

March 28, 2016

Department of Defense
Office of the Deputy Chief Management Officer
Directorate of Oversight and Compliance
Regulatory and Audit Matters Office
9010 Defense Pentagon
Washington, D.C. 20301-9010

**RE: TRICARE; Mental Health and Substance Use Disorder Treatment, Proposed Rule,
RIN 0720-AB65**

To Whom It May Concern:

The American Civil Liberties Union, Human Rights Campaign, National Center for Lesbian Rights, National Center for Transgender Equality, Palm Center, and Transgender Law Center appreciate the opportunity to provide comments in response to this Notice of Proposed Rulemaking. We support the Department of Defense's commitment to providing comprehensive medical care for members of the armed forces and eligible dependents, including those who are transgender. We applaud the Department of Defense (Department) for its recognition that the broad coverage exclusions for treatments of gender dysphoria in the current TRICARE Policy Manual are no longer justifiable and contradict contemporary medical science and practice. We therefore strongly support the proposed rule inasmuch as it would increase eligible individuals' access to medically necessary care.

We are concerned, however, that the Department's view that it must continue to exclude surgical treatments for gender dysphoria is based on a significant misinterpretation of federal law. Our comment explains why 10 U.S.C. § 1079(a)(11) does not require blanket exclusions for either surgical or non-surgical treatment for gender dysphoria. In accordance with federal statutes and the Department's policy of ensuring access to medically necessary care for TRICARE recipients, we therefore urge the Department to remove all categorical exclusions for the care of gender dysphoria from the regulations.

I. The proposed rule properly recognizes that exclusions related to gender dysphoria are medically unjustifiable.

It is the overwhelming consensus among medical experts that transition-related treatments, including surgical procedures, are medically necessary, effective and safe when clinically indicated to alleviate gender dysphoria.¹ Numerous research trials and meta-analyses have demonstrated the significant benefits of transition-related care in the treatment of gender dysphoria.² While inadequately treated gender dysphoria is correlated with negative physical and

¹ Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition 451 (2013).

² William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES OF SEXUAL BEHAVIOR 759 (2012); Marco Colizzi, Rosalia Costa & Orlando Todarello,

mental health outcomes, the vast majority of studies have shown that surgical care and other transition-related treatments have a clearly beneficial impact on individuals with gender dysphoria.³

In accordance with current scientific research, every major medical association in the United States recognizes the safety, efficacy and necessity of medical interventions for gender dysphoria, including appropriate surgical treatments, and opposes coverage exclusions for transition-related care.⁴ This consensus informed the U.S. Department of Health and Human Services' decision to overturn Medicare's ban on transition-related care,⁵ as well as its 2015 proposed rule clarifying that such bans constitute gender-based discrimination under the Affordable Care Act.⁶ The "evolving professional consensus that treatment may be medically necessary to address a diagnosis of gender dysphoria" also informed the Office of Personnel Management's June 2015 carrier letter prohibiting such exclusions in federal employee health plans.⁷

Current medical science therefore strongly supports the Department's recognition that "it is no longer justifiable to categorically exclude and not cover currently accepted medically and psychologically necessary treatments for gender dysphoria."⁸ Removing coverage exclusions of surgical procedures used to treat gender dysphoria would bring the Department in line with the medical community, other federal agencies and, as discussed below, its obligations under federal laws such as the Affordable Care Act.

Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from a Longitudinal Study, 39 PSYCHONEUROENDOCRINOLOGY 65 (2014); Audrey Gorin-Lazard et al., *Hormonal Therapy is Associated with Better Self-Esteem, Mood, and Quality of Life in Transsexuals*, 201 J. Nervous & Mental Disorders 996 (2013); M. Hussan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY, 214 (2010); World Prof. Ass'n for Transgender Health, *Standards of Care of the Health of Transsexual, Transgender, and Gender Nonconforming People*, Seventh Edition (2011) [hereinafter *Standards of Care*].

³ Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 ARCHIVES OF SEXUAL BEHAVIOR 679 (2005); Giulio Garaffa, Nim A. Christopher & David J. Ralph, *Total Phallic Reconstruction in Female-to-Male Transsexuals*, 57 EUROPEAN UROLOGY 715 (2010); Caroline Klein & Boris B. Gorzalka, *Sexual Functioning in Transsexuals Following Hormone Therapy and Genital Surgery: A Review*, 6 J. OF SEXUAL MEDICINE 2922 (2009).

