded "pre-enforcement review of [a rule issued under HHS's authority]." *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 683 (N.D. Tex. 2016).

Texas is not asking the Court intercede in a pending administrative action, so the remedial scheme applicable to such actions is irrelevant and does not bar judicial review. The forums available under that scheme "are not adequate because Texas can only reach them by deliberately violating the law to test its validity." *Natl. Fedn. of Indep. Bus. v. Dougherty*, No. 3:16-CV-2568-D, 2017 WL 1194666, at *10 (N.D. Tex. Feb. 3, 2017) (Fitzwater, J.). *See also id.* (rejecting similar preclusion challenge because each case agency cited "was a challenge to an ongoing or impending enforcement proceeding"). The Court has jurisdiction to consider Texas's claim, and it should reject the Defendants' arguments to the contrary.

B. Texas has standing to challenge the HHS Rule.

As with the EEOC Rule, *see* ECF No. 18 at 31–38, Texas has standing to challenge the HHS Rule because it directly regulates the State. When the plaintiff is "an object of the [agency's] action,"

"there is ordinarily little question that the action . . . has caused him injury, and that a judgment preventing . . . the action will redress it." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561–62 (1992). Here, there is no doubt that the State of Texas, which HHS specifically identified in issuing the HHS Rule, is "an object of [HHS's] action." Because Texas is an "object" of the Rule, all three of the constitutional standing requirements are satisfied. *Id.*

"Whether someone is an object of a regulation is a flexible inquiry rooted in common sense." *EEOC*, 933 F.3d at 446 (citation omitted). "That common sense inquiry is easy here [because the Rule] explicitly states that it applies to" entities that receive federal financial assistance from HHS; "[t]hus, by its own terms, the [HHS Rule] covers Texas." *Id.*; *see also Religious Sisters of Mercy v. Azar*, 513 F. Supp. 3d 1113, 1136 (D.N.D. 2021) ("Plaintiffs, as entities that operate health programs receiving federal financial assistance from HHS, qualify as objects of Section 1557 and its implementing regulations" and therefore have standing to challenge an interpretation of Section 1557).

Secretary Becerra's accompanying statement makes clear that one particular recipient is the primary target of the HHS Rule—the State of Texas. Supp.App.006. Because it is the object of the mandates in the HHS Rule, Texas suffers an increased regulatory burden because the HHS Rule "deems unlawful" its current child abuse policies and "warns the [S]tate that . . . it will be able to show that its current policies . . . are lawful under [Section 1557 and other provisions] only if it abandons those policies." *EEOC*, 933 F.3d at 447. "Texas [thus] faces the possibility of investigation by [HHS] and [withdrawal of federal funding] if it fails to align its laws with the [HHS Rule.]" *Id.* Texas has shown imminent injury because it "has opted to express certain values [in its child abuse laws] and the [HHS Rule] imposes a regulatory burden on Texas to comply with the [HHS Rule] to avoid enforcement actions and, consequently, pressures it to abandon its laws and policies." *Id.*; *see also EEOC*, 827 F.3d 372 at 379 (injury-in-fact requirement satisfied where "the Guidance does, at the very least, force Texas to undergo an analysis, agency by agency, regarding whether the certainty of EEOC

investigations stemming from the Enforcement Guidance's standards overrides the State's interest in not hiring felons for certain jobs").

1. Texas has alleged imminent injury and its claims are ripe.

Just as with the EEOC Rule, ECF No. 18 at 33–36, Texas is threatened with imminent injury and its challenge is ripe for pre-enforcement review.

"[S]tates may have standing based on . . . federal assertions of authority to regulate matters [states] believe they control." *Texas v. United States*, 809 F.3d 134, 153 (5th Cir. 2015) (citation omitted). "States possess special proficiency in the field of domestic relations, including child custody," *Reno v. Flores*, 507 U.S. 292, 310 (1993) (cleaned up), and "a significant role to play in regulating the medical profession," *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007), especially where there is "medical and scientific uncertainty," *id.* at 163. This is just such a case. *See Gibson v. Collier*, 920 F.3d 212, 216, 224 (5th Cir. 2019) ("[S]ex reassignment surgery remains one of the most hotly debated topics within the medical community today."); *see also In re Burrus*, 136 U.S. 586, 593–94 (1890) ("The whole subject of the domestic relations of husband and wife, parent and child, belongs to the laws of the states, and not to the laws of the United States.").

"[T]he threat of future enforcement . . . is substantial" because the plain text of the HHS Rule applies to Texas. *Driehaus,* 573 U.S. at 157-59; *cf. Alexis Bailly Vineyard, Inc. v. Harrington*, 931 F.3d 774, 778 (8th Cir. 2019) (if "a plaintiff 's intended course of action falls within a codified law's 'plain text,' a 'credible threat' of enforcement necessarily exists without more."). The HHS Rule—in both the Becerra statement and the OCR document—condemn the application of Texas's child abuse laws to "gender-affirming care." Supp.App.002, 006.

And the Defendants have not "disavowed enforcement" of the HHS Rule. *See Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 165 (2014). Defendants' assertion that Texas lacks a basis to claim that "HHS has made a final determination as to the lawfulness of a particular act by the state with regard

to transgender minors," Supp. MTD at 13, is risible. Indeed, Secretary Becerra could hardly have threatened Texas more explicitly. Supp.App.006. When a plaintiff is subject to a threat of enforcement, "an actual . . . enforcement action is not a prerequisite to challenging the law." *Driehaus*, 573 U.S. at 158 (citing *Steffel v. Thompson*, 415 U.S. 452, 459 (1974)); *see also Bear Creek Bible Church v. EEOC*, No. 4:18-CV-00824-O, 2021 WL 5449038, at *9–12 (N.D. Tex. Nov. 22, 2021) (O'Connor, J.) (finding credible fear of enforcement satisfied ripeness and standing requirements).

"[W]here a regulation requires an immediate and significant change in the plaintiffs' conduct of their affairs with serious penalties attached to noncompliance, hardship has been demonstrated." *Suitum v. Tahoe Regional Planning Agency*, 520 U.S. 725, 743–44 (1997) (internal quotation marks omitted). And the "fear of future sanctions" to "force immediate compliance" with the HHS Rule is a sufficient hardship. *Ohio Forestry Assn. v. Sierra Club*, 523 U.S. 726, 734 (1998) (being "force[d] . . . to modify [one's] behavior in order to avoid future adverse consequences" constitutes a practical harm); *see also Barrick Goldstrike Mines*, 215 F.3d at 49 (sufficient hardship where plaintiff's "only alternative to obtaining judicial review now is to violate EPA's directives, refuse to report releases involving waste rock, and then defend an enforcement proceeding on the grounds it raises here.").

Texas is therefore injured due to the HHS Rule's "pressure[] to change state law . . . because states have a sovereign interest in the power to create and enforce a legal code." *EEOC*, 933 F.3d at 446–47 (citation omitted); *see also Tex. Office of Pub. Util. Counsel v FCC*, 183 F.3d 393, 449 (5th Cir. 1999) (federal agency's declaring authority over object of state law was a sufficient injury, even though agency had not yet exercised that authority); *Alaska v. U.S. Dept. of Transp.*, 868 F.2d 441, 443 (D.C. Cir. 1989) (standing to seek declaratory and injunctive relief "because DOT claims that its rules preempt state consumer protection statutes, [and therefore] the States have suffered injury to their sovereign power to enforce state law"). Texas's claims are ripe because they are purely legal and denying judicial review would be a hardship for Texas. *See Franciscan All.*, 227 F. Supp. 3d at 680–82

(rejecting need for factual development because "the parties do not dispute that Plaintiffs are covered entities under the Rule" and parties' disagreement "as to the Rule's exact application and effect on Plaintiffs" did not make claim unripe). The claims need no factual development because they do not involve a particular enforcement action—as discussed earlier, an "order" under the APA—but challenge the legality of a generally applicable "rule." *See Appalachian Power Co. v. EPA*, 208 F.3d 1015, 1023 n.18 (D.C. Cir. 2000); *Ciba–Geigy*, 801 F.2d at 435.

"[T]hese injuries are sufficient to confer constitutional standing, especially when considering Texas's unique position as a sovereign state defending its existing practices and threatened authority." *EEOC*, 827 F.3d at 379.

2. Texas's injuries are traceable to the HHS Rule and redressable by this Court.

The same analysis that showed why Texas's injuries were traceable to and redressable by a judgment against EEOC, ECF No. 18 at 36–38, shows why Texas's injuries here are traceable to and redressable by a judgment against the Defendants.

