

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION**

AUGUST DEKKER, et al.,

Plaintiffs,

v.

JASON WEIDA, et al.,

Defendants.

Case No. 4:22-cv-00325-RH-
MAF

**BRIEF OF *AMICI CURIAE* AMERICAN ACADEMY OF PEDIATRICS
AND ADDITIONAL NATIONAL AND STATE MEDICAL AND MENTAL
HEALTH ORGANIZATIONS IN SUPPORT OF PLAINTIFFS'
OPPOSITION TO DEFENDANTS' MOTION FOR
SUMMARY JUDGMENT**

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Civil Procedure 7.1, the undersigned counsel for the American Academy of Pediatrics (“AAP”), the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry (“AACAP”), the American Academy of Family Physicians (“AAFP”), the American Academy of Nursing (“AAN”), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality (“GLMA”), the American College of Obstetricians and Gynecologists (“ACOG”), the American College of Osteopathic Pediatricians (“ACOP”), the American College of Physicians (“ACP”), the American Medical Association (“AMA”), the American Pediatric Society (“APS”), the American Psychiatric Association (“APA”), the Association of American Medical Colleges (“AAMC”), Association of Medical School Pediatric Department Chairs, Inc. (“AMSPDC”), the Endocrine Society, the Florida Chapter of the American Academy of Pediatrics (“FCAAP”), the National Association of Pediatric Nurse Practitioners (“NAPNAP”), the Pediatric Endocrine Society (“PES”), the Societies for Pediatric Urology (“SPU”), the Society for Adolescent Health and Medicine (“SAHM”), the Society for Pediatric Research (“SPR”), the Society of Pediatric Nurses (“SPN”), and the World Professional Association for Transgender Health (“WPATH”) certify that:

1. AAP, the Academic Pediatric Association, AACAP, AAFP, AAN,

GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, FCAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, and WPATH, respectively, have no parent corporation.

2. No corporations hold any stock in AAP, the Academic Pediatric Association, AACAP, AAFP, AAN, GLMA, ACOG, ACOP, ACP, AMA, APS, APA, AAMC, AMSPDC, the Endocrine Society, FCAAP, NAPNAP, PES, SPU, SAHM, SPR, SPN, or WPATH.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae are the American Academy of Pediatrics (“AAP”), the Academic Pediatric Association, the American Academy of Child & Adolescent Psychiatry (“AACAP”), the American Academy of Family Physicians (“AAFP”), the American Academy of Nursing (“AAN”), the American Association of Physicians for Human Rights, Inc. d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality (“GLMA”), the American College of Obstetricians and Gynecologists (“ACOG”), the American College of Osteopathic Pediatricians (“ACOP”), the American College of Physicians (“ACP”), the American Medical Association (“AMA”), the American Pediatric Society (“APS”), the American Psychiatric Association (“APA”), the Association of American Medical Colleges (“AAMC”), Association of Medical School Pediatric Department Chairs, Inc. (“AMSPDC”), the Endocrine Society, the Florida Chapter of the American Academy of Pediatrics (“FCAAP”), the National Association of Pediatric Nurse Practitioners (“NAPNAP”), the Pediatric Endocrine Society (“PES”), the Societies for Pediatric Urology (“SPU”), the Society for Adolescent Health and Medicine (“SAHM”), the Society for Pediatric Research (“SPR”), the Society of Pediatric Nurses (“SPN”), and the World Professional Association for Transgender Health (“WPATH”).¹

¹ Plaintiffs and Defendants have consented to the filing of this brief. *Amici* affirm that no counsel for a party authored this brief in whole or in part and that no person

Amici are professional medical and mental health organizations seeking to ensure that all individuals, including those with gender dysphoria, receive the optimal medical and mental healthcare they need and deserve. *Amici* represent thousands of healthcare providers who have specific expertise with the issues raised in this brief. The Court should consider *amici*'s brief because it provides important expertise and addresses misstatements about the treatment of gender dysphoria.

other than *amici* or their counsel made any monetary contributions intended to fund the preparation or submission of this brief.

INTRODUCTION

Rule 59G-1.010(7) of the Florida Administrative Code (the “Medicaid Ban”) eliminates Florida Medicaid coverage for critical, medically necessary, evidence-based treatments for gender dysphoria. Denying coverage for such care effectively denies access to it for Florida Medicaid recipients who meet the requisite medical criteria, putting them at risk of significant harm. The basis for the Medicaid Ban, the Division of Florida Medicaid’s June 2, 2022 “Generally Accepted Professional Medical Standards Determination on the Treatment of Gender Dysphoria” (the “GAPMS Report”)², mischaracterizes the professionally-accepted medical guidelines for treating gender dysphoria and the guidelines’ supporting evidence. Below, *amici* provide the Court with an accurate description of these treatment guidelines and summarize the scientific evidence supporting the medical interventions prohibited by the Medicaid Ban. While the Medicaid Ban affects all patients who are receiving treatment for gender dysphoria, this brief focuses primarily on the experience of transgender adolescents.³

Gender dysphoria is a clinical condition that is marked by distress due to an

² Available at https://www.ahca.myflorida.com/letkidsbekids/docs/AHCA_GAPMS_June_2022_Report.pdf.

³ Because this brief focuses primarily on adolescents, it does not discuss surgeries that are typically available to transgender adults.

incongruence between the patient’s gender identity (i.e., the innate sense of oneself as being a particular gender) and sex assigned at birth. This incongruence can lead to clinically significant distress and impair functioning in many aspects of the patient’s life.⁴ If not treated, or treated improperly, gender dysphoria can result in debilitating anxiety, depression, and self-harm, and is associated with higher rates of suicide. As such, the effective treatment of gender dysphoria saves lives.