⁴ See, e.g., Am. College of Physicians, *Lesbian, Gay, Bisexual and Transgender Health Disparities: A Policy Position Paper from the American College of Physicians*, 163 ANNALS OF INTERNAL MEDICINE 135, 140 (2015); Am. Psychiatric Ass'n, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012); Am. Medical Ass'n, *AMA Policies on GLBT Issues, Patient-Centered Policy H-185.950, Removing Financial Barriers to Care for Transgender Patients* (2008); Am. Psychological Ass'n, *Policy on Transgender, Gender Identity & Gender Expression Non-Discrimination* (2008). Am. College of Obstetricians and Gynecologists, *Committee Opinion No. 512: Health Care for Transgender Individuals*, 118 OBSTETRICS & GYNECOLOGY (2011).

⁵ See Dep't of Health & Human Servs., NCD 140.3, Transsexual Surgery (2014) (hereinafter "NCD Ruling").

⁶ See Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,189 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

⁷ FEHB Program Carrier Letter No. 2015-12, Covered Benefits for Gender Transition Services (June 23, 2015).

⁸ TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 5061, 5066 (proposed Feb. 1, 2016) (to be codified at 32 C.F.R. pt. 199).

II. Federal law does not prohibit the Department from covering surgeries that are medically necessary to treat gender dysphoria.

While the proposed rule eliminates exclusions for non-surgical care for gender dysphoria, it retains exclusions for surgical treatments based on 10 U.S.C. § 1079, which states that contracts for certain TRICARE coverage cannot include coverage of “[s]urgery which improves physical appearance but is not expected to significantly restore functions.”⁹ As illustrative examples of such procedures, the statute lists “mammary augmentation, face lifts, and sex gender changes” in a parenthetical.

As discussed below, by excluding coverage for all surgical procedures to treat gender dysphoria even when those procedures are medically necessary, the proposed rule misapplies the relevant federal statute and misconstrues its limited application. Surgeries for the treatment of gender dysphoria may and should be covered under TRICARE when medically necessary.

A. 10 U.S.C. § 1079(a)(11) does not prohibit the Department from covering treatments for gender dysphoria that are medically necessary under contemporary standards of care.

Medically necessary surgeries to treat gender dysphoria do not fall under the exclusion in § 1079(a)(11) because their purpose is to restore a transgender person’s ability to function, not to improve appearance. The inclusion of “sex gender changes” as an example of surgeries that *could* fall under the exclusion does not mean that surgery altering gender characteristics is *always* excluded from coverage. The exclusion in 10 U.S.C. § 1079(a)(11) must be interpreted in accordance with modern medical science and contemporary standards of care and in a reasonable manner that avoids conflict with later-enacted provisions of the Affordable Care Act—which prohibit blanket exclusions of transition-related care in federal health plans—as well as the Fifth Amendment’s guarantee of equal protection. Under such a reading, medically necessary surgeries for the treatment of gender dysphoria may and should be covered under TRICARE.

1. Many surgical treatments for gender dysphoria are medically necessary surgeries that “restore function” and do not merely “improve[] appearance.”

Medically necessary surgeries to treat gender dysphoria do not fall under the exclusion in 10 U.S.C. § 1079(a)(11) because they are reconstructive and seek to restore function, not to improve appearance.

Classifying transition-related surgeries as cosmetic treatments aimed at “improv[ing] appearance” fundamentally misconstrues the nature of transition-related care, which is to therapeutically treat gender dysphoria, not to improve a person’s appearance. The World Professional Association for Transgender Health (WPATH) states:

⁹ 10 U.S.C. § 1079(a)(11).

The medical procedures attendant to sex reassignment are not ‘cosmetic’ or ‘elective’ or for the mere convenience of the patient. These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.¹⁰

As the Department has already recognized, transition-related medical procedures are currently accepted as clinically effective treatments for gender dysphoria, a significant, recognized medical condition. According to the DSM 5, gender dysphoria is defined by “clinically significant distress or impairment in social, occupational, or other important areas of functioning.”¹¹ Transition-related surgeries are intended—and expected—to significantly restore areas of social, psychological, and physical functioning that may have been impaired by gender dysphoria, and allow the body to function in a manner consistent with the patient’s innate gender identity. The WPATH *Standards of Care* recognize that while patients’ needs differ and treatment decisions should be individualized, for many individuals “relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.”¹²

In contrast, as the WPATH *Standards of Care* note, cosmetic surgeries typically “involve only a private mutually consenting contract between a patient and a surgeon.” In contrast, “medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals,” and “may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment.”¹³ This is because their purpose is to treat a serious medical condition and restore functionality, not to improve appearance. The American Medical Association recognizes the WPATH *Standards* as authoritative and calls the view that transition-related procedures are generally cosmetic a “myth.”¹⁴ In a recent proposed rule (discussed further below), the Department of Health and Human Services states that “such across-the-board categorization is now recognized as outdated and not based on current standards of care.”¹⁵