There is nothing "novel" or "expansive" about Texas's request that the Court enjoin HHS from adopting the interpretation advanced in the HHS Rule rather than enjoining enforcement of the OCR memorandum. *Cf.* Supp. MTD at 8–10. The Fifth Circuit recognizes a distinction between the challenged agency action and the documents that explain it. *Texas MPP*, 20 F.4th at 950–51. Just as an appellate court's reversal of a trial court's order operates against the judgment rather than the opinion explaining that judgment, judicial relief against an agency action operates against the action—here, the adoption of the interpretation—and not just the explanatory documents. *Id.* at 951.

This would not be the first bench of this Court to grant relief of the sort Texas seeks. Indeed, it would not be the first bench to do so in the specific context of a challenge to an interpretation of Section 1557. Judge O'Connor in *Franciscan Alliance v. Becerra*:

> **PERMANENTLY ENJOIN[ED]** HHS [and] Secretary Becerra . . . from interpreting or enforcing Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116(a), or any implementing regulations thereto[,] against Plaintiffs . . . in a manner that would require them to perform or provide insurance coverage for gender-transition procedures or abortions, including by denying Federal financial assistance because of their failure to perform or provide insurance coverage for such procedures or by otherwise pursuing, charging, or assessing any penalties, fines, assessments, investigations, or other enforcement actions.

553 F. Supp. 3d 361, 378 (N.D. Tex. 2021) (emphases added).

Such relief has also survived Supreme Court scrutiny in high-profile cases. In *New York v. Department of Commerce*, for example, the district court held that the Secretary of Commerce violated the APA by deciding to ask about citizenship on the census. 351 F. Supp. 3d 502, 516 (S.D.N.Y. 2019), *aff'd in part, rev'd in part on other grounds*, 139 S. Ct. 2551 (2019). In addition to vacating the memorandum reflecting that decision, that court enjoined the Secretary from asking the question "based on any reasoning that is substantially similar to the reasoning contained in that memorandum." 351 F. Supp. 3d at 676–77. Absent an injunction, the court reasoned, the Secretary "could theoretically reinstate his decision by simply re-issuing his memorandum under a new date or by changing the memorandum in some immaterial way." *Id.* (Perhaps not coincidentally, this is precisely what the Defendants claim they could do here were the HHS Rule vacated.) Despite the federal government's direct argument that such an injunction was error, the Supreme Court affirmed. *Compare* Br. for Pets., *Dept. of Commerce v. New York*, No. 18-966, 2019 WL 1093053, at *17 (U.S. Mar. 6, 2019) ("The District Court Erred in Enjoining the Secretary from Reinstating the Citizenship Question to the 2020 Decennial Census") *with* 139 S. Ct. at 2575–76 (affirming).

The relief sought by plaintiff here is apparently not so novel.

CONCLUSION

Defendants' supplemental motion to dismiss the First Amended Complaint should be denied.

DATED: April 29, 2022

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CERTIFICATE OF SERVICE

I certify that a true and accurate copy of the foregoing document was filed electronically (via CM/ECF) on April 29, 2022, which automatically serves all counsel of record who are registered to receive notices in this case.

/s/ Ryan D. Walters
RYAN D. WALTERS

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

THE STATE OF TEXAS,	§	
	§	
Plaintiff,	§	
	§	Case No. 2:21-cv-00194-Z
v.	§	
	§	
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, ET AL.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL MOTION TO DISMISS FIRST AMENDED COMPLAINT

Exhibit	Description	Page(s)
A	U.S Department of Health and Human Services Office of Civil Rights: HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy	Supp.App.001 - 004
B	Statement by HHS Secretary Zavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth	Supp.App.005-008
C	Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972 (CFR Parts 86 and 92)	Supp.App.009-011
D	Texas Governor Greg Abbott's letter to Hon. Jaime Masters, Commissioner, Texas Department of Family and Protective Services re Texas Attorney General Opinion No. KP-0401	Supp.App.012-027

Dated: April 29, 2022

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CERTIFICATE OF SERVICE

I certify that on April 29, 2022, a true and accurate copy of the foregoing document was filed electronically (via CM/ECF) and served on all counsel of record.

/s/ Ryan D. Walters
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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

THE STATE OF TEXAS,	§	
	§	
Plaintiff,	§	
	§	
v.	§	Case No. 2:21-cv-00194-Z
	§	
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, ET AL.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL MOTION TO DISMISS FIRST AMENDED COMPLAINT

EXHIBIT A

March 2, 2022

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office for Civil Rights

HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy

The Department of Health & Human Services (HHS) stands with transgender and gender nonconforming youth and their families—and the significant majority of expert medical associations—in unequivocally stating that gender affirming care for minors, when medically appropriate and necessary, improves their physical and mental health. Attempts to restrict, challenge, or falsely characterize this potentially lifesaving care as abuse is dangerous. Such attempts block parents from making critical health care decisions for their children, create a chilling effect on health care providers who are necessary to provide care for these youth, and ultimately negatively impact the health and well-being of transgender and gender nonconforming youth. The HHS Office for Civil Rights (OCR) will continue working to ensure that transgender and gender nonconforming youth are able to access health care free from the burden of discrimination. HHS understands that many families and health care providers are facing fear and concerns about attempts to portray gender affirming care as abuse. To help these families and providers navigate those concerns, HHS is providing additional information on federal civil rights protections and federal health privacy laws that apply to gender affirming care.

As a law enforcement agency, OCR is investigating and, where appropriate, enforcing Section 1557 of the Affordable Care Act[1] cases involving discrimination on the basis of sexual orientation and gender identity in accordance with all applicable law. This means that if people believe they have been discriminated against in a health program or activity that receives financial assistance from HHS, they can file a complaint.

Federal Civil Rights Laws:

Parents or caregivers who believe their child has been denied health care, including gender affirming care, on the basis of that child's gender identity, may file a complaint with OCR.

Health care providers who believe that they are or have been unlawfully restricted from providing health care to a patient on the basis of that patient's gender identity may file a complaint with OCR.

OCR enforces federal civil rights laws that prohibit discriminatory restrictions on access to health care. Among these laws is Section 1557, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in covered health programs or activities. OCR

[1] 42 U.S.C. 18116; *see also* 45 C.F.R. part 92.

also enforces Section 504 of the Rehabilitation Act,[2] which prohibits discrimination on the basis of disability in any program or activity receiving federal financial assistance.

Section 1557 protects the right of individuals to access the health programs and activities of recipients of federal financial assistance without facing discrimination on the basis of sex, which includes discrimination on the basis of gender identity. Categorically refusing to provide treatment to an individual based on their gender identity is prohibited discrimination. Similarly, federally-funded covered entities restricting an individual's ability to receive medically necessary care, including gender-affirming care, from their health care provider solely on the basis of their sex assigned at birth or gender identity likely violates Section 1557. For example, if a parent and their child visit a doctor for a consultation regarding or to receive gender affirming care, and the doctor or other staff at the facility reports the parent to state authorities for seeking such care, that reporting may constitute violation of Section 1557 if the doctor or facility receives federal financial assistance. Restricting a health care provider's ability to provide or prescribe such care may also violate Section 1557.

Section 504 protects qualified individuals with disabilities from discrimination in programs and activities receiving federal financial assistance. Title II of the Americans with Disabilities Act[3] (ADA) protects qualified individuals with disabilities from discrimination in state and local government programs. Gender dysphoria may, in some cases, qualify as a disability under these laws. Restrictions that prevent otherwise qualified individuals from receiving medically necessary care on the basis of their gender dysphoria, gender dysphoria diagnosis, or perception of gender dysphoria may, therefore, also violate Section 504 and Title II of the ADA.

If you believe that you or another party has been discriminated against on the basis of gender identity or disability in seeking to access gender affirming health care, visit the OCR complaint portal to file a complaint online. To read more about Section 1557 and other laws that OCR enforces, please visit our website at https:www.hhs.gov/ocr.

Federal Health Care Privacy Laws - Health Insurance Portability and Accouutability Act of 1996 (HIPAA):

HIPAA, the cornerstone patient privacy law, limits the circnmstances nnder which health care providers and other entities may disclose protected health information, such as gender affirming physical or mental health care administered by a licensed provider.

Providers who may be concerned about their obligations to disclose information concerning gender affirming care should seek additional legal guidance regarding their legal responsibilities and other laws.