The widely accepted recommendation of the medical community, including that of the respected professional organizations participating here as *amici*, is that the standard of care for treating gender dysphoria is “gender-affirming care.”⁵ Gender-affirming care is care that supports individuals with gender dysphoria as they explore their gender identity—in contrast with efforts to change the individual’s gender identity to match their sex assigned at birth, which are known to be ineffective and harmful.⁶ For adolescents with persistent gender dysphoria that worsens with the onset of puberty, gender-affirming care may include medical

⁴ See, e.g., Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142(4) PEDIATRICS e20182162, at 2–3, tbl.1 (2018) (hereinafter, “AAP Policy Statement”), <https://publications.aap.org/pediatrics/article/142/4/e20182162/37381/Ensuring-Comprehensive-Care-and-Support-for>.

⁵ *Id.* at 10.

⁶ See, e.g., Christy Mallory et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (June 2019), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf>.

interventions to align their physiology with their gender identity. Empirical evidence indicates that gender-affirming care, including gender-affirming medical interventions, in carefully evaluated patients who meet diagnostic criteria can alleviate clinically significant distress and lead to significant improvements in the mental health and overall well-being of adolescents with gender dysphoria.⁷

The Medicaid Ban disregards this medical evidence by precluding Florida Medicaid reimbursement for the treatment of patients with gender dysphoria in accordance with the accepted standard of care. Accordingly, *amici* urge this Court to deny Defendants' motion for summary judgment.

ARGUMENT

This brief first provides background on gender identity and gender dysphoria. It then describes the professionally-accepted medical guidelines for treating gender dysphoria as they apply to adolescents, the scientifically rigorous process by which these guidelines were developed, and the evidence that supports the effectiveness of this care for adolescents with gender dysphoria. Finally, the brief corrects multiple inaccuracies in the GAPMS Report, and explains how the Medicaid Ban would irreparably harm adolescents with gender dysphoria by denying crucial care to those who need it.

⁷ See Martin, *infra* note 32, at 2.

I. Understanding Gender Identity and Gender Dysphoria.

A person's gender identity is a person's deep internal sense of belonging to a particular gender.⁸ Most people have a gender identity that aligns with their sex assigned at birth.⁹ However, transgender people have a gender identity that does not align with their sex assigned at birth.¹⁰ In the United States, it is estimated that approximately 1.4 million individuals are transgender.¹¹ Of these individuals, approximately 10% are teenagers aged 13 to 17.¹² Individuals often start to understand their gender identity during prepubertal childhood and adolescence.

Today, there is an increasing understanding that being transgender is a normal variation of human identity.¹³ However, many transgender people suffer from

⁸ AAP Policy Statement, *supra* note 4, at 2 tbl.1.

⁹ See Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) AMERICAN PSYCHOLOGIST 832, 862 (2015) (hereinafter, "Am. Psychological Ass'n Guidelines"), <https://www.apa.org/practice/guidelines/transgender.pdf>.

¹⁰ See *id.* at 863.

¹¹ See Jody L. Herman et al., *Ages of Individuals Who Identify as Transgender in the United States*, Williams Inst., at 2 (Jan. 2017), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Age-Trans-Individuals-Jan-2017.pdf>.

¹² See *id.* at 3.

¹³ James L. Madara, *AMA to States: Stop Interfering in Healthcare of Transgender Children*, Am. Med. Ass'n (Apr. 26, 2021), <https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children>; see also Am. Psychological Ass'n, *APA Resolution on Gender Identity Change Efforts*, 4 (Feb. 2021), <https://www.apa.org/about/policy/resolution-gender->

gender dysphoria, a serious medical condition in which the patient experiences significant distress that can lead to “impairment in peer and/or family relationships, school performance, or other aspects of their life.”¹⁴ Gender dysphoria is a formal diagnosis under the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-5-TR).¹⁵

If untreated or inadequately treated, gender dysphoria can cause depression, anxiety, self-harm, and suicidality.¹⁶ Indeed, over 60% of transgender adolescents and young adults reported having engaged in self-harm during the preceding 12 months, and over 75% reported symptoms of generalized anxiety disorder in the preceding two weeks.¹⁷ Even more troubling, more than 50% of this population reported having seriously considered attempting suicide,¹⁸ and more than one in three transgender adolescents reported having attempted suicide in the preceding

identity-change-efforts.pdf.

¹⁴ AAP Policy Statement, *supra* note 4, at 3.

¹⁵ See Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5 – TR* at 512–13 (2022).

¹⁶ See Brayden N. Kameg & Donna G. Nativio, *Gender Dysphoria In Youth: An Overview For Primary Care Providers*, 30(9) J. AM. ASSOC. NURSE PRAC. 493 (2018), <https://pubmed.ncbi.nlm.nih.gov/30095668>.

¹⁷ See Amit Paley, *The Trevor Project 2020 National Survey*, at 1, <https://www.thetrevorproject.org/wp-content/uploads/2020/07/The-Trevor-Project-National-Survey-Results-2020.pdf>.

¹⁸ See *id.* at 2.

12 months.¹⁹ The statistics are similar for transgender adults.²⁰

II. The Widely Accepted Guidelines for Treating Adolescents with Gender Dysphoria Provide for Medical Interventions When Indicated.

The widely accepted view of the professional medical community is that gender-affirming care is the appropriate treatment for gender dysphoria and that, for some adolescents, gender-affirming medical interventions are necessary.²¹ This care greatly reduces the negative physical and mental health consequences that result

¹⁹ See Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students—19 States and Large Urban School Districts, 2017*, US Dep’t of Health and Human Servs., Centers for Disease Control & Prevention, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 70 (2019), <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6803a3-H.pdf>.

²⁰ Transgender adults, like adolescents, have a higher prevalence of depression and suicidality than the general population. See, e.g., Jody L. Herman et al., *Suicide Thoughts And Attempts Among Transgender Adults: Findings From The 2015 US Transgender Survey*, UCLA Williams Inst. (2019), <https://escholarship.org/uc/item/1812g3hm>. Elevated rates of depression and suicidality in transgender adults have also been linked to societal stigma, abuse, violence, and discrimination. See, e.g., Larry Nuttbrock et al., *Gender Abuse, Depressive Symptoms, And Substance Use Among Transgender Women: A 3-Year Prospective Study*, 104(11) AM. J. PUB. HEALTH 2199–2206 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4202966/>; Amanda L. Peterson et al., *Ambient Discrimination, Victimization, And Suicidality In A Non-Probability US Sample Of LGBTQ Adults*, 50(3) ARCHIVES SEXUAL BEHAV. 1003–1014 (2021).

