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IN THE SUPREME COURT OF MISSOURI

NO. SC100933

E.N., individually and as a next friend on behalf of her minor child N.N., et al.

***Plaintiffs/Appellants*,**

v.

MIKE KEHOE, in his official capacity as Governor of Missouri, et al.

***Defendants/Respondents*.**

APPEAL FROM THE CIRCUIT COURT

OF COLE COUNTY, MISSOURI

The Honorable R. Craig Carter

AMICUS CURIAE BRIEF OF THE NATIONAL HEALTH LAW PROGRAM SUPPORTING APPELLANTS

FILED WITH CONSENT OF ALL PARTIES

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CONSENT OF PARTIES TO FILING THE *AMICUS CURIAE* BRIEF

Pursuant to Missouri Supreme Court Rule 84.05(f)(2), *Amicus Curiae* certify that all parties have consented to the filing of this brief.

IDENTITY OF *AMICUS CURIAE* AND STATEMENT OF INTEREST

The National Health Law Program ("NHeLP") submits this brief to provide additional context about the federal laws that govern the Medicaid program and the importance of the Medicaid program to low-income people in Missouri.

Founded in 1969, NHeLP advocates, educates, and litigates at the federal and state levels to further its mission of improving access to quality health care for low-income and underserved people, particularly those eligible for Medicaid.

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ARGUMENT

In 2023, the State of Missouri drastically restricted medically necessary gender-affirming care for transgender Missourians by enacting the Missouri Save Adolescents from Experimentation (SAFE) Act. While the title suggests that the Act is limited to adolescents, it prohibits Medicaid coverage of gender-affirming care for individuals of all ages.[1] *See* R.S. Mo. §208.152.15. On November 25, 2024, the Circuit Court of Cole County, Missouri held that the SAFE Act was constitutional. *See Noe ex. rel Noe v. Parson et al.*, 23AC-CC-4530 (Mo. Cir. Ct. Nov. 25, 2004) (hereinafter "Circuit Court Decision"). In its decision, the Circuit Court concluded that it is permissible for Missouri to prohibit Medicaid coverage of medically necessary gender-affirming services. In doing so, the Circuit Court misconstrued Title XIX of the Social Security Act. *See* 42 U.S.C. §§ 1396-1396w-8 (the "Medicaid Act").

I. SCOPE OF THIS BRIEF

NHeLP submits this brief to address the errors in the Circuit Court's discussion of the Medicaid coverage ban and to further inform the Court of the real-world impact of Medicaid coverage for transgender Missourians.

The Circuit Court held that Plaintiffs had not adequately pled or argued a challenge to the Medicaid provisions of the SAFE Act. *See* Circuit Court Decision at 46-47. The

[1] In *United States v. Skrmetti*, No. 23-477, 2025 WL 1698785 (U.S. June 18, 2025), the Court examined whether a state law prohibiting certain gender-affirming care for minors violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. The decision did not involve Medicaid coverage of gender-affirming care for transgender adults.

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Circuit Court also suggested that Plaintiffs lack standing to challenge the Medicaid coverage ban. *Id.* at 48. Those issues are beyond the scope of this Brief. Should the Court conclude that the point was not adequately pled or argued below, or that no Plaintiff has standing to bring the challenge, NHeLP respectfully suggests that the Court should not address the issue, other than to state that it expresses no view of the Circuit Court's discussion of the merits of the Medicaid Act claims. *Weber v. St. Louis County*, 342 S.W.3d 318, 323 (Mo. banc 2011) ("If a party is without standing to bring a particular claim, a court shall dismiss the claim because the court lacks the authority to decide the merits of the claim."); *In re Estate of Shaw*, 256 S.W.2d 72 (Mo. banc 2008) (an appellate court's "jurisdiction does not extend to a determination of the appeal on its merits unless the trial court had jurisdiction to determine the issues presented on their merits.")