[2] 29 U.S.C. 794; *see also* 45 C.F.R. part 84.
[3] 42 U.S.C. 12132.

OCR enforces the HIPAA Privacy, Security and Breach Notification Rules,[4] which establish requirements with respect to the use, disclosure, and protection of protected health information (PHI) by covered entities and business associates;[5] provide health information privacy and security protections; and establish rights for individuals with respect to their PHI.[6]

OCR reminds covered entities (health plans, health care providers, health care clearinghouses) and business associates that the HIPAA Privacy Rule permits, **but does not require**, covered entities and business associates to disclose PHI about an individual, without the individual's authorization,[7] when such disclosure is required by another law and the disclosure complies with the requirements of the other law.[8] This "required by law" exception to the authorization requirement is limited to "a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law."[9] Where a disclosure is required by law, the disclosure is limited to the relevant requirements of such law.[10] Disclosures of PHI that do not meet the "required by law definition" or exceed what is required by such law do not qualify as permissible disclosures under this exception.

HIPAA prohibits disclosure of gender affirming care that is PHI without an individuals' consent[11] except in limited circumstances.

If you believe that your (or someone else's) health privacy rights have been violated, visit the OCR complaint portal to file a complaint online.

DISCLAIMER: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or the Departments' policies.

To obtain this information in an alternate format, contact the HHS Office for Civil Rights at (800) 368-1019, TDD toll-free: (800) 537-7697, or by emailing OCRMail@hhs.gov. Language assistance services for OCR matters are available and provided free of charge.

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[4] 45 C.F.R. Parts 160 and 164, Subparts A, C, D, and E.

[5] *See* 45 C.F.R. 160.103 ("covered entity" and "business associate" definitions).

[6] *See* 45 C.F.R. 160.103 ("protected health information" and "individually identifiable health information" definitions).

[7] *See* 45 C.F.R. 164.508(c) (HIPAA authorization required elements).

[8] 45 C.F.R. 164.512(a)(1).

[9] 45 C.F.R. 164.103 ("required by law" definition). Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

[10] 45 C.F.R. 164.512(a)(1).

[11] For purposes of this guidance, "consent" refers to a valid HIPAA authorization. *See 45 C.F.R. 164.508.*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

THE STATE OF TEXAS,	§	
	§	
Plaintiff,	§	
	§	Case No. 2:21-cv-00194-Z
v.	§	
	§	
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, ET AL.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL MOTION TO DISMISS FIRST AMENDED COMPLAINT

EXHIBIT B

FOR IMMEDIATE RELEASE
March 2, 2022

Contact: HHS Press Office
202-690-6343
media@hhs.gov

Statement by HHS Secretary Xavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth

Today, on the heels of a discriminatory gubernatorial order in Texas, Health and Human Services (HHS) Secretary Xavier Becerra released the following statement reaffirming HHS's commitment to supporting and protecting transgender youth and their parents, caretakers and families. Secretary Becerra also announced several immediate actions HHS is taking actions to support LGBTQI+ youth and further remind Texas and others of the federal protections that exist to ensure transgender youth receive the care they need:

"The Texas government's attacks against transgender youth and those who love and care for them are discriminatory and unconscionable. These actions are clearly dangerous to the health of transgender youth in Texas. At HHS, we listen to medical experts and doctors, and they agree with us, that access to affirming care for transgender youth is essential and can be life-saving.

"HHS is committed to protecting young Americans who are targeted because of their sexual orientation or gender identity, and supporting their parents, caretakers and families. That is why I directed my team to evaluate the tools at our disposal to protect trans and gender diverse youth in Texas, and today I am announcing several steps we can take to protect them.

"HHS will take immediate action if needed. I know that many youth and their supportive families are feeling scared and isolated because of these attacks. HHS is closely monitoring the situation in Texas, and will use every tool at our disposal to keep Texans safe.

"Any individual or family in Texas who is being targeted by a child welfare investigation because of this discriminatory gubernatorial order is encouraged to contact our Office for Civil Rights to report their experience."

New HHS Actions Announced by Secretary Xavier Becerra:

- HHS is releasing guidance to state child welfare agencies through an Information Memorandum that makes clear that states should use their child welfare systems to advance safety and support for

- HHS is also releasing guidance - PDF on patient privacy, clarifying that, despite the Texas government's threat, health care providers are not required to disclose private patient information related to gender affirming care;

- HHS also issued guidance - PDF making clear that denials of health care based on gender identity are illegal, as is restricting doctors and health care providers from providing care because of a patient's gender identity;

- The Secretary also called on all of HHS to explore all options to protect kids, their parents, caretakers and families; and

- HHS will also ensure that families and health care providers in Texas are aware of all the resources available to them if they face discrimination as a result of this discriminatory gubernatorial order.

If you believe that you or another party has been discriminated against on the basis of gender identity or disability in seeking to access gender affirming health care, visit the OCR complaint portal to file a complaint online.

If you have questions regarding patient privacy laws, please reach out to the Office for Civil Rights email: OCRPrivacy@hhs.gov or call Toll-free: (800) 368-1019

Resources for kids, parents, caretakers and families:

- SAMHSA supports the Center of Excellence on LGBTQ+ Behavioral Health Equity, which provides behavioral health practitioners with vital information on supporting the population of people identifying as lesbian, gay, bisexual, transgender, queer, questioning, intersex, two-spirit, and other diverse sexual orientations, gender identities and expressions. The Center's website includes a recorded webinar on Gender Identity, Expression & Behavioral Health 101. Upcoming webinars will include topics such as: How to Signal to Youth that You are an LGBTQ+ Affirming Provider; How to Respond When a Young Person Discloses their SOGIE; Supporting Families of LGBTQ+ Youth; and Safety Planning for LGBTQ+ Students.

- A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children is a resource guide developed by SAMHSA that offers information and resources to help practitioners throughout health and social service systems implement best practices in engaging and helping families and caregivers to support their lesbian, gay, bisexual, and transgender (LGBT) children.

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news.
Like HHS on Facebook, follow HHS on Twitter @HHSgov, and sign up for HHS Email Updates.
Last revised: March 2, 2022

Media Inquiries

For general media inquiries, please contact media@hhs.gov.

Content created by Office for Civil Rights (OCR)
Content last reviewed March 2, 2022

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

THE STATE OF TEXAS,	§	
	§	
Plaintiff,	§	
	§	Case No. 2:21-cv-00194-Z
v.	§	
	§	
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, ET AL.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL MOTION TO DISMISS FIRST AMENDED COMPLAINT

EXHIBIT C

review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its reqnirements. *See* section 307(b)(2).

List of Subjects in 40 CFR Part 81

Environmental protection, Air pollution control, National parks, Wilderness areas.

Dated: May 17, 2021.

John Blevins,

Acting Regional Administrator, Region 4.

For the reasons stated in the preamble, EPA amends 40 CFR part 81 as follows:

PART 81—DESIGNATION OF AREAS FOR AIR OUALITY PLANNING PURPOSES

■ 1. The authority citation for part 81 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

■ 2. In § 81.343, the table titled "Tennessee–2010 Sulfur Dioxide NAAQS (Primary)" is amended by revising the entry for "Sumner County, TN" to read as follows:

§ 81.343 Tennessee.

* * * * *

TENNESSEE—2010 SULFUR DIOXIDE NAAQS

[Primary]

Designated area	Designation	
	Date [1]	Type
* *	* * *	* *
Sumner County, TN [2] Sumner County	June 24, 2021	Attainment/Unclassifiable.
* *	* * *	* *

[1] This date is April 9, 2018, unless otherwise noted.
[2] Excludes Indian country located in each area, if any, unless otherwise specified.

* * * * *

[FR Doc. 2021–10983 Filed 5–24–21; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 112

Definitions

CFR Correction

■ In Title 40 of the Code of Federal Regulations, Protection of Environment, Parts 100 to 135, revised as of July 1, 2020, on page 26, in section 112.2, reinstate the definition of "worst case discharge," in alphabetical order, to read as follows:

* * * * *

Worst case discharge for an on-shore non-transportation related facility means the largest foreseeable discharge in adverse weather conditions as determined using the worksheets in Appendix D to this part.

[FR Doc. 2021–11115 Filed 5–24–21; 8:45 am]

BILLING CODE 0099–10–D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 86 and 92

Notification of Interpretation and Enforcement of Section 1557 of the Affordable Care Act and Title IX of the Education Amendments of 1972

AGENCY: Office of the Secretary, Department of Health and Hnman Services (HHS).