²¹ See, e.g., Endocrine Soc’y, *Transgender Health: An Endocrine Society Position Statement* (2020), <https://www.endocrine.org/advocacy/position-statements/transgender-health>.

when gender dysphoria is untreated.²²

A. The Gender Dysphoria Treatment Guidelines Include Thorough Mental Health Assessments and, for Some Adolescents, Medical Interventions.

The treatment protocols for gender dysphoria are laid out in established, evidence-based clinical guidelines: (i) the Endocrine Society Clinical Practice Guideline for Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, and (ii) the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (together, the “Guidelines”).²³ The Guidelines have been developed by expert clinicians and researchers who have worked with patients with gender dysphoria for many years.

The Guidelines provide that all youth with gender dysphoria should be evaluated, diagnosed, and treated by a qualified health care professional (“HCP”). Further, the Guidelines provide that each patient who receives gender-affirming care should receive only evidence-based, medically necessary, and appropriate interventions that are tailored to the patient’s individual needs.

²² See *id.*

²³ Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (Nov. 2017) (hereinafter, “Endocrine Soc’y Guidelines”), <https://academic.oup.com/jcem/article/102/11/3869/4157558>; WPATH, *Standards of Care for the Health of Transgender and Gender Diverse People* (8th Version) (hereinafter “WPATH Guidelines”), <https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644>.

1. A Robust Diagnostic Assessment Is Required Before Medical Interventions Are Provided.

According to the Guidelines, gender-affirming care for adolescents begins with a thorough evaluation by a HCP who: (1) is licensed by their statutory body and holds a master’s degree or equivalent in a relevant clinical field; (2) has expertise and received theoretical and evidence-based training in child, adolescent, and family mental health; (3) has expertise and received training in gender identity development, gender diversity in children and adolescents, can assess capacity to consent, and possesses knowledge about gender diversity across the life span; (4) has expertise and received training in autism spectrum disorders and other neurodevelopmental presentations, or collaborates with a developmental disability expert when working with neurodivergent patients; and (5) continues engagement in professional development in areas relevant to gender diverse children, adolescents, and families.²⁴

Prior to developing a treatment plan, the HCP should conduct a “comprehensive biopsychosocial assessment” of the adolescent patient.²⁵ The HCP conducts this assessment to “understand the adolescent’s strengths, vulnerabilities, diagnostic profile, and unique needs,” so that the resulting treatment plan is

²⁴ See WPATH Guidelines, *supra* note 23, at S49.

²⁵ *Id.* at S50.

appropriately individualized.²⁶ This assessment must be conducted collaboratively with the patient and their caregiver(s).²⁷

2. The Guidelines Recommend Only Non-Medical Interventions for Prepubertal Children With Gender Dysphoria.

For prepubertal children with gender dysphoria, the Guidelines provide for mental health care and support for the child and their family.²⁸ The Guidelines do *not* recommend that any medical interventions (such as medications or surgery) be provided to prepubertal children with gender dysphoria.²⁹

3. In Certain Circumstances, the Guidelines Provide for the Use of Medical Interventions to Treat Adolescents With Gender Dysphoria.

For youths with gender dysphoria that continues into adolescence—after the onset of puberty—the Guidelines provide that, in addition to mental health care, medical interventions may be indicated. Before an adolescent may receive any medical interventions for gender dysphoria, a qualified HCP must determine that: (1) the adolescent meets the diagnostic criteria of gender incongruence according to the World Health Organization’s International Classification of Diseases; (2) the

²⁶ *Id.*

²⁷ *Id.*

²⁸ *See id.* at S73–S74; Endocrine Soc’y Guidelines at 3877–78.

²⁹ *See* WPATH Guidelines, *supra* note 23, at S64; Endocrine Soc’y Guidelines, *supra* note 23, at 3871.

adolescent has demonstrated a sustained and persistent pattern of gender nonconformity or gender dysphoria; (3) the adolescent has demonstrated the emotional and cognitive maturity required to provide informed consent for treatment; (4) any coexisting psychological, medical, or social problems that could interfere with diagnosis, treatment, or the adolescent's ability to consent have been addressed; (5) the adolescent has been informed of the reproductive effects of treatment in the context of their stage in pubertal development and discussed fertility preservation options; and (6) the adolescent has reached Tanner stage 2 of puberty to initiate pubertal suppression.³⁰ Further, a pediatric endocrinologist or other clinician experienced in pubertal assessment must (7) agree with the indication for treatment, (8) confirm the patient has started puberty, and (9) confirm that there are no medical contraindications.³¹

If all of the above criteria are met, the Guidelines instruct that gonadotropin-releasing hormone (GnRH) analogues, or “puberty blockers,” may be offered beginning at the onset of puberty.³² The purpose of puberty blockers is to delay

³⁰ WPATH Guidelines, *supra* note 23, at S59–65.

³¹ Endocrine Soc’y Guidelines, *supra* note 23, at 3878 tbl.5.

³² WPATH Guidelines, *supra* note 23, at S64; Simona Martin et al., *Criminalization of Gender-Affirming Care—Interfering with Essential Treatment for Transgender Children and Adolescents*, 385 NEW ENG. J. MED. 579 (2021), <https://www.nejm.org/doi/full/10.1056/NEJMp2106314>.

pubertal development until adolescents are old enough and have had sufficient time to make more informed decisions about whether to pursue further treatments.³³ Puberty blockers also can make pursuing transition later in life easier, because they prevent irreversible bodily changes such as protrusion of the Adam's apple or breast growth.³⁴ Puberty blockers have well-known efficacy and side-effect profiles and their effects are generally reversible.³⁵ In fact, puberty blockers have been used by pediatric endocrinologists for more than 40 years for the treatment of precocious puberty.³⁶ The risks of any serious adverse effects from these treatments are exceedingly rare when provided under clinical supervision.³⁷

Later in adolescence—and if the criteria below are met—hormone therapy

³³ WPATH Guidelines, *supra* note 23, at S112.