II. THE CIRCUIT COURT OPINION MISCONSTRUED FEDERAL MEDICAID LAW.

A. Medicaid Is a Federal-State Partnership Program, and State Discretion Is Limited by Federal Law.

Title XIX of the Social Security Act establishes the federal-state partnership program known as Medicaid. Congress enacted the Medicaid program to enable states to provide medical assistance to families and individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1. States do not have to participate in Medicaid, but all states do. Each participating state must: (1) designate a single state agency that is responsible for administering the state's Medicaid program, 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10; and (2) operate its program according to a state plan that has been approved by the Secretary of the U.S. Department

of Health and Human Services, 42 U.S.C. §§ 1396a, 1396c. The state plan describes the nature and scope of the state's program and affirms the state's commitment to adhere to the requirements imposed by the Medicaid Act and implementing regulations. 42 C.F.R. § 430.10; *see Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004) ("[O]nce a State elects to join the program, it must administer a state plan that meets federal requirements."); *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006) ("[I]f a state decides to participate [in the Medicaid program], it must comply with all federal statutory and regulatory requirements."); *Bechtel ex rel. Bechtel v. State Dep't of Soc. Servs., Fam. Support Div.*, 274 S.W.3d 464, 467 (Mo. 2009) (recognizing that Missouri "must comply with all federal statutory and regulatory requirements" in administering its Medicaid program); *Mo. Div. of Fam. Servs. v. Wilson*, 849 S.W.2d 104, 106 (Mo. Ct. App. 1993) ("Federal law governs Missouri's participation in the Medicaid program.").

The federal government reimburses states for a portion of "the total amount expended … as medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1); *see also* 42 U.S.C. § 1396d(b) (establishing reimbursement formulas); Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2024 through September 30, 2025, 88 Fed. Reg. 81092 (Nov. 21, 2023) (setting federal reimbursement for Missouri at approximately 65%).

The Medicaid Act describes the population groups that are eligible to receive coverage. 42 U.S.C. § 1396a(a)(10)(A), (C). States must provide medical assistance to certain groups. 42 U.S.C.§ 1396a(a)(10)(A)(i) (the "mandatory categorically needy").

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States have the option to cover additional groups. 42 U.S.C. §§ 1396a(a)(10)(A)(ii) (the "optional categorically needy"), 1396a(a)(10)(C) (the "medically needy").

The Medicaid Act also describes the health care services that beneficiaries can receive. For categorically needy adult populations, states are mandated to cover some categories of services and have the option to cover additional services. 42 U.S.C. § 1396a(a)(10)(A) (requiring states to cover at least the services described in §§ 1396d(a)(1)-(5), (13)(B), (17), (21), (28), (29), and (30)); 42 C.F.R. § 440.210 (listing mandatory services for the categorically needy). For example, mandatory categories of services include inpatient hospital services, outpatient hospital services, laboratory and x-ray services, and services provided by a physician. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1), 1396d(a)(2)(A), 1396d(a)(3)(A), 1396d(a)(5)(A). Optional categories include outpatient prescription drugs, among others. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(12).

The Medicaid Act requires states to ensure that the coverage provided "to any [categorically needy] individual" is not "less in amount, duration, or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B); *see* 42 C.F.R. § 440.240(a). Federal regulations make clear that states "may not arbitrarily deny or reduce the amount, duration, or scope of a required service … to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c). Courts have repeatedly held that these requirements prohibit "discrimination among individuals with the same medical needs stemming from different medical conditions." *Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016); *see White v. Beal*, 555 F.2d

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1146, 1151(3d Cir. 1977) (the Medicaid Act "must be construed to envision an evenhanded sharing of benefits and burdens among those having the same needs."); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 993 (N.D. Cal. 2010) ("[T]he Medicaid Act mandates comparable services for individuals with comparable needs and is violated when some recipients are treated differently than others where each has the same level of need.").

In addition, for both mandatory and optional categories of services, long-standing federal regulations require states to cover the services in sufficient "amount, duration, and scope to reasonably achieve their purpose." 42 C.F.R. § 440.230(b). States may place appropriate limits on covered services based on "medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d); *see* 42 U.S.C. § 1396a(a)(30)(A).[2]

B. Federal Medicaid Law Requires States to Cover Medically Necessary Services.

The Circuit Court was correct that Medicaid "is designed to advance cooperative federalism," and that federal law establishes a floor regarding coverage. *See* Circuit Court Decision at 47 (quoting *Wisc. Dep't of Health and Fam. Servs. v. Blumer*, 534 U.S. 473, 495 (2002)). However, it misunderstood the nature of that floor, asserting that States have the discretion to exclude coverage of medically necessary services. *See* Circuit Court Decision at 47 (Missouri properly "excludes all kinds of procedures that a physician may

[2] While federal regulations do not define "utilization controls," courts have made clear that they are designed to safeguard against unnecessary use of Medicaid services and cannot preclude access to medically necessary care. *See, e.g.*, *Bontrager v. Ind. Fam. & Soc. Servs. Admin.,* 697 F.3d 604, 611 (7th Cir. 2012).