ACTION: Notification of interpretation and enforcement.

SUMMARY: This Notification is to inform the public that, consistent with the Supreme Court's decision in *Bostock* and Title IX, beginning May 10, 2021, the Department of Health and Human Services (HHS) will interpret and enforce section 1557 of the Affordable Care Act prohibition on discrimination on the basis of sex to include: Discrimination on the basis of sexual orientation; and discrimination on the basis of gender identity. This interpretation will guide the Office for Civil Rights (OCR) in processing complaints and condncting investigations, but does not itself determine the outcome in any particular case or set of facts.

DATES: This notification of interpretation became effective May 10, 2021.

FOR FURTHER INFORMATION CONTACT: Rachel Seeger at (202) 619–0403 or (800) 537–7697 (TDD).

SUPPLEMENTARY INFORMATION: HHS is informing the public that, consistent with the Supreme Court's decision in *Bostock* [1] and Title IX,[2] beginning May 10, 2021, the Department of Health and Human Services (HHS) will interpret and enforce Section 1557's [3] prohibition on discrimination on the basis of sex to include: (1) Discrimination on the basis of sexual orientation; and (2) discrimination on the basis of geoder identity.

I. Background

The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (the Department) is responsible for enforcing Section 1557 of the Affordable Care Act (Section 1557) and regulations issued nnder Section 1557, protecting the civil rights of individuals who access or seek to access covered health programs or activities. Section 1557 prohibits discrimination on the bases of race, color, national origin, sex, age, and

[1] *Bostock* v. *Clayton County*, 140 S. Ct. 1731 (2020). *https://www.supremecourt.gov/opinions/19pdf/17-1618_hfci.pdf.*

[2] Title IX of the Education Amendments of 1972, 20 U.S.C. 1681 *et seq. https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-part86.pdf.*

[3] Section 1557 of the Patient Protection and Affordable Care Act. *https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap157-subchapVI-sec18116.pdf.*

disability in covered health programs or activities. 42 U.S.C. 18116(a).

On June 15, 2020, the U.S. Supreme Court held that Title VII of the Civil Rights Act of 1964 (Pub. L. 88–352) (Title VII)'s [4] prohibition on employment discrimination based on sex encompasses discrimination based on sexual orientation and gender identity. *Bostock* v. *Clayton County, GA,* 140 S. Ct. 1731 (2020). The *Bostock* majority concluded that the plain meaning of "because of sex" in Title VII necessarily included discrimination because of sexual orientation and gender identity. *Id.* at 1753–54.

Since *Bostock,* two federal circuits have concluded that the plain language of Title IX of the Education Amendments of 1972's (Title IX) prohibition on sex discrimination must be read similarly. See *Grimm* v. *Gloucester Cnty. Sch. Bd.,* 972 F.3d 586, 616 (4th Cir. 2020), *as amended* (Aug. 28, 2020),[5] *reh'g en banc denied,* 976 F.3d 399 (4th Cir. 2020), *petition for cert. filed,* No. 20–1163 (Feb. 24, 2021); *Adams* v. *Sch. Bd. of St. Johns Cnty.,* 968 F.3d 1286, 1305 (11th Cir. 2020), *petition for reh'g en banc pending,* No. 18–13592 (Aug. 28, 2020).[6] In addition, on March 26, 2021, the Civil Rights Division of the U.S. Department of Justice issued a memorandum to Federal Agency Civil Rights Directors and General Counsel [7] concluding that the Supreme Court's reasoning in *Bostock* applies to Title IX of the Education Amendments of 1972. As made clear by the Affordable Care Act, Section 1557 prohibits discrimination "on the grounds prohibited under . . . Title IX." 42 U.S.C. 18116(a).

Consistent with the Supreme Court's decision in *Bostock* and Title IX, beginning today, OCR will interpret and enforce Section 1557's prohibition on discrimination on the basis of sex to include: (1) Discrimination on the basis of sexual orientation; and (2) discrimination on the basis of gender identity. This interpretation will guide OCR in processing complaints and conducting investigations, but does not itself determine the outcome in any particular case or set of facts.

In enforcing Section 1557, as stated above, OCR will comply with the Religious Freedom Restoration Act, 42 U.S.C. 2000bb *et seq.,*[8] and all other legal requirements. Additionally, OCR will comply with any applicable court orders that have been issued in litigation involving the Section 1557 regulations, including *Franciscan Alliance, Inc.* v. *Azar,* 414 F. Supp. 3d 928 (N.D. Tex. 2019); [9] *Whitman-Walker Clinic, Inc.* v. *U.S. Dep't of Health & Hum. Servs.,* 485 F. Supp. 3d 1 (D.D.C. 2020); [10] *Asapansa-Johnson Walker* v. *Azar,* No. 20–CV–2834, 2020 WL 6363970 (E.D.N.Y. Oct. 29, 2020); [11] and *Religious Sisters of Mercy* v. *Azar,* No. 3:16–CV–00386, 2021 WL 191009 (D.N.D. Jan. 19, 2021).[12]

OCR applies the enforcement mechanisms provided for and available under Title IX when enforcing Section 1557's prohibition on sex discrimination. 45 CFR 92.5(a). Title IX's enforcement procedures can be found at 45 CFR 86.71 (adopting the procedures at 45 CFR 80.6 through 80.11 and 45 CFR part 81).

If you believe that a covered entity violated your civil rights, you may file a complaint at *https://www/hhs.gov/ocr/complaints.*

Dated: May 13, 2021.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2021–10477 Filed 5–24–21; 8:45 am]

BILLING CODE 4153–01–P

[4] Title VII of the Civil Rights Act of 1964 (Pub. L. 88–352) (41 CFR part 60–20). *https://www.govinfo.gov/content/pkg/FR-2015-01-30/pdf/2015-01422.pdf.*

[5] *Grimm* v. *Gloucester Cnty. Sch. Bd.,* 972 F.3d 586, 616 (4th Cir. 2020). *https://www.ca4.uscourts.gov/opinions/191952.P.pdf.*

[6] *Adams* v. *Sch. Bd. of St. Johns Cnty.,* 968 F.3d 1286, 1305 (11th Cir. 2020). *https://media.ca11.uscourts.gov/opinions/pub/files/201813592.pdf.*

[7] March 26, 2021, the Civil Rights Division of the U.S. Department of Justice memorandum to Federal Agency Civil Rights Directors and General Counsel re: Application *of Bostock* v. *Clayton County* to Title IX of the Education Amendments of 1972. *https://www.justice.gov/crt/page/file/1383026/download.*

[8] Religious Freedom Restoration Act, 42 U.S.C. 2000bb *et seq. https://www.govinfo.gov/content/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap21B-sec2000bb-1.pdf.*

[9] *Franciscan Alliance, Inc.* v. *Azar,* 414 F. Supp. 3d 928 (N.D. Tex. 2019). *https://www.govinfo.gov/content/pkg/USCOURTS-nyed-1_20-cv-02834/pdf/USCOURTS-nyed-1_20-cv-02834-0.pdf.*

[10] *Whitman-Walker Clinic, Inc.* v. *U.S. Dep't of Health & Hum. Servs.,* 485 F. Supp. 3d 1 (D.D.C. 2020). *http://www.ca5.uscourts.gov/opinions/unpub/20/20-10093.0.pdf.*

[11] *Asapansa-Johnson Walker* v. *Azar,* No. 20–CV–2834, 2020 WL 6363970 (E.D.N.Y. Oct. 29, 2020). *https://www.govinfo.gov/content/pkg/USCOURTS-nyed-1_20-cv-02834/pdf/USCOURTS-nyed-1_20-cv-02834-0.pdf.*

[12] *Religious Sisters of Mercy* v. *Azar,* No. 3:16–CV–00386, 2021 WL 191009 (D.N.D. Jan. 19, 2021). *https://www.hhs.gov/sites/default/files/document-124-memorandum-opinion-and-order.pdf.*

NATIONAL SCIENCE FOUNDATION

45 CFR Part 670

RIN 3145–AA59

Conservation of Antarctic Animals and Plants

AGENCY: National Science Foundation.

ACTION: Final rule.