The U.S. Tax Court reached a similar conclusion in determining that surgical treatment for gender dysphoria did not fall under the U.S. tax code’s exception for “cosmetic surgery.”¹⁶ The tax code defines “cosmetic surgery” as “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.”¹⁷ The court recognized that, consistent with prevailing

¹⁰ World Prof. Ass’n for Transgender Health, *Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* (2008); see also *O’Donnabhain v. Comm’r of Internal Revenue*, 134 T.C. 34, 76-77 (2010) (The stigma that frequently accompanies transition-related surgeries and the atypical nature of the desire for anatomy associated with a gender different than the gender one was assigned at birth “requires an explanation [for the need for such surgeries] beyond mere dissatisfaction with appearance.”).

¹¹ Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition 453 (2013).

¹² *Standards of Care*, *supra* note 2, at 54-55.

¹³ *Id.*

¹⁴ Am. Medical Ass’n, *AMA Policies on GLBT Issues, Patient-Centered Policy H-185.950, Removing Financial Barriers to Care for Transgender Patients* (2008).

¹⁵ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,189.

¹⁶ *O’Donnabhain*, 134 T.C. at 34.

¹⁷ *Id.* at 52 (citing 26 U.S.C. §213(d)(9)).

medical research, transition-related surgeries must be considered to be treatments of a disease, noting that gender dysphoria “is a widely recognized and accepted diagnosis in the field of psychiatry” that medical professionals believe to warrant treatment. This position is consistent with the conclusions of the HHS Departmental Appeals Board in overturning Medicare’s transgender surgery exclusion, and with the view of every federal appellate court that has considered the question of whether gender dysphoria constitutes a “serious medical need” under the Eighth Amendment.¹⁸

2. The plain text of 10 U.S.C. § 1079(a)(11) indicates that the parenthetical references are merely illustrative and not controlling.

In enacting 10 U.S.C. § 1079(a)(11), Congress did not enact a freestanding prohibition on covering surgery for “sex gender changes.” It prohibited coverage for surgeries that “improve[] physical appearance but [are] not expected to significantly restore functions,” and it listed “sex gender changes” as one of three illustrative examples. In 1984, when Congress first adopted the statutory language at issue,¹⁹ there was a widespread but erroneous belief that surgical treatment for gender dysphoria (then known as transsexualism) was cosmetic or experimental. But as explained in a ruling striking down Medicare’s ban on coverage for “gender reassignment surgery,” there is now a “consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for [gender dysphoria].”²⁰

The Supreme Court has explained that, when interpreting the plain meaning of a statute “[t]he use of parentheses emphasizes the fact that that which is within is meant simply to be illustrative, hence redundant.”²¹ When there is tension between parenthetical illustrations and the non-parenthetical text, “[t]he presence of a bad example in a statute does not warrant rewriting the remainder of the statute’s language”²²: “[a] parenthetical is, after all, a parenthetical, and it cannot be used to overcome the operative terms of the statute.”²³ Courts should not “rel[y] on the parenthetical to drive the interpretation of the whole provision, thereby allowing the statutory tail to wag the dog.”²⁴

To be sure, at the time Congress adopted the relevant language in 10 U.S.C. § 1079(a), the legislators did not foresee that “sex gender changes” would eventually be deemed medically necessary in many cases under contemporary standards of care. But “[o]ld laws apply to changed

¹⁸ See *De'lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003); *Allard v. Gomez*, 9 Fed. Appx. 793, 794 (9th Cir. 2001); *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000); *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995); *Phillips v. Mich. Dep't of Corr.*, 932 F.2d 969 (6th Cir. 1991); *White v. Farrier*, 849 F.2d 322, 325-327 (8th Cir. 1988); *Meriwether v. Faulkner*, 821 F.2d 408, 411-413 (7th Cir. 1987). See also *O'Donnabhain*, 134 T.C. at 60-63 (noting that no U.S. Court of Appeals has held that gender dysphoria does not constitute a “serious medical need” under the Eighth Amendment).

¹⁹ See Pub. L. No. 98-525 (1984).

²⁰ See NCD Ruling at 20.

²¹ *Chickasaw Nation v. United States*, 534 U.S. 84, 89 (2001).

²² *Id.* at 90.

²³ *Id.* at 94-95 (quoting *Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984, 990 (4th Cir. 1996)).