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determine to be medically necessary"). As explained below, States do not have that discretion.

The principle that states must provide coverage for "medically necessary" services has been "judicially accepted as implicit to the legislative scheme" of the Medicaid Act. *Pinneke v. Prisker*, 623 F.2d 546, 548 n.2 (8th Cir. 1980). Indeed, numerous courts have determined that the Medicaid Act requires a state to cover services when they: (1) fall within a category of mandatory medical services or optional medical services that the state has elected to provide; and (2) are "medically necessary" for a particular individual. *See, e.g., Lankford*, 451 F.3d at 511 ("[F]ailure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid."); *Bontrager*, 697 F.3d at 608 (7th Cir. 2012) (a state may not "den[y] coverage for medically necessary dental services outright"); *Alvarez v. Betlach*, 572 Fed. Appx. 519, 521 (9th Cir. 2014) (the Medicaid Act "prohibits states from denying coverage of 'medically necessary' services that fall under a category in their Medicaid plans"); *McNeil-Terry v. Roling*, 142 S.W.3d 828, 838 (Mo. Ct. App. 2004) (state limit on Medicaid coverage of dental services violated federal Medicaid regulations because it "was not rationally related to the federal purpose of treating dental disease, injury, or impairment that may affect the oral or general health of Medicaid-eligible adults").

In suggesting that Missouri has the authority to categorically ban coverage of medically necessary treatment, the Circuit Court made errors in its interpretation of federal case law. First, the Circuit Court relied on three U.S. Supreme Court decisions, *Beal v.*

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Doe, 432 U.S. 438 (1977), *Harris v. McRae*, 448 U.S. 297 (1980), and *Rust v. Sullivan*, 500 U.S. 173 (1991), that do not support the Circuit Court's conclusion that states need not fund medically necessary services.

In *Beal v. Doe*, the Court concluded that the Medicaid Act does not require states to provide coverage of "nontherapeutic" abortions. 432 U.S. at 447. The decision rested on the premise that the abortion services at issue were *not* medically necessary. The *Beal* Court, therefore, was careful to distinguish between the exclusion of medically necessary and medically unnecessary services, stating that "[a]though serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services." *Id.* at 444.

In *Harris v. McRae*, the Court examined the question of whether the Medicaid Act requires states to use their own funds to cover the cost of medically necessary abortions when Congress had prohibited the use of federal funds for that purpose. 448 U.S. at 301. The Court concluded that, because Congress "did not intend a participating State to assume a unilateral funding obligation for any health service in an approved Medicaid plan," states did not have an obligation to cover medically necessary abortions for which federal reimbursement is not available. *Id.* at 309.

Unlike the services in *Harris*, federal Medicaid funds are available for the services at issue in this matter. No federal law currently restricts Medicaid reimbursement for medically necessary gender-affirming care, and numerous state Medicaid programs cover the gender-affirming care that the SAFE Act excludes from coverage. *See, e.g.*, Ill. Admin.

Code tit. 89, § 140.413(a)(16) (detailing coverage requirements for "Gender-affirming Surgeries, Services and Procedures."); Minn. Stat. § 256B.0625, subd. 3a (setting forth that the state Medicaid program covers "gender-affirming care").

In *Rust*, the Court upheld regulations that prohibited agencies that receive federal funding under Title X from providing abortion counseling. 500 U.S. at 193. The Circuit Court cited *Rust* for the proposition that the "government may 'fund one activity to the exclusion of the other.'" Circuit Court Decision at 46 (quoting *Rust*, 500 U.S. at 193). *Rust* is not a Medicaid case. Nor does it construe the Medicaid Act or any other provision of federal Medicaid law. The decision, therefore, is inapposite.