³⁴ See AAP Policy Statement, *supra* note 4, at 5.

³⁵ See Martin, *supra* note 32, at 2..

³⁶ See F. Comite et al., *Short-Term Treatment of Idiopathic Precocious Puberty with a Long-Acting Analogue of Luteinizing Hormone-Releasing Hormone — A Preliminary Report*, 305 NEW ENG. J. MED. 1546 (1981).

³⁷ See, e.g., Annemieke S. Staphorsius et al., *Puberty Suppression and Executive Functioning: An Fmri-Study in Adolescents with Gender Dysphoria*, 6 PSCYHONEUROENDOCRINOLOGY 190 (2015), <https://pubmed.ncbi.nlm.nih.gov/25837854> (no adverse impact on executive functioning); Ken C. Pang et al., *Long-term Puberty Suppression for a Nonbinary Teenager*, 145(2) PEDIATRICS e20191606 (2019), https://watermark.silverchair.com/peds_20191606.pdf (exceedingly low risk of delayed bone mineralization from hormone treatment).

may be used to initiate puberty consistent with the patient's gender identity.³⁸ Hormone therapy involves using gender-affirming hormones to allow adolescents to develop secondary sex characteristics consistent with their gender identity.³⁹ Hormone therapy is only prescribed when a qualified mental health professional ("MHP") has confirmed the persistence of the patient's gender dysphoria, the patient's mental capacity to assent to the treatment, and that any coexisting problems have been addressed.⁴⁰ A pediatric endocrinologist or other clinician experienced in pubertal induction must also agree with the indication, and the patient and their parents or guardians must be informed of the potential effects and side effects and give their informed consent.⁴¹ Although some of the changes caused by hormone therapy become irreversible after those secondary sex characteristics are fully developed, others are partially reversible if the patient discontinues use of the hormones.⁴²

The Guidelines contemplate that the prescription of puberty blockers and/or hormone therapy be coupled with education on the safe use of such medications and

³⁸ Martin, *supra* note 32, at 2.

³⁹ See AAP Policy Statement, *supra* note 4, at 6.

⁴⁰ Endocrine Soc'y Guidelines, *supra* note 23, at 3878 tbl.5.

⁴¹ See *id.*

⁴² See AAP Policy Statement, *supra* note 4, at 5–6.

close monitoring to mitigate any potential risks.⁴³ Decisions regarding the appropriate treatment for each patient with gender dysphoria are made in consultation with the patient, their parents or guardians, and the medical and mental health care team. There is “no one-size-fits-all approach to this kind of care.”⁴⁴

B. The Guidelines for Treating Gender Dysphoria Were Developed Through a Robust and Transparent Process, Employing the Same Scientific Rigor That Underpins Other Medical Guidelines.

The Guidelines are the product of careful and robust deliberation following the same types of processes—and subject to the same types of rigorous requirements—as other guidelines promulgated by *amici* and other medical organizations.

For example, the Endocrine Society’s Guidelines were developed following a 26-step, 26-month drafting, comment, and review process.⁴⁵ The Endocrine Society imposes strict evidentiary requirements based on the internationally recognized Grading of Recommendations Assessment, Development and Evaluation (GRADE) system.⁴⁶ That GRADE assessment is then reviewed, re-reviewed, and reviewed

⁴³ See Endocrine Soc’y Guidelines, *supra* note 23, at 3871, 3876.

⁴⁴ Martin, *supra* note 33, at 1.

⁴⁵ See, e.g., Endocrine Soc’y Guidelines, *supra* note 23, at 3872–73 (high-level overview of methodology).

⁴⁶ See Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. CLINICAL EPIDEMIOLOGY 383 (2011),

again by multiple, independent groups of professionals.⁴⁷ Reviewers are subject to strict conflict of interest rules, and there is ample opportunity for feedback and debate through the years-long review process.⁴⁸ Further, the Endocrine Society continually reviews its own guidelines and recently determined that the 2017 transgender care guidelines continue to reflect the best, most up-to-date available evidence.

First published in 1979, the WPATH Standards of Care are currently in their 8th Edition. The current Standards of Care are the result of a robust drafting, comment, and review process that collectively took five years.⁴⁹ The draft guidelines went through rigorous review and were publicly available for discussion and debate, receiving a total of 2,688 comments.⁵⁰ 119 authors were ultimately involved in the final draft, including feedback from experts in the field as well as

<https://ahpsr.who.int/docs/librariesprovider11/publications/supplementary-material/hsr-synthesis-guyatt-2011.pdf>; Gordon H. Guyatt et al., *GRADE: An Emerging Consensus on Rating Quality of Evidence and Strength of Recommendations*, 336 BMJ 924 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2335261/>.

⁴⁷ Endocrine Society, *Methodology*, <https://www.endocrine.org/clinical-practice-guidelines/methodology>.

⁴⁸ *See id.*

⁴⁹ *See* WPATH Guidelines, *supra* note 23, at S247–51.

⁵⁰ *See id.*

from transgender individuals and their families.⁵¹

C. Scientific Evidence Indicates the Effectiveness of Treating Gender Dysphoria According to the Guidelines.

Multiple studies indicate that adolescents with gender dysphoria who receive gender-affirming medical care experience improvements in their overall well-being.⁵² Nine studies have been published that investigated the use of puberty blockers on adolescents with gender dysphoria,⁵³ and nine studies have been

⁵¹ See *id.*

⁵² See Martin, *supra* note 33, at 2.