²⁴ *Cabell Huntington Hosp., Inc.*, 101 F.3d at 990.

situations,” and “[t]he reach of the act is not sustained or opposed by the fact that it is sought to bring new situations under its terms.”²⁵ The Supreme Court has repeatedly affirmed that “if Congress has made a choice of language which fairly brings a given situation within a statute, it is unimportant that the particular application may not have been contemplated by the legislators.”²⁶

Construing 10 U.S.C. § 1079(a)(11) in accordance with contemporary standards of care is also consistent with the United States’ interpretation of the Americans with Disabilities Act (the “ADA”) in a recent statement of interest in *Blatt v. Cabela’s Retail, Inc.*²⁷ The ADA excludes “transsexualism . . . [and] gender identity disorders not resulting from physical impairments” from the statutory definition of disability.²⁸ In the *Blatt* Statement of Interest, the United States explained that the statute should not be interpreted to exclude gender dysphoria from the definition of disability “[i]n light of the evolving scientific evidence suggesting that gender dysphoria may have a physical basis.”²⁹ The United States explained that “[i]f our evolving understanding of [gender identity disorders] has changed the scope of the Exclusion, that would reflect the ADA’s own distinction between gender identity disorders with a physical cause and those without such a cause – a distinction drawn by Congress and inherent in the language of the [statute] itself.”³⁰

The same reasoning applies here. The text of 10 U.S.C. § 1079(a)(11) lists “sex gender changes” as an illustrative example of a procedure that is not covered if it merely improves appearance and does not restore functionality. The statute must therefore be interpreted in accordance with our current scientific understanding of medical necessity in order to give effect to a “distinction drawn by Congress and inherent in the language of the [statute] itself.”³¹

3. Section 1079(a)(11) should be interpreted to avoid conflict with Section 1557 of the Affordable Care Act and the constitutional guarantee of equal protection.

Providing equal coverage for medically necessary transition-related surgeries is consistent not only with the language of § 1079 and current medical research, but also with the nondiscrimination principles and standards of the later-enacted Section 1557 of the Affordable Care Act.

²⁵ *Browder v. United States*, 312 U.S. 335, 339 (1941) (footnotes omitted).

²⁶ *Barr v. United States*, 324 U.S. 83, 90 (1945).

²⁷ Statement of Interest of the United States at 3-4, *Blatt v. Cabela*, No. 5:14-cv-4822-JFL (E.D. Pa. filed Nov. 16, 2015), <http://www.glad.org/uploads/docs/cases/blatt-v-cabelas/blatt-v-cabelas-doj-soi-11-16-15.pdf> [hereinafter “*Blatt* SOI”].

²⁸ 42 U.S.C. § 12211(b)(1).

²⁹ *Blatt* SOI at 5.

³⁰ *Id.* at 5 n.3. For similar reasons, even if medically necessary surgery for gender dysphoria were otherwise excluded by § 1079(a)(11), such surgery could still be covered by the exception in subsection 1079(a)(11)(B), which authorizes coverage for surgery that treats a “congenital anomal[y].” As the United States explained in its Statement of Interest in *Blatt*, “the current research increasingly indicates that gender dysphoria has physiological or biological roots.” *Blatt* SOI at 4.

³¹ *Id.* at 5 n.3.

Section 1557 of the Affordable Care Act prohibits discrimination on the basis of gender in “any health program or activity, any part of which is receiving Federal financial assistance...or under any program or activity that is administered by an Executive Agency,” including the Department of Defense.³² As the agency vested by Congress with the authority to interpret Section 1557 through regulations,³³ the Department of Health and Human Services has affirmed that Section 1557 prohibits health coverage practices that result in discrimination on the basis of gender identity or transgender status.³⁴

HHS’s proposed rule clarified that many restrictions on coverage for treatments of gender dysphoria unlawfully discriminate against transgender people, in violation of Section 1557. For example, a covered entity may not categorically exclude all care related to gender transition.³⁵ HHS further clarified that, even in the absence of a blanket exclusion of transition-related care, certain coverage exclusions of specific services may also constitute illegal discrimination.³⁶ For example, the proposed rule made clear that Section 1557 prohibits policies that deny coverage for services used in the treatment of gender dysphoria when similar services are covered for the purpose of treating other conditions.³⁷

Pursuant to HHS’s authoritative interpretation, the Department’s current rules excluding coverage of medically necessary transition-related surgeries appear to conflict with the requirements of Section 1557. Surgeries used in the treatment of gender dysphoria are analogous to therapeutic services that are regularly covered under TRICARE for other medical conditions for non-transgender individuals.³⁸ For example, TRICARE frequently covers the following treatments for conditions other than gender dysphoria:

- prophylactic mastectomies, oophorectomies, and hysterectomies for the purpose of cancer prevention;³⁹
- surgery to treat severe gynecomastia;⁴⁰

³² 42 U.S. Code § 18116(a).