The Circuit Court also incorrectly applied *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980). The Circuit Court inserted an out-of-context quote from *Rush* to suggest that Missouri is prohibited from providing coverage for treatment that is not medically necessary. *See* Circuit Court Decision at 47 (quoting *Rush*, 625 F.2d at 1156). The excerpted quote, moreover, comes directly from 42 U.S.C. § 1395y(a)(1), a federal law governing the *Medicare* – not the *Medicaid* – program. The *Rush* court acknowledged the difference between the laws governing Medicare and Medicaid, and explained that "[t]he statute creating Medicare, unlike that creating the Medicaid program, sets out specific statutory limitations on what types of care are to be provided." *Rush*, 625 F.2d at 1156. On the other hand, "the Medicaid statutes and regulations permit a state to define medical necessity in a way tailored to the requirements of its own Medicaid program." *Id.* Nothing

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in *Rush* indicates that Medicaid coverage of medically necessary gender-affirming care is prohibited.[3]

Indeed, courts nationwide have recognized that states must cover gender-affirming care when medically necessary for a particular Medicaid beneficiary.[4] *See Kadel v. Folwell*, 100 F.4th 122, 161 (4th Cir. 2024), *cert. granted, opinion vacated sub nom. Folwell v. Kadel*, No. 24-99, 2025 WL 1787687 (U.S. June 30, 2025)[5]; *Ellis ex rel. Ellis v. Patterson*, 859 F.2d 52, 54 (8th Cir. 1988) ("relying on language in [*Beal*,] courts have held that Medicaid must fund these services whenever they are 'medically necessary'."); *Dekker v. Weida*, 679 F. Supp. 3d 1271, 1288 (N.D. Fla. 2023), *argued*, No. 23-12155 (11th Cir. Nov. 22, 2024); *Flack v. Wis. Dep't of Health Servs.*, 395 F.Supp.3d 1001, 1015,

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[3] The Circuit Court also erroneously relied on a state provider manual. *See* Circuit Court Decision at 47 (citing MoHealthNet, *Ambulatory Surgical Center Provider Manual* (Mar. 7, 2024), https://mydss.mo.gov/media/pdf/ambulatory-surgical-center-provider-manual). First, a provider manual cannot be used to justify a violation of the Medicaid Act's requirement to provide coverage of medically necessary care. Contrary to the Circuit Court's suggestion, moreover, the Missouri Medicaid Ambulatory Surgical Center (ASC) Provider Manual does not indicate that the state excludes coverage of medically necessary services. Rather, it simply states that certain services "are not covered by [Medicaid] as ASC services." *See* ASC Provider Manual at 13. It does not apply to services provided elsewhere; but only to those that are not appropriate for an Ambulatory Surgical Center.

[4] As detailed more fully in Appellant's brief, the record in this matter demonstrates that gender affirming care is medically necessary for many transgender individuals. *See, e.g.* Trial Tr. Vol. 1 at 142:6-146:15; Vol. 2 at 330:8-20, 333:7-12, 344:17-23, 362:1-12, 377:11-19; Vol. 3 at 584:17-25, 585:1-17; 591:21-25, 592:1-7, 594:2-25, 723:7-10; 853:12-16; *see also* Pls. Tr. Ex. 5, 84 & 306.

[5] In *Kadel*, the Fourth Circuit held that West Virginia's Medicaid coverage ban violated the Equal Protection Clause and the Medicaid Act. The Supreme Court remanded for reconsideration in light of *Skrmetti*. As noted above, *Skrmetti* would have no bearing on the Fourth Circuit's decision that the Medicaid coverage ban violated the Medicaid Act.

1018 (W.D. Wis. 2019)); *Cruz v. Zucker*, 195 F. Supp. 3d 554, 571 (S.D.N.Y. 2016), *on reconsideration*, 218 F. Supp. 3d 246, 248 (S.D.N.Y. 2016).

In sum, the federal case law cited by the Circuit Court does not support a decision that the Medicaid Act permits states to exclude medically necessary care.