SUMMARY: Pursuant to the Antarctic Conservation Act of 1978, as amended, the National Science Foundation (NSF) is amending its regulations to reflect changes to Annex II to the Protocol on Environmental Protection to the Antarctic Treaty (Protocol) agreed to by the Antarctic Treaty Consultative Parties. These changes reflect the outcomes of a legally binding Measure already adopted by the Parties at the Thirty-Second Antarctic Treaty Consultative Meeting (ATCM) in Baltimore, MD (2009).

DATES: Effective May 25, 2021.

FOR FURTHER INFORMATION CONTACT: Bijan Gilanshah, Assistant General Counsel, Office of the General Counsel, at 703–292–8060, National Science Foundation, 2415 Eisenhower Avenue, W 18200, Alexandria, VA 22314.

SUPPLEMENTARY INFORMATION: Measure 16 (2009) was adopted at the Thirty-Second ATCM at Baltimore, MD, on April 17, 2009 and amends Annex II to the Protocol. The revisions were composed primarily of minor clarifying, editorial and technical updates which would result in generally insignificant changes in current practice or legal requirements. For example, Antarctic terrestrial and freshwater invertebrates (generally microscopic or miniscule) are already protected by statute and regulation from "harmful interference" and related permitting requirements. These Annex II changes brought such protections in line with other Antarctic species for purposes of "takes" of such organisms. Other changes would also result in no significant change in U.S. practice, including changes to language in Annex II regarding criteria for taking zoo specimens, criteria for introduction of non-native species, and criteria for lethal takings of specially protected species, etc. Finally, one change removes an erroneous reference to "marine algae" in the current regulation and a new section is added specifically designating Antarctic native invertebrates.

The Antarctic Conservation Act of 1978, as amended ("ACA") (16 U.S.C. 2401, *et seq.*) implements the Protocol. Section 2405 of title 16 of the ACA directs the Director of the National

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
AMARILLO DIVISION

THE STATE OF TEXAS,	§	
	§	
Plaintiff,	§	
	§	
v.	§	Case No. 2:21-cv-00194-Z
	§	
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, ET AL.,	§	
	§	
Defendants.	§	

APPENDIX IN SUPPORT OF PLAINTIFF'S RESPONSE TO DEFENDANTS' SUPPLEMENTAL MOTION TO DISMISS FIRST AMENDED COMPLAINT

EXHIBIT D

GOVERNOR GREG ABBOTT

February 22, 2022

The Honorable Jaime Masters
Commissioner
Texas Department of Family and Protective Services
701 West 51st Street
Austin, Texas 78751

Dear Commissioner Masters:

Consistent with our correspondence in August 2021, the Office of the Attorney General (OAG) has now confirmed in the enclosed opinion that a number of so-called "sex change" procedures constitute child abuse under existing Texas law. Because the Texas Department of Family and Protective Services (DFPS) is responsible for protecting children from abuse, I hereby direct your agency to conduct a prompt and thorough investigation of any reported instances of these abusive procedures in the State of Texas.

As OAG Opinion No. KP-0401 makes clear, it is already against the law to subject Texas children to a wide variety of elective procedures for gender transitioning, including reassignment surgeries that can cause sterilization, mastectomies, removals of otherwise healthy body parts, and administration of puberty-blocking drugs or supraphysiologic doses of testosterone or estrogen. *See* TEX. FAM. CODE § 261.001(1)(A)–(D) (defining "abuse"). Texas law imposes reporting requirements upon all licensed professionals who have direct contact with children who may be subject to such abuse, including doctors, nurses, and teachers, and provides criminal penalties for failure to report such child abuse. *See id.* §§ 261.101(b), 261.109(a-1). There are similar reporting requirements and criminal penalties for members of the general public. *See id.* §§ 261.101(a), 261.109(a).

Texas law also imposes a duty on DFPS to investigate the parents of a child who is subjected to these abusive gender-transitioning procedures, and on other state agencies to investigate licensed facilities where such procedures may occur. *See* TEX. FAM. CODE § 261.301(a)–(b). To protect Texas children from abuse, DFPS and all other state agencies must follow the law as explained in OAG Opinion No. KP-0401.

Sincerely,

Greg Abbott
Governor

GA:jsd

Enclosure

cc: Ms. Cecile Young, Executive Commissioner, Health and Human Services Commission
Mr. Stephen B. Carlton, Executive Director, Texas Medical Board
Ms. Katherine A. Thomas, Executive Director, Texas Board of Nursing
Dr. Tim Tucker, Executive Director, Texas State Board of Pharmacy
Mr. Darrell Spinks, Executive Director, Texas Behavioral Health Executive Council
Mr. Mike Morath, Commissioner, Texas Education Association
Ms. Cristina Galindo, Chair, Texas State Board of Educator Certification
Ms. Camille Cain, Executive Director, Texas Juvenile Justice Department

KEN PAXTON
ATTORNEY GENERAL OF TEXAS

February 18, 2022

The Honorable Matt Krause
Chair, House Committee on General
Investigating
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. KP-0401

Re: Whether certain medical procedures performed on children constitute child abuse (RQ-0426-KP)

Dear Representative Krause:

You ask whether the performance of certain medical and chemical procedures on children—several of which have the effect of sterilization—constitute child abuse.[1] You specifically ask about procedures falling under the broader category of "gender reassignment surgeries." Request Letter at 1. You state that such procedures typically are performed to "transition individuals with gender dysphoria to their desired gender," and you identify the following specific "sex-change procedures":

> (1) sterilization through castration, vasectomy, hysterectomy, oophorectomy, metoidioplasty, orchiectomy, penectomy, phalloplasty, and vaginoplasty; (2) mastectomies; and (3) removing from children otherwise healthy or non-diseased body part or tissue.

Id. at 1 (footnotes omitted). Additionally, you ask whether "providing, administering, prescribing, or dispensing drugs to children that induce transient or permanent infertility" constitutes child abuse. *See id.* at 1–2. You include the following categories of drugs: (1) puberty-suppression or puberty-blocking drugs; (2) supraphysiologic doses of testosterone to females; and (3) supraphysiologic doses of estrogen to males. *See id.*

[1] *See* Letter from Honorable Matt Krause, Chair, House Comm. on Gen. Investigating, to Honorable Ken Paxton, Tex. Att'y Gen. at 1 (Aug. 23, 2021), https://www2.texasattorneygeneral.gov/opinions/opinions/51paxton/rq/2021/pdf/RQ0426KP.pdf ("Request Letter"); *see also* Letter from Honorable Jaime Masters, Comm'r, Tex. Dept. of Family & Protective Servs., to Honorable Greg Abbott, Governor, State of Tex. at 1 (Aug. 11, 2021), https://gov.texas.gov/uploads/files/press/Response_to_August_6_2021_OOG_Letter_08.11.2021.pdf (on file with the Op. Comm.) (hereinafter "Commissioner's Letter").

You qualify your question with the following statement: "Some children have a medically verifiable genetic disorder of sex development or do not have the normal sex chromosome structure for male or female as determined by a physician through genetic testing that require procedures similar to those described in this request." *Id.* at 2. In other words, in rare circumstances, some of the procedures you list are borne out of medical necessity. For example, a minor male with testicular cancer may need an orchiectomy. This opinion does not address or apply to medically necessary procedures.

I. Executive Summary

Based on the analysis herein, each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

- These procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." TEX. FAM. CODE § 261.001(1)(A).

- These procedures and treatments can "caus[e] or permit[] the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning." *Id.* § 261.001(1)(B).

- These procedures and treatments can cause a "physical injury that results in substantial harm to the child." *Id.* § 261.001(1)(C).

- These procedures and treatments often involve a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" particularly by parents, counselors, and physicians. *Id.* § 261.001(1)(D).

In addition to analysis under the Family Code, we discuss below the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards. Each of the procedures and treatments you ask about can constitute child abuse when performed on minor children.

II. Nature and context of the question presented

Forming the basis for your request, you contend that the "sex change" procedures and treatments you ask about are typically performed to transition individuals with gender dysphoria to their desired gender. *See* Request Letter at 1. The novel trend of providing these elective sex changes to minors often has the effect of permanently sterilizing those minor children. While you refer to these procedures as "sex changes," it is important to note that it remains medically impossible to truly change the sex of an individual because this is determined biologically at

conception. No doctor can replace a fully functioning male sex organ with a fully functioning female sex organ (or vice versa). In reality, these "sex change" procedures seek to destroy a fully functioning sex organ in order to cosmetically create the illusion of a sex change.