⁵³ See, e.g., Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Wellbeing of Transgender Youths: Preliminary Results*, 8 INT’L J PEDIATRIC ENDOCRINOLOGY 1–5 (2020), <https://pubmed.ncbi.nlm.nih.gov/32368216>; Polly Carmichael et al., *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People With Persistent Gender Dysphoria in the UK*, 16(2) PLOS ONE e0243894 (2021), <https://pubmed.ncbi.nlm.nih.gov/33529227>; Rosalia Costa et al., *Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria*, 12(11) J. SEXUAL MED. 2206–2214 (2015), <https://pubmed.ncbi.nlm.nih.gov/26556015>; Annelou L.C. de Vries et al., *Puberty Suppression In Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study*, 8(8) J. SEXUAL MED. 2276–2283 (2011), <https://pubmed.ncbi.nlm.nih.gov/20646177>; Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression And Gender Reassignment*, 134(4) PEDIATRICS 696–704 (2014), <https://pubmed.ncbi.nlm.nih.gov/25201798>; Laura E. Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) PEDIATRICS e20193006 (2020), <https://pubmed.ncbi.nlm.nih.gov/32220906>; Jack L. Turban et al., *Pubertal Suppression For Transgender Youth And Risk of Suicidal Ideation*, 145(2) PEDIATRICS e20191725 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269>; Anna I.R. van der

published that investigated the use of hormone therapy to treat adolescents with gender dysphoria.⁵⁴ These studies find positive mental health outcomes for those adolescents who received puberty blockers or hormone therapy, including statistically significant reductions in anxiety, depression, and suicidal ideation.⁵⁵

Miesen, *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*, 66(6) J. ADOLESCENT HEALTH 699–704 (2020); Diana M. Tordoff et al., *Mental Health Outcomes In Transgender And Nonbinary Youths Receiving Gender-Affirming Care*, 5(2) JAMA NETWORK OPEN e220978 (2022), <https://pubmed.ncbi.nlm.nih.gov/35212746/>.

⁵⁴ See, e.g., Christal Achille et al., *Longitudinal Impact of Gender-Affirming Endocrine Intervention on The Mental Health and Well-Being of Transgender Youths: Preliminary Results*, 8 INT’L J. PEDIATRIC ENDOCRINOLOGY 1–5 (2020), <https://pubmed.ncbi.nlm.nih.gov/32368216/>; Luke R. Allen et al., *Well-Being and Suicidality Among Transgender Youth After Gender-Affirming Hormones*, 7(3) CLINICAL PRAC. PEDIATRIC PSYCH. 302 (2019), <https://psycnet.apa.org/record/2019-52280-009>; Diane Chen et al., *Psychosocial Functioning in Transgender Youth after 2 Years of Hormones*, 388(3) NEW ENG. J. MED 240–50 (2023); Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93(1) ANALES DE PEDIATRIA 41–48 (English ed. 2020), <https://www.researchgate.net/publication/342652073>; Annelou L.C. De Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134(4) PEDIATRICS 696–704 (2014); Rittakerttu Kaltiala et al., *Adolescent Development And Psychosocial Functioning After Starting Cross-Sex Hormones For Gender Dysphoria*, 74(3) NORDIC J. PSYCHIATRY 213 (2020); Kuper, *supra* note 53; Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, J. ADOLESCENT HEALTH (2021), [https://www.jahonline.org/article/S1054-139X\(21\)00568-1/fulltext](https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext); Jack L. Turban et al., *Access To Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, J. PLOS ONE (2022), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0261039>.

⁵⁵ The data likewise indicates that adults who receive gender-affirming care

For example, a 2020 study analyzed survey data from 89 transgender adults who had access to puberty blockers while adolescents and from more than 3,400 transgender adults who did not.⁵⁶ The study found that those who received puberty blocking treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.⁵⁷ Approximately *nine in ten* transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.⁵⁸ Additionally, a longitudinal study of nearly 50 transgender adolescents found that suicidality was decreased by a statistically-significant degree after receiving gender-affirming hormone treatment.⁵⁹ A study published in January 2023, following 315 participants age 12 to 20 who received gender-affirming hormone treatment, found that the treatment was associated with decreased symptoms of depression and anxiety.⁶⁰

experience positive mental health outcomes. *See, e.g.,* Zoe Aldridge et al., *Long Term Effect of Gender Affirming Hormone Treatment on Depression and Anxiety Symptoms in Transgender People: A Prospective Cohort Study*, 9 ANDROLOGY 1808–1816 (2021).

⁵⁶ *See* Turban, *supra* note 53.

⁵⁷ *See id.*

⁵⁸ *See id.*

⁵⁹ *See* Allen, *supra* note 54.

⁶⁰ *See* Chen et al., *supra* note 54.

As another example, a prospective two-year follow-up study of adolescents with gender dysphoria published in 2011 found that treatment with puberty blockers was associated with decreased depression and improved overall functioning.⁶¹ A six-year follow-up study of 55 individuals from the 2011 study found that subsequent treatment with hormone therapy followed by surgery in adulthood was associated with a statistically significant decrease in depression and anxiety.⁶² “Remarkably, this study demonstrated that these transgender adolescents and young adults had a sense of well-being that was equivalent or superior to that seen in age-matched controls from the general population.”⁶³

As scientists and researchers, *amici* always welcome more research, including on this crucial topic. However, the available data indicate that the gender-affirming treatments prohibited by the Medicaid Ban are effective for the treatment of gender dysphoria. As the U.S. Court of Appeals for the Eighth Circuit recently recognized

⁶¹ See Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8(8) J. SEXUAL MED. 2276 (2011), <https://pubmed.ncbi.nlm.nih.gov/20646177>.

⁶² Annelou L.C. de Vries et al., *Young Adult Psychological outcome After Puberty Suppression and gender Reassignment*, 134(4) PEDIATRICS 696 (2014), <https://pubmed.ncbi.nlm.nih.gov/25201798>.