C. Missouri Cannot Evade its Obligation to Cover Medically Necessary Services Due to Fiscal Concerns.

In support of its decision, the Circuit Court concluded that Missouri's refusal to provide Medicaid coverage of medically necessary treatment was justified because states "must triage" their limited funding and decide what to cover based on "which procedure will lead to the best outcomes overall." *See* Circuit Court Decision at 46. This proposition is without legal support. States cannot evade federal coverage requirements because of financial concerns. *See, e.g., Pashby v. Delia*, 709 F.3d 307, 331 (4th Cir. 2013) ("[S]tate budgetary concerns cannot be the conclusive factor in decisions regarding Medicaid.") (cleaned up); *Bontrager*, 697 F.3d at 611 ("[P]otential budgetary concerns … do not outweigh Medicaid recipients' interests in access to medically necessary health care."); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 659 (9th Cir. 2009) ("A budget crisis does not excuse ongoing violations of federal [Medicaid] law. . . ."); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993) ("[T]he state may not ignore the Medicaid Act's requirements in order to suit budgetary needs."); *Ala. Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5th Cir. 1980) ("Inadequate state appropriations do not excuse noncompliance [with the Medicaid Act]."); *see also McNeil-Terry*, 142 S.W.3d at

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834 (recognizing that any fiscal constraints that Missouri places on a Medicaid service "must not interfere with the purpose of offering that medical service in the first instance").

Moreover, *Ellis*, which the Circuit Court cited to bolster is decision, *see* Circuit Court Decision at 46, does not hold that states may refuse to provide Medicaid coverage for medically necessary treatment due to fiscal concerns. On the contrary, the *Ellis* court recognized that if a state elects to provide optional Medicaid services, those services "must be reasonably funded." *Id.* at 56. *Ellis* also confirmed that states are required to cover medically necessary care, in the absence of explicit congressional intent that a specific procedure need not be covered. *Id.* at 55.

Budgetary concerns are not an acceptable rationale to deny coverage of medically necessary care.

III. MEDICAID IS CRITICAL FOR TRANSGENDER MISSOURIANS.

The Circuit Court decision ignores the real world importance of Medicaid for transgender Missourians. This is especially so as the bulk of the Circuit Court's analysis focuses on gender-affirming care for youth, ignoring that the SAFE Act prevents both minor and adult Missourians from accessing Medicaid coverage of medically necessary gender-affirming care.

Medicaid ensures that the lowest income Missourians have access to medically necessary health care. To qualify for Medicaid, individuals must meet strict income requirements. For a single adult to qualify for full Medicaid coverage in Missouri, their income must be less than or equal to 133% of the federal poverty level. Mo. Const. art.

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IV, § 36(c). A single person who earns more than $20,814 per year, therefore, does not qualify.[6]

Transgender individuals are statistically more likely to be living in poverty as compared to the general U.S. population, meaning they are more likely to rely on Medicaid for their health care coverage. *See* Bryan Mena, *These millions of Americans are more likely to live in poverty, be unemployed and have no family support*, CNN (July 13, 2024).[7]

In contrast with Missouri's stringent income limits for Medicaid eligibility, the cost of living in Missouri is rapidly rising. The U.S. Bureau of Economic Analysis tracks state-by-state "personal consumption expenditures" (PCE), which measure "consumer spending on goods and services among households in the U.S." U.S. Bureau of Labor Statistics, *Consumer Expenditure Surveys* (last modified Nov. 9, 2023).[8] The total PCE for Missouri in 2023 was $52,097 person. *See* U.S. Bureau of Economic Analysis, *Table 4. Per Capita Personal Consumption Expenditures by State, 2023* (Oct. 3, 2024).[9] This figure is $12,000 more than it was just five years prior. *See* U.S. Bureau of Economic Analysis, *Table 4. Per Capita Personal Consumption Expenditures by State, 2018* (Oct. 3, 2019) (the PCE in

[6] The U.S. Department of Health and Human Services annually updates the federal poverty guidelines (commonly referred to as the federal poverty level or "FPL"). In 2025, the FPL for a single person is only $15,650, and the FPL for a family of three is only modestly more at $26,650. *See* Annual Update of the HHS Poverty Guidelines, 90 FR 5917 (Jan. 15, 2025) (notice).

[7] https://www.cnn.com/business/economy/transgender-americans-economy.

[8] https://www.bls.gov/cex/cecomparison/pce_profile.htm.

[9] https://www.bea.gov/sites/default/files/2024-10/pce1024.pdf.