Beyond the obvious harm of permanently sterilizing a child, these procedures and treatments can cause side effects and harms beyond permanent infertility, including serious mental health effects, venous thrombosis/thromboembolism, increased risk of cardiovascular disease, weight gain, decreased libido, hypertriglyceridemia, elevated blood pressure, decreased glucose tolerance, gallbladder disease, benign pituitary prolactinoma, lowered and elevated triglycerides, increased homocysteine levels, hepatotoxicity, polycythemia, sleep apnea, insulin resistance, chronic pelvic pain, and increased cancer and stroke risk.[2]

While the spike in these procedures is a relatively recent development,[3] sterilization of minors and other vulnerable populations without clear consent is not a new phenomenon and has an unsettling history. Historically weaponized against minorities, sterilization procedures have harmed many vulnerable populations, such as African Americans, female minors, the disabled, and others.[4] These violations have been found to infringe upon the fundamental human right to procreate. Any discussion of sterilization procedures in the context of minor children must, accordingly, consider the fundamental right that is at stake: the right to procreate. Given the uniquely vulnerable nature of children, and the clear dangers of sterilization demonstrated throughout history, it is important to emphasize the crux of the question you present today—*whether facilitating (parents/counselors) or conducting (doctors) medical procedures and treatments that could permanently deprive minor children of their constitutional right to procreate, or impair their ability to procreate, before those children have the legal capacity to consent to those procedures and treatments, constitutes child abuse.*

The medical evidence does not demonstrate that children and adolescents benefit from engaging in these irreversible sterilization procedures. The prevalence of gender dysphoria in children and adolescents has never been estimated, and there is no scientific consensus that these sterilizing procedures and treatments even serve to benefit minor children dealing with gender dysphoria. As stated by the Centers for Medicare and Medicaid Services, "There is not enough high-quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[5] Also, "several studies show a higher rate of regret at being sterilized among younger women than among those

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[2]*See* Timothy Cavanaugh, M.D., *Cross-Sex Hormone Therapy*, FENWAY HEALTH (2015), https://www.lgbtqiahealtheducation.org/wp-content/uploads/Cross-Sex-Hormone-Therapy1.pdf.

[3]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/ (demonstrating a spike in referrals to Gender Identify Development Services around the mid-2010s).

[4]Alexandra Stern, Ph.D., *Forced sterilization policies in the US targeted minorities and those with disabilities – and lasted into the 21st Century*, (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st.

[5]Centers for Medicare and Medicaid Services, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) (Aug. 30, 2016), http://www.lb7.uscourts.gov/documents/17-264URL1DecisionMemo.pdf.

who were sterilized at a later age." 43 FED. REG. at 52,151, 52,152. This further indicates that minor children are not sufficiently mature to make informed decisions in this context.

There is no evidence that long-term mental health outcomes are improved or that rates of suicide are reduced by hormonal or surgical intervention. "Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. No studies to date have evaluated the natural course and rate of gender dysphoria resolution among the novel cohort presenting with adolescent-onset gender dysphoria."[6] One of the few relevant studies monitored transitioned individuals for 30 years. It found high rates of post-transition suicide and significantly elevated all-cause mortality, including increased death rates from cardiovascular disease and cancer, although causality could not be established.[7] The lack of evidence in this field is why the Centers for Medicare & Medicaid Services rejected a nationwide coverage mandate for adult gender transition surgeries during the Obama Administration. Similarly, the World Professional Association for Transgender Health states that with respect to irreversible procedures, genital surgery should not be carried out until patients reach the legal age of majority to give consent for medical procedures in a given country.[8]

Generally, the age of majority is eighteen in Texas. TEX. CIV. PRAC. & REM. CODE § 129.001. With respect to consent to sterilization procedures, Medicaid sets the age threshold even higher, at twenty-one years old. Children and adolescents are promised relief and asked to "consent" to life-altering, irreversible treatment—and to do so in the midst of reported psychological distress, when they cannot weigh long-term risks the way adults do, and when they are considered by the State in most regards to be without legal capacity to consent, contract, vote, or otherwise. Legal and ethics scholars have suggested that it is particularly unethical to radically intervene in the normal physical development of a child to "affirm" a "gender identity" that is at odds with bodily sex.[9]

State and federal governments have "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Thus, states routinely regulate the medical profession and routinely update their regulations as new trends arise and new evidence becomes available. In the opioid context, for instance, states responded to an epidemic caused largely by pharmaceutical companies and medical professionals. Dismissing as "opioidphobic" any concern that "raising pain treatment to a 'patients' rights' issue could lead to overreliance on opioids," these experts created new pain standards and assured doctors that

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[6]SOCIETY FOR EVIDENCE BASED GENDER MEDICINE, https://segm.org/.

[7]*See* Cecilia Dhejne, et al., *Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE, Issue 2, 5 (Feb. 22, 2011) (19 times the expected norm overall (Table 2), and 40 times the norm for biological females (Table s1)), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885.

[8]WORLD PROFESSIONAL ASS'N FOR TRANSGENDER HEALTH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* at 59 (7th ed. 2012), available at https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?_t=1613669341.

[9]Ryan T. Anderson & Robert P. George, Physical Interventions on the Bodies of Children to "Affirm" their "Gender Identity" Violate Sound Medical Ethics and Should Be Prohibited, PUBLIC DISCOURSE: THE JOURNAL OF THE WITHERSPOON INSTITUTE (Dec. 8, 2019), https://www.thepublicdiscourse.com/2019/12/58839/.

prescribing more opioids was largely risk free.[10] *Id.* As we know now, the results were—indeed, *are*—nothing short of tragic.[11] There is always the potential for novel medical determinations to promote purported remedies that may not improve patient outcomes and can even result in tragic harms. The same potential for harm exists for minors who have engaged in the type of procedures or treatments above.

The State's power is arguably at its zenith when it comes to protecting children. In the Supreme Court's words, that is due to "the peculiar vulnerability of children." *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *see also Ginsberg v. New York*, 390 U.S. 629, 640 (1968) ("The State also has an independent interest in the well-being of its youth."). The Supreme Court has explained that children's "inability to make critical decisions in an informed, mature manner" makes legislation to protect them particularly appropriate. *Bellotti*, 443 U.S. at 634. The procedures that you ask about impose significant and irreversible effects on children, and we therefore address them with extreme caution, mindful of the State's duty to protect its children. *See generally T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9, 42 (Tex. App.—Fort Worth 2020), *cert. denied*, 141 S. Ct. 1069 (2021) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*. In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's *parens patriae* interest in preserving and promoting the welfare of the child.") (citation omitted).

III. To the extent that these procedures and treatments could result in sterilization, they would deprive the child of the fundamental right to procreate, which supports a finding of child abuse under the Family Code.

A. The procedures you describe can and do cause sterilization.

The surgical and chemical procedures you ask about can and do cause sterilization.[12] Similarly, the treatments you ask about often involve puberty-blocking medications. Such medications suppress the body's production of estrogen or testosterone to prevent puberty and are being used in this context to pause the sexual development of a person that occurs during puberty. The use of these chemical procedures for this purpose is not approved by the federal Food and Drug Administration and is considered an "off-label" use of the medications. These chemical procedures prevent a person's body from developing the capability to procreate. There is insufficient medical evidence available to demonstrate that discontinuing the medication resumes a normal puberty process. *See generally Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1042 (D. Ariz. 2021), citing *Bell v. Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274,

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[10] *See* David W. Baker, *The Joint Commission's Pain Standards: Origins and Evolution* 4 (May 5, 2017) (footnotes omitted), https://perma.cc/RZ42-YNRC ("[N]o large national studies were conducted to examine whether the standards improved pain assessment or control.").

[11] *See generally* U.S. HEALTH & HUMAN SERVS., WHAT IS THE U.S. OPIOID EPIDEMIC?, https://www.hhs.gov/opioids/about-the-epidemic/index html.

[12] *See* Philip J. Cheng, *Fertility Concerns of the Transgender Patient*, TRANSL ANDROL UROL. 2019;9(3):209-218 (explaining that hysterectomy, oophorectomy, and orchiectomy "results in permanent sterility"), https://www ncbi nlm nih.gov/pmc/articles/PMC6626312/.

¶ 134 (Dec. 1, 2020) (referring to *Bell's* conclusion that a clinic's practice of prescribing puberty-suppressing medication to individuals under age 18 with gender dysphoria and determining such treatment was experimental). Thus, because the procedures you inquire about can and do result in sterilization, they implicate a minor child's constitutional right to procreate.