⁶³ Stephen M. Rosenthal, *Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist’s View*, 17(10) NATURE REV. ENDOCRINOLOGY 581, 586 (Oct. 2021), <https://pubmed.ncbi.nlm.nih.gov/34376826>.

in affirming an order preliminarily enjoining enforcement of a similar Arkansas law, “there is substantial evidence ... that the [Arkansas] Act prohibits medical treatment that conforms with the recognized standard of care.”⁶⁴

III. The GAPMS Report Is Factually Inaccurate and Ignores the Recommendations of the Medical Community.

The GAPMS Report asserts that puberty blockers, gender-affirming hormone therapy, and gender-affirming surgeries are not consistent with professional medical standards and that there is insufficient evidence that these interventions are safe and effective.⁶⁵ However, this assertion is premised on speculative and discredited claims about gender dysphoria and mischaracterizations of the Guidelines and scientific research regarding these gender-affirming medical interventions.

A. There is No Evidence That Gender Dysphoria Can Be Caused by Underlying Mental Illness or “Social Contagion”

The GAPMS Report speculates that mental health concerns such as depression and anxiety may cause individuals to develop a gender identity that is

⁶⁴ *Brandt ex rel. Brandt v. Rutledge*, 47 F.4th 661, 671 (8th Cir. Aug. 25, 2022); *see also Brandt v. Rutledge*, 551 F. Supp. 3d 882, 890 (E.D. Ark. 2021) (“The consensus recommendation of medical organizations is that the only effective treatment for individuals at risk of or suffering from gender dysphoria is to provide gender-affirming care.”).

⁶⁵ GAPMS Report, *supra* note 2, at 38.

incongruent with their sex assigned at birth.⁶⁶ However, the report cites no evidence for this assertion, and the scientific research suggests that the reverse is true: research has shown that transgender individuals frequently experience discrimination, harassment, and even violence on account of their gender identity,⁶⁷ and that these experiences lead to mental health concerns, including, for example, depression and anxiety.⁶⁸

The GAPMS Report also claims that exposure to “peer groups and social media that emphasized transgender lifestyles” can cause “rapid-onset gender dysphoria” in adolescents.⁶⁹ However, there is no credible evidence to support this

⁶⁶ GAPMS Report, *supra* note 2, at 6. (In light of the “number of adolescents who reported anxiety and depression diagnoses prior to transitioning,” the GAPMS Report asserts that “available research raises questions as to whether [individuals’] distress is secondary to pre-existing behavioral health disorders[.]”)

⁶⁷ See, e.g., Rebecca L. Stotzer, *Violence Against Transgender People: A Review of United States Data*, 14(3) AGGRESSION & VIOLENT BEHAV. 170–179 (2009); Joseph G. Kosciw et al., *The 2017 National School Climate Survey*, GLSEN, at 94 (2018), <https://www.glsen.org/sites/default/files/2019-10/GLSEN-2017-National-School-Climate-Survey-NSCS-Full-Report.pdf>; see also Amit Paley, *The Trevor Project 2020 National Survey*, <https://www.thetrevorproject.org/survey-2020/> (“Discrimination & Physical Harm” section) (noting that 40 percent of transgender students reported being physically threatened or harmed due to their gender identity).

⁶⁸ See Rylan J. Testa et al., *Suicidal Ideation in Transgender People: Gender Minority Stress and Interpersonal Theory Factors*, 126(1) J. ABNORMAL PSYCH. 125–36 (2017); Jessica Hunter et al., *Gender Minority Stress in Trans and Gender Diverse Adolescents and Young People*, 26(4) CLINICAL CHILD PSYCH. & PSYCHIATRY 1182–95 (2021).

⁶⁹ GAPMS Report at 12–13.

argument. The term “rapid onset gender dysphoria” was coined in 2018 by the author of an anonymous survey of parents of transgender youth, who were recruited from websites that promote the belief that “social contagion” causes transgender identity.⁷⁰ The survey, which is the only source cited by the GAPMS Report in support of its claim, suffers from numerous flaws and has been widely discredited.⁷¹ Moreover, the journal in which the survey was published subsequently published an extensive correction stating, among other things, that “[r]apid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis,” and that the “report did not collect data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon.”⁷²

⁷⁰ *Id.* at 12; Lisa Littman, *Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 14(3) PLOS ONE e0214157, at 2, 8–9 (Aug. 2018), <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330> (stating that survey participants were recruited from the websites YouthTransCriticalProfessionals.org, TransgenderTrend.com, and 4thWaveNow.com).

⁷¹ *See, e.g.,* Susan D. Boulware et al., *Biased Science: The Texas and Alabama Measures Criminalizing Medical Treatment for Transgender Children and Adolescents Rely on Inaccurate and Misleading Scientific Claims* 1, 18 (Apr. 28, 2022), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4102374.

⁷² Lisa Littman, *Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria*, 14(3) PLOS ONE e0214157 (Mar. 2019), <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0214157>.

Significantly, the GAPMS Report does not cite or even mention this correction.⁷³

Moreover, subsequent peer-reviewed research has not found support “for a new etiologic phenomenon of rapid onset gender dysphoria during adolescence.”⁷⁴ On the contrary, one recent study showed that most adolescents—nearly 70%—referred to a clinic for puberty blockers or hormone therapy had known their gender was different from the one assigned at birth for three or more years.⁷⁵ The study also showed no correlation between recent gender knowledge (defined as two years or less having passed since you “realized your gender was different from what other people called you”) and support from online friends or transgender friends.⁷⁶

⁷³ The GAPMS Report’s reliance on the survey is also puzzling: According to the report, studies (such as surveys) that “rel[y] heavily” on participants’ subjective responses “likely [have] biased and invalid” results. GAPMS Report. *supra* note 2, at 15.

⁷⁴ Greta R. Bauer et al., *Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria”?*, 243 J. PEDIATRICS 224, 225–26 (2022), [https://www.jpeds.com/article/S0022-3476\(21\)01085-4/pdf](https://www.jpeds.com/article/S0022-3476(21)01085-4/pdf) (“This putative phenomenon was posited based on survey data from a convenience sample of parents recruited from websites, and may represent the perceptions or experiences of those parents, rather than of adolescents, particularly those who may enter into clinical care.” (internal citations omitted)).