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Missouri in 2018 was $40,060).[10] Similarly, the April 2025 consumer price index for the St. Louis, Missouri area indicates that the overall cost of consumer goods and services such as food, housing, and medical expenses increased by 2.2% during the period of April 2024 to April 2025. U.S. Bureau of Labor Statistics, Consumer Price Index, St. Louis Area – April 2025.[11] These increases are typical of those seen across the State of Missouri, making it difficult for Missourians to make ends meet. A recent study from the Massachusetts Institute of Technology indicates that a household of three in Missouri, with one working adult and one child, must earn a minimum of $73,180 annually to meet the family's basic needs under its "living wage" standard. *See* Living Wage Institute, *Living Wage Calculation for Missouri*.[12]

Facing a cost of living that is multiple times higher than the levels of income that qualify them for Medicaid, many Missourians have struggled to cover their living expenses such as food, housing, and other essentials. One study estimates that 15.4% of Missouri's population, around 951,330 individuals, experience food insecurity, which is "when a household cannot access enough food due to a lack of money and other essential resources." Feeding America, *Food Insecurity among the Overall Population in*

[10] https://www.bea.gov/sites/default/files/2019-10/pce1019_0.pdf

[11] https://www.bls.gov/regions/mountain-plains/news-release/consumerpriceindex_stlouis.htm (last modified May 13, 2025)

[12] The Living Wage Calculator estimates "the local wage rate that a full-time worker requires to cover the costs of their family's basic needs where they live." Living Wage Institute, *Living Wage Calculator*, https://livingwage.mit.edu/ (last visited June 30, 2025). https://livingwage.mit.edu/states/29 (last updated Feb. 10, 2025)

Missouri.[13] In addition, from the time period of January 2023 to January 2024, "[r]ents rose faster in Missouri . . . than any other state in the U.S." Savannah Hawley-Bates, *Rents in Kansas City and Missouri are rising faster than almost anywhere else in the U.S.*, KCUR (Feb. 28, 2024).[14]

With the rising cost of living in Missouri, along with restrictive income eligibility criteria, Missouri's Medicaid program is exceedingly important for many Missourians. Without Medicaid, working Missourians who are struggling to put a meal on the table and pay their rent have no viable means to cover their necessary medical expenses. Medicaid coverage is especially important for the lowest income Missourians, because it provides access to a wide range of health care services, including preventive care, primary care, specialist care, hospital care, prescription drugs, and mental health services. Medicaid also covers many long-term care services, such as nursing home care and home health care, which can be very expensive for families to pay for out-of-pocket.

Access to gender-affirming care is associated with improved mental health and reduced risk of suicide among Transgender individuals. *See* Sari L. Reisner, et al., *Gender-Affirming Hormone Therapy and Depressive Symptoms Among Transgender Adults*, 8 JAMA Network Open 3 (2025),[15] (gender-affirming hormone therapy was "associated with lower rates of moderate-to-severe depressive symptoms" in transgender Adults); Anthony

[13] https://map.feedingamerica.org/county/2023/overall/missouri (last visited, June 13, 2025).

[14] https://www.kcur.org/housing-development-section/2024-02-28/rents-kansas-city-missouri-housing-prices-affordable-kc-tenants.

[15] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2831643.

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N. Almazan et al., *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA Surgery 611, 611 (2021),[16] ("undergoing 1 or more types of gender-affirming surgery was associated with lower past-month psychological distress . . ., past-year smoking . . ., and past-year suicidal ideation").

If low-income transgender Missourians cannot access gender-affirming care through Medicaid, they will likely not receive care at all, due to its high cost. Accordingly, for those who are eligible for Medicaid, coverage of gender-affirming care is crucial for improving health outcomes and reducing health disparities for transgender and gender non-conforming individuals.

CONCLUSION

The Circuit Court's discussion of the Medicaid issue erroneously indicated that the Medicaid Act permits Missouri to deny coverage for medically necessary gender-affirming care. The Court should either (1) correct that error or (2) make clear that its decision does not address the issue.

[16] https://jamanetwork.com/journals/jamasurgery/fullarticle/2779429.

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CERTIFICATE OF COMPLIANCE AND SERVICE

I hereby certify that this Brief:

1. includes the information required by Supreme Court Rule 55.03;

2. was served upon all counsel of record through the Court's electronic filing system, pursuant to Supreme Court Rule 103.08, on July 8, 2025;

3. complies with the limitations contained in Supreme Court Rule 84.06(b); and

4. contains 5,420 words, excluding the cover page, signature block, and this certification, as counted by Stinson's word-processing system.

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