B. The United States Constitution protects a fundamental right to procreation.

The United States Supreme Court recognizes that the right to procreate is a fundamental right under the Fourteenth Amendment. *See Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). Almost a century ago, the Court explained the unique concerns sterilization poses respecting this fundamental right:

> The power to sterilize, if exercised, may have subtle, far reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear. There is no redemption for the individual whom the law touches. Any experiment which the State conducts is to his irreparable injury. He is forever deprived of a basic liberty.

Id. To the extent the procedures you describe cause permanent damage to reproductive organs and functions of a child before that child has the legal capacity to consent, they unlawfully violate the child's constitutional right to procreate. *See generally* 43 FED. REG. at 52,146–52,152 (discussing ripeness for coercion and regret rates among minor children).

C. Because children are legally incompetent to consent to sterilization, procedures and treatments that result in a child's sterilization are unauthorized and infringe on the child's fundamental right to procreate.

Under Texas law, a minor is a person under eighteen years of age that has never been married and never declared an adult by a court. *See* TEX. CIV. PRAC. & REM. CODE § 129.001; TEX. FAM. CODE §§ 1.104, 101.003 (including a minor on active duty in the military, one who does not live with a parent or guardian and who manages their own financial affairs, among others). State law recognizes seven instances in which a minor can consent to certain types of medical treatment on their own. *See id.* § 32.003. None of the express provisions relating to a minor's ability to consent to medical treatment addresses consent to the procedures used for "gender-affirming" treatment. *See generally id.*

The lack of authority of a minor to consent to an irreversible sterilization procedure is consistent with other law. The federal Medicaid program does not allow for parental consent, has established a minimum age of 21 for consent to sterilization procedures, and imposes detailed requirements for obtaining that consent. 42 C.F.R. §§ 441.253(a); 441.258 ("Consent form requirements"). Federal Medicaid funds may not be used for any sterilization without complying with the consent requirements, meaning a doctor may not be reimbursed for sterilization procedures performed on minors. *Id.* § 441.256(a).

The higher age limit for sterilization procedures was implemented due to a number of special concerns, including historical instances of forced sterilization. *See* 43 FED. REG. 52146, 52148. "[M]inors and other incompetents have been sterilized with federal funds and . . . an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization." *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D.C. 1974), *vacated*, 565 F.2d 722 (D.C. Cir. 1977). In addition, the 21-year minimum age-of-consent rule accounted for concerns that minors were more susceptible to coercion than those over 21 and that younger women had higher rates of regret for sterilization than those who were sterilized at a later age. 43 FED. REG. at 52,151 (pointing to comments suggesting that "persons under 21 are more susceptible to coercion than those over 21 and are more likely to lack the maturity to make an informed decision" and acknowledging "these considerations favor protecting such individuals by limiting their access to the procedure"); *see id.* at 52,151–52,152 (pointing to "several studies [that] show a higher rate of regret at being sterilized among younger women than among those who were sterilized at a later age").

Regarding parental consent, Texas law generally recognizes a parent's right to consent to a child's medical care. TEX. FAM. CODE § 151.001(a)(6) ("A parent of a child has the following rights and duties: . . . (6) the right to consent to the child's . . . medical and dental care, and psychiatric, psychological, and surgical treatment . . ."). But this general right to consent to certain medically necessary procedures does not extend to elective (not medically necessary) procedures and treatments that infringe upon a minor child's constitutional right to procreate. Indeed, courts have analyzed the imposition of unnecessary medical procedures upon children in similar circumstances in the past to determine whether doing so constitutes child abuse.

One such situation that the law has addressed is often referred to as "Munchausen by proxy" or "factitious disorder imposed on another":

> [A] psychological disorder that is characterized by the intentional feigning, exaggeration, or induction of the symptoms of a disease or injury in oneself or another and that is accompanied by the seeking of excessive medical care from various doctors and medical facilities typically resulting in multiple diagnostic tests, treatments, procedures, and hospitalizations. Unlike the malingerer, who consciously induces symptoms to obtain something of value, the patient with a factitious disorder consciously produces symptoms for unconscious reasons, without identifiable gain.[13]

In situations such as this, an individual intentionally seeks to procure—often by deceptive means, such as exaggeration—unnecessary medical procedures or treatments either for themselves or others, usually their children. In Texas, courts have found that these "Munchausen by proxy" situations can constitute child abuse. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure

[13] *Factitious disorder*, MERRIAM-WEBSTER.COM DICTIONARY, https://www merriam-webster.com/dictionary/factitious%20disorder.

may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code).[14]

In the context of elective sex change procedures for minors, the Legislature has not provided any avenue for parental consent, and no judicial avenue exists for the child to proceed with these procedures and treatments without parental consent. By comparison, Texas law respecting abortion requires parental consent and, in extenuating circumstances, permits non-parental consent for a minor to obtain an abortion. TEX. OCC. CODE § 164.052(19) (requiring written consent of a child's parent before a physician may perform an abortion on an unemancipated minor); TEX. FAM. CODE § 33.003 (authorizing judicial approval of a minor's abortion without parental consent in limited circumstances). But the Texas Legislature has not decided to make those same allowances for consent to sterilization, and thus a parent cannot consent to sterilization procedures or treatments that result in the permanent deprivation of a minor child's constitutional right to procreate.[15] Thus, no avenue exists for a child to consent to or obtain consent for an elective procedure or treatment that causes sterilization.

IV. The procedures and treatments you describe can constitute child abuse under the Family Code.

Having established the legal and cultural context of this opinion request, we now consider whether these procedures and treatments qualify as child abuse under the Family Code. *See* Request Letter at 1. Where, as a factual matter, one of these procedures or treatments cannot result in sterilization, a court would have to go through the process of evaluating, on a case-by-case basis, whether that procedure violates any of the provisions of the Family Code—and whether the procedure or treatment poses a similar threat or likelihood of substantial physical and emotional harm. Thus, where a factual scenario involving non-medically necessary, gender-based procedures or treatments on a minor causes or threatens to cause harm or irreparable harm[16] to the child—comparable to instances of Munchausen syndrome by proxy or criminal injury to a child—or demonstrates a lack of consent, etc., a court could find such procedures to constitute child abuse under section 261.001.

A. The Texas Legislature defines child abuse broadly.

Family Code chapter 261 provides for the reporting and investigation of abuse or neglect of a child. *See* TEX. FAM. CODE §§ 261.001–.505; *see also* TEX. PENAL CODE § 22.04 (providing for the offense of injury to a child). Section 261.001 defines abuse through a broad and nonexclusive list of acts and omissions. TEX. FAM. CODE § 261.001(1); *see also In re Interest of*

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[14] *See also* Tex. Dep't of Fam. & Protective Servs., Tex. Practice Guide for Child Protective Servs. Att'ys. § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp.

[15] Federal Medicaid programs will not reimburse for these types of procedures on minors, regardless of whether the child or parent consents, because of the numerous concerns outlined in the Federal Register provisions discussed above. *See* 43 FED. REG. at 52,146–52,159.

[16] For example, a non-medically necessary procedure or treatment that seeks to alter a minor female's breasts in such a way that would or could prevent that minor female from having the ability to breastfeed her eventual children likely causes irreparable harm and could form the basis for a finding of child abuse.

S.M.R., 434 S.W.3d 576, 583 (Tex. 2014). Of course, this broad definition of abuse would apply to and include criminal acts against children, such as "female genital mutilation"[17] or "injury to a child."[18]

Your questions implicate several components of section 261.001(1). Subsection 261.001(1)(A) identifies "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." Subsection 261.001(1)(B) provides that "causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning" is abuse. Subsection 261.001(1)(C) includes as abuse a "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child." And subsection 261.001(1)(D) includes "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child."

Offering some clarity to the scope of "abuse" under subsection 261.001(1), the Texas Department of Family and Protective Services ("Department") adopted rules giving meaning to the key terms and phrases used in the definition. The Department acknowledges that emotional abuse is a subset of abuse that includes "[m]ental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning." 40 TEX. ADMIN. CODE § 707.453(a) (Tex. Dept. of Fam. & Protective Servs., What is Emotional Abuse?). The Department's rules provide that "[m]ental or emotional injury" means

> [t]hat a child of any age experiences significant or serious negative effects on intellectual or psychological development or functioning. . . . and exhibits behaviors indicative of observable and material impairment . . . . mean[ing] discernable and substantial damage or deterioration to a child's emotional, social, and cognitive development.

Id. § 707.453(b)(1)–(2).