⁷⁵ *See id.* at 225 fig.

⁷⁶ *Id.* at 224–27.

B. The Vast Majority of Adolescents Diagnosed with Gender Dysphoria Will Persist Through Adulthood.

The GAPMS Report asserts that “the majority of young adolescents who exhibit signs of gender dysphoria eventually desist and conform to their natal sex[.]”⁷⁷ However, the sources it cites in support of its “desistance” claim—an editorial written by James Cantor and an “assessment” that Cantor prepared for AHCS—state only that “desistance” is common among *prepubertal children* with gender dysphoria.⁷⁸ The GAPMS Report improperly conflates prepubertal children with adolescents, which is an important distinction, as prepubertal children are not eligible under the Guidelines for any of the gender-affirming, medical interventions excluded from coverage by the Medicaid Ban.⁷⁹ The Guidelines endorse the use of medical interventions only to treat adolescents and adults with gender dysphoria, and only when the relevant criteria are met.⁸⁰

⁷⁷ GAPMS Report, *supra* note 2, at 14.

⁷⁸ *See id.* at 20, 27–28, 39; James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, J. Sex & Marital Therapy 307, 308–09 (2019), https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IES_OGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf (hereinafter “Cantor Editorial”); James M. Cantor, *The Science of Gender Dysphoria and Transsexualism* (May 17, 2022), GAPMS Report Attach. D ¶¶ 14–16 (hereinafter “Cantor Report”).

⁷⁹ *See* Boulware, *supra* note 71, at 18.

⁸⁰ *See* Endocrine Soc’y Guidelines, *supra* note 23, at 3871, 3879; WPATH

There are *no* studies to support the proposition that adolescents with gender dysphoria are likely to later identify as their sex assigned at birth, whether they receive treatment or not.⁸¹ On the contrary, “[l]ongitudinal studies have indicated that the emergence or worsening of gender dysphoria with pubertal onset is associated with a very high likelihood of being a transgender adult.”⁸²

Moreover, while desistance may occur for many reasons, detransitioning is not the same as regret. The State incorrectly assumes that an individual who detransitions—the definition of which varies from study to study⁸³—must do so because they have come to identify with their sex assigned at birth. This ignores the most common reported factors that contribute to a person’s choice to

Guidelines, *supra* note 23, at S32, S48.

⁸¹ See, e.g., Stewart L. Adelson, *Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Non-Conformity, and Gender Discordance in Children and Adolescents*, 51 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 957, 964 (2020), <https://pubmed.ncbi.nlm.nih.gov/22917211> (“In contrast, when gender variance with the desire to be the other sex is present in adolescence, this desire usually does persist through adulthood”).

⁸² Rosenthal, *supra* note 63, at 585.

⁸³ Michael S. Irwig, *Detransition Among Transgender and Gender-Diverse People—An Increasing and Increasingly Complex Phenomenon*, J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 1 (June 2022), <https://pubmed.ncbi.nlm.nih.gov/35678284> (“Detransition refers to the stopping or reversal of transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.”).

detransition, such as pressure from parents and discrimination.⁸⁴

In addition, while the percentage of adolescents seeking gender-affirming care has increased, that percentage remains very low—only 1.8% of high-school students identify as transgender.⁸⁵ Further, research supports that this increase in adolescents seeking care is very likely the result of reduced social stigma and expanded care options.⁸⁶

C. There Is No Accepted Protocol of “Watchful Waiting” for Adolescents with Gender Dysphoria.

Based on its unsupported claim that many adolescents with gender dysphoria will eventually come to identify as their sex assigned at birth, the GAPMS Report questions the medical necessity of puberty blockers and hormone therapy for adolescents and suggests that a “watchful waiting” approach may be more appropriate. In this regard, some practitioners use a “watchful waiting” approach for prepubertal children with gender dysphoria, which involves waiting until the patient reaches adolescence before considering social transition.⁸⁷ However,

⁸⁴ See *id.* (discussing “largest study to look at detransition”).

⁸⁵ See Michelle M. Johns et al., *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students — 19 States and Large Urban School Districts, 2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 67, 68 (2019), <https://pubmed.ncbi.nlm.nih.gov/30677012>.

⁸⁶ See Boulware, *supra* note 71, at 20.

⁸⁷ Jason Rafferty, *Ensuring Comprehensive Care & Support for Transgender &*

“watchful waiting” is not recommended for adolescents with gender dysphoria.⁸⁸

It can cause immense harm by denying these patients the evidence-based treatments that could alleviate their distress, and forcing them to experience full endogenous puberty, resulting in physical changes that may be reversed—if at all—only through surgery.⁸⁹

D. The International Medical Community Has Endorsed Gender-Affirming Care, Contrary to the State’s Assertions.

The GAPMS Report wrongly suggests that an international debate rages over whether to provide gender-affirming care, at all.⁹⁰ It attempts to rely on examples from, *inter alia*, France, Sweden, and Finland,⁹¹ but all of these countries provide gender-affirming care to adolescents when medically indicated. France’s

Gender-Diverse Children & Adolescents, Am. Acad. of Pediatrics, at 4 (Oct. 2018).

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ See GAPMS Report at 35–37.