With respect to physical injuries, the Department further clarified the meaning of the phrase "[p]hysical injury that results in substantial harm to the child," explaining that it means in relevant part a

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[17]A person commits an offense if the person: (1) knowingly circumcises, excises, or infibulates any part of the labia majora or labia minora or clitoris of another person who is younger than 18 years of age; (2) is a parent or legal guardian of another person who is younger than 18 years of age and knowingly consents to or permits an act described by Subdivision (1) to be performed on that person; or (3) knowingly transports or facilitates the transportation of another person who is younger than 18 years of age within this state or from this state for the purpose of having an act described by Subdivision (1) performed on that person. TEX. HEALTH & SAFETY CODE § 167.001.

[18]A person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to a child, elderly individual, or disabled individual: (1) serious bodily injury; (2) serious mental deficiency, impairment, or injury; or (3) bodily injury. TEX. PENAL CODE § 22.04.

> real and significant physical injury or damage to a child that includes but is not limited to . . . [a]ny of the following, if caused by an action of the alleged perpetrator directed toward the alleged victim: . . . *impairment of or injury to any bodily organ or function*; . . . .

Id. § 707.455(b)(2)(A) (emphasis added). The Department's rules also define a "[g]enuine threat of substantial harm from physical injury" to include the

> *declaring or exhibiting the intent or determination to inflict real and significant physical injury or damage to a child.* The declaration or exhibition does not require actual physical contact or injury.

Id. § 707.455(b)(1) (emphasis added).

Subsection 261.001(1) and these rules define "abuse" broadly to include mental or emotional injury in addition to a physical injury. To the extent the specific procedures about which you ask may cause mental or emotional injury or physical injury within these provisions, they constitute abuse.

Further, the Legislature has explicitly defined "female genital mutilation" and made such act a state jail felony. *See* TEX. HEALTH & SAFETY CODE § 167.001(a)–(b). While the Legislature has not elsewhere defined the phrase "genital mutilation", nor specifically for males of any age,[19] the Legislature's criminalization of a particular type of genital mutilation supports an argument that analogous procedures that include genital mutilation—potentially including gender reassignment surgeries—could constitute "abuse" under the Family Code's broad and non-exhaustive examples of child abuse or neglect.[20] *See* TEX. FAM. CODE § 261.001(1)(A)–(M); *see generally* Commissioner's Letter at 1 (concluding that genital "mutilation may cause a genuine threat of substantial harm from physical injury to the child"). Thus, many of the procedures and treatments you ask about can constitute "female genital mutilation," a standalone criminal act. But even where these procedures and treatments may not constitute "female genital mutilation" under Texas law, a court could still find that these procedures and treatments constitute child abuse under section 261.001 of the Family Code.

B. Each of these procedures and treatments can constitute abuse under Texas Family Code § 261.001(1)(A), (B), (C), or (D).

The Texas Family Code is clear—causing or permitting substantial harm to the child or the child's growth and development is child abuse. Courts have held that an unnecessary surgical

[19]Your letter does not mention nor request an analysis under federal law. However, under federal law, there are at least two definitions of female genital mutilation, 8 U.S.C § 1374 and 18 U.S.C. § 116. For purposes of this opinion, we have not considered federal statutes, nor have we undertaken any analysis under state or federal constitutions beyond that included here.

[20]The Eighty-seventh Legislature considered multiple bills that would have amended Family Code subsection 261.001(1) to expressly include in the definition of abuse the performing of surgery or other medical procedures on a child for the purpose of gender transitioning or gender reassignment. Those bills did not pass. *See, e.g.*, Tex. H.B. 22, 87th Leg., 3d C.S. (2021).

procedure that removes a healthy body part from a child can constitute a real and significant injury or damage to the child. *See generally Williamson v. State*, 356 S.W.3d 1, 19–21 (Tex. App.—Houston [1st Dist.] 2010, pet. ref'd) (recognizing that an unnecessary medical procedure may cause serious bodily injury, supporting a charge of injury to a child under section 22.04 of the Penal Code). The *Williamson* case involved a "victim of medical child abuse, sometimes referred to as Munchausen Syndrome by Proxy." *Id.* at 5. Munchausen syndrome by proxy is "where an alleged perpetrator . . . attempts to gain medical procedures and issues for [their] child for secondary gain for themselves . . . . [A]s a result, the children are subjected to multiple diagnostic tests, therapeutic procedures, sometimes operative procedures, in order to treat things that aren't really there." *Williamson*, 356 S.W.3d at 11. In the *Williamson* case, the abuse was perpetrated on the child when he was five and six years old by his mother. *Id.* The evidence showed that two surgeries performed on the child "were not medically necessary and that [his mother] knowingly and intentionally caused the unnecessary procedures to be performed by fabricating, exaggerating, and inducing the symptoms leading to the surgeries." *Id.*

Similarly, in *Austin v. State*, a court of appeals upheld the conviction for felony injury of a child of a mother suffering from Munchausen syndrome by proxy who injected her son with insulin. *See* 222 S.W.3d 801, 804 (Tex. App.—Austin 2007, pet. ref'd); *see also In re McCabe*, 580 S.E.2d 69, 73 (N.C. Ct. App. 2003) (concluding that abuse through Munchausen syndrome by proxy was abuse under state statute defining abuse in a similar manner as chapter 261); *Matter of Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993), *aff'd sub nom. Matter of Suffolk Cnty. Dep't of Soc. Servs on Behalf of Aaron S.*, 626 N.Y.S.2d 227 (App. Div. 1995) (finding that a mother neglected her son by subjecting him to a continuous course of medical treatment for condition which he did not have and that he was a neglected child under state statute governing abuse of a child). In guidance documents published for its child protective services attorneys, the Texas Department of Family and Protective Services explains that "Munchausen by proxy syndrome is relatively rare, but when it occurs, it is frequently a basis for a finding of child abuse."[21] Whether motivated by Munchausen syndrome by proxy or otherwise, it is clear that unnecessary medical treatment inflicted on a child by a parent can constitute child abuse under the Family Code.

By definition, procedures and treatments resulting in sterilization cause "physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child" by surgically altering key physical body parts of the child in ways that render entire body parts, organs, and the entire reproductive system of the child physically incapable of functioning. Thus, such procedures and treatments can constitute child abuse under section 261.001(1)(C). Even where the procedure or treatment does not involve the physical removal or alteration of a child's reproductive organs (*i.e.* puberty blockers), these procedures and treatments can cause "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning" by subjecting a child to the mental and emotional injury associated with lifelong sterilization—an impairment to

[21] TEX. DEP'T OF FAM. & PROTECTIVE SERVS., TEX. PRACTICE GUIDE FOR CHILD PROTECTIVE SERVS. ATT'YS, § 7, at 15 (2018), https://www.dfps.state.tx.us/Child_Protection/Attorneys_Guide/default.asp (citing *Reid v. State*, 964 S.W.2d 723 (Tex. App.—Amarillo 1998, pet. ref'd) (mem. op.) (expert testimony admitted regarding general acceptance of Munchausen diagnosis as a form of child abuse)).

one's growth and development. Therefore, a court could find these procedures and treatments to be child abuse under section 261.001(1)(A). Further, attempts by a parent to consent to these procedures and treatments on behalf of their child may, if successful, "cause or permit the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning[,]" and could be child abuse under section 261.001(1)(B). Additionally, the failure to stop a doctor or another parent from conducting these treatments and procedures on a minor child can constitute a "failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child[,]" and this "failure to make a reasonable effort to prevent" can also constitute child abuse under section 261.001(1)(D). Any person that conducts or facilitates these procedures or treatments could be engaged in child abuse, whether that be parents, doctors, counselors, etc.

It is important to note that anyone who has "a reasonable cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report" as described in the Family Code. TEX. FAM. CODE § 261.101(a). Further, "[i]f a professional has reasonable cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has reasonable cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first has reasonable cause to believe that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code." TEX. FAM. CODE § 261.101(b). The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers. *Id.* A failure to report under these circumstances is a criminal offense. TEX. FAM. CODE § 261.109(a).

SUMMARY

Each of the "sex change" procedures and treatments enumerated above, when performed on children, can legally constitute child abuse under several provisions of chapter 261 of the Texas Family Code.

When considering questions of child abuse, a court would likely consider the fundamental right to procreation, issues of physical and emotional harm associated with these procedures and treatments, consent laws in Texas and throughout the country, and existing child abuse standards.

Very truly yours,

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