⁹¹ The GAPMS report also discusses the United Kingdom. See *id.* at 36. Policies regarding gender-affirming care for adolescents vary throughout the jurisdictions in the United Kingdom and permit gender affirming medical care for adolescents. See, e.g., NHS Services, *The Young People’s Gender Service*, available at https://www.sandyford.scot/media/4173/304280_2_0-yp-gender-service-information_s-1.pdf. The NHS in England and Wales recently closed a public comment period on an interim service specification that may alter some of their policies regarding gender-affirming medical treatments for adolescents. The interim service specification has yet to be published, and a non-interim (i.e. “a national service specification”) is not expected for several months.

health care system covers gender-affirming care for young people.⁹² Sweden offers gender-affirming care through its national health care system, and youth in Sweden are able to access gender-affirming care when their providers deem it medically necessary.⁹³ Finland also offers gender-affirming care to transgender adolescents through its national healthcare system.⁹⁴

Transgender youth also have access to gender-affirming care in developed

⁹² See Emmanuel Allory et al., *The Expectations of Transgender People in the Face of their Health-Care Access Difficulties and How They Can Be Overcome: A Qualitative Study in France*, 21 PRIMARY HEALTH CARE RSCH. & DEV. 1, 2 (2020), <https://www.cambridge.org/core/services/aop-cambridge-core/content/view/A0A151385D44C3FB8B971956DBFB5EFF/S1463423620000638a.pdf/div-class-title-the-expectations-of-transgender-people-in-the-face-of-their-health-care-access-difficulties-and-how-they-can-be-overcome-a-qualitative-study-in-france-div.pdf>.

⁹³ See *Care of Children and Adolescents with Gender Dysphoria: Summary*, SOCIALSTYRELSEN (2022), <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>.

⁹⁴ *Recommendation (In Finnish)*, COHERE (June 2020), <https://palveluvalikoima.fi/documents/1237350/22895838/Transsukupuolisuus+suositus.pdf/82b60104-291c-7d8c-9e88-1b1fc9bba527/Transsukupuolisuus+suositus.pdf?t=1592318544000>.

nations across the world including Australia,⁹⁵ Canada,⁹⁶ Denmark,⁹⁷ Germany,⁹⁸ Mexico,⁹⁹ New Zealand,¹⁰⁰ Norway,¹⁰¹ and Spain,¹⁰² among others. Although some of these countries have debated how best to care for transgender patients,

⁹⁵ See *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*, ROYAL CHILDREN'S HOSP. MELBOURNE (Oct. 2021), https://auspath.org.au/wp-content/uploads/2021/10/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents_v1-3.pdf.

⁹⁶ See Greta R. Bauer et al., *Transgender Youth Referred to Clinics for Gender-Affirming Medical Care in Canada*, 148(5) PEDIATRICS 1 (2021).

⁹⁷ See *Guidelines on Healthcare Concerning Gender Identity Matters*, RETSINFORMATION (2018), <https://www.retsinformation.dk/eli/retsinfo/2019/9060>.

⁹⁸ See *Ethics Council Publishes Ad Hoc Recommendation on Transgender Identity in Children and Adolescents*, GERMAN ETHICS COUNSEL (Feb. 20, 2020), <https://www.ethikrat.org/mitteilungen/mitteilungen/2020/deutscher-ethikrat-veroeffentlicht-ad-hoc-empfehlung-zu-trans-identitaet-bei-kindern-und-jugendlichen>.

⁹⁹ See *Protocol for Access Without Discrimination to Health Care Services for Lesbian, Gay, Bisexual, Transsexual, Transvestite, Transgender and Intersex Persons and Specific Care Guidelines*, GOV'T OF MEX. (June 15, 2020), https://www.gob.mx/cms/uploads/attachment/file/558167/Versi_n_15_DE_JUNIO_2020_Protocolo_Comunidad_LGBTTI_DT_Versi_n_V_20.pdf.

¹⁰⁰ See *Transgender New Zealanders: Children and Young People*, NEW ZEALAND MINISTRY OF HEALTH (2020), <https://www.health.govt.nz/your-health/healthy-living/transgender-new-zealanders/transgender-new-zealanders-children-and-young-people>.

¹⁰¹ See *Gender Incongruence: National Academic Guideline*, HELSEDIREKTORATET (2020), <https://www.helsedirektoratet.no/retningslinjer/kjonnsinkongruens>.

¹⁰² See Diego Lopez de Lara et al., *Psychosocial Assessment in Transgender Adolescents*, 93 ANALES DE PEDIATRÍA ENGLISH EDITION 1 (2020), <https://europepmc.org/article/MED/32144041>.

none have come close to banning gender-affirming care for all minors.¹⁰³ As described below, the Medicaid Ban would make Florida an outlier in the international medical community, not the norm.

IV. The Medicaid Ban Would Irreparably Harm Many Medicaid Recipients with Gender Dysphoria By Denying Them the Treatment They Need.

The Medicaid Ban denies Medicaid recipients in Florida with gender dysphoria access to medical interventions that are designed to improve health outcomes and alleviate suffering and that are grounded in science and endorsed by the medical community. The medical treatments excluded from coverage by the Medicaid Ban can be a crucial part of treatment for adolescents with gender dysphoria and necessary to preserve their health. As discussed above, research shows that adolescents with gender dysphoria who receive puberty blockers and/or hormone therapy experience less depression, anxiety, and suicidal ideation. Several studies have found that hormone therapy is associated with reductions in the rate of suicide attempts and significant improvement in quality of life.¹⁰⁴ In light of this

¹⁰³ See *Brandt*, 47 F.4th 661, 671 (observing that “[e]ven international bodies that consider hormone treatment for adolescents to be ‘experimental’ have not banned the care” implicated by the Arkansas law banning gender-affirming care).

¹⁰⁴ See M. Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72(2) CLINICAL ENDOCRINOLOGY 214 (Feb. 2010), <https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2265.2009.03625.x>; see also Turban, *supra* note 53.

evidence supporting the connection between lack of access to gender-affirming care and lifetime suicide risk, banning such care can put patients' lives at risk.

CONCLUSION

For the foregoing reasons, Defendants' motion for summary judgment should be denied.

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CERTIFICATE OF SATISFACTION OF ATTORNEY-CONFERENCE REQUIREMENT

Pursuant to Local Rule 7.1(B), counsel for *amici* conferred with counsel for the parties on April 28, 2023. Plaintiffs and Defendants consented to the filing of *amici's* brief.

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