³³ 42 U.S. Code § 18116(c). While the ACA authorized HHS to implement 1557 without limitation, HHS limited its proposed rule to apply to HHS-funded programs and activities, and stated that other federal agencies such as DOD “are encouraged to adopt the standards set forth in this proposed rule in their own enforcement of Section 1557.” Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,173 n. 2.

³⁴ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,176.

³⁵ *Id.* at 54,219.

³⁷ *Id.* at 54,190. State nondiscrimination laws applicable to insurance have been interpreted similarly. *See, e.g.*, 10 Cal. Admin. Code § 2561.2(a)(4) (prohibiting exclusion of services for gender transition “if coverage is available for those services under the policy when the services are not related to gender transition”); Oregon Insurance Division Bulletin INS 2012-1 (“A health insurer may not deny or limit coverage or deny a claim for a procedure provided for [gender dysphoria] if the same procedure is allowed in the treatment of another [non-GD] condition.”).

³⁷ *Id.* at 54,190. State nondiscrimination laws applicable to insurance have been interpreted similarly. *See, e.g.*, 10 Cal. Admin. Code § 2561.2(a)(4) (prohibiting exclusion of services for gender transition “if coverage is available for those services under the policy when the services are not related to gender transition”); Oregon Insurance Division Bulletin INS 2012-1 (“A health insurer may not deny or limit coverage or deny a claim for a procedure provided for [gender dysphoria] if the same procedure is allowed in the treatment of another [non-GD] condition.”).

³⁸ *See* NCD Ruling at 11.

³⁹ *Id.* at § 5.3 (“Prophylactic Mastectomy, Prophylactic Oophorectomy, and Prophylactic Hysterectomy”).

⁴⁰ *Id.* at § 5.7 (“Gynecomastia”).

- surgeries to treat illnesses and injuries affecting the genital system,⁴¹ including penile implants and testicular prostheses,⁴² and
- reconstructive facial surgeries to repair injuries.⁴³

Denying coverage for substantially similar reconstructive surgeries simply because those procedures are used for the treatment of gender dysphoria would likely constitute unlawful discrimination against transgender people in violation of Section 1557.

Denying coverage for medically necessary surgery to treat gender dysphoria would also raise serious constitutional concerns under the Fifth Amendment's guarantee of equal protection. Discrimination based on gender identity or transgender status constitutes sex-based discrimination and is subject to the demanding standard of heightened scrutiny.⁴⁴ Moreover, singling out people with gender dysphoria and categorically denying them medically necessary care would constitute an arbitrary and irrational exclusion that could be explained only by disapproval or prejudice toward transgender people as a class.⁴⁵ The United States recognized these serious constitutional concerns in its Statement of Interest in *Blatt* and explained that those concerns required the court to adopt a narrower interpretation under the doctrine of constitutional avoidance.⁴⁶

Thus, in order to resolve any ambiguity and to avoid conflict with a later-enacted statute and the requirements of equal protection, the Department should modify the proposed rule to make clear that 10 U.S.C. § 1079(a)(11) does not exclude medically necessary procedures to treat gender dysphoria.

4. At a minimum, interpreting the exclusion in 10 U.S.C. § 1079(a)(11) not to exclude medically necessary treatment of gender dysphoria is a permissible construction entitled to *Chevron* deference.

At a minimum, the text of 10 U.S.C. § 1079(a)(11) does not foreclose DOD from adopting a reasonable construction of the statutory language that aligns with contemporary medical science and practice, namely that the statute prohibits surgery that is cosmetic in nature. The Supreme Court has held that “if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute.”⁴⁷ When resolving an ambiguity left in a statute, the agency is not limited to using the traditional tools of statutory construction used by courts and may “properly rely upon the incumbent administration’s views of wise policy to inform its judgments.”⁴⁸ Indeed, “the agency...must consider varying interpretations and the wisdom of its policy on a continuing

⁴¹ *Id.* at § 15.1 (“Male Genital System”); § 17.1 (“Female Genital System”).

⁴² *Id.* at § 15.1.

⁴³ *Id.* at § 2.1.2

⁴⁴ *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011)

⁴⁵ *Cf. Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432 (1985), *Dep’t of Agriculture v. Moreno*, 413 U.S. 528, 534 (1973).

⁴⁶ *See Blatt* SOI at 2.

⁴⁷ *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843 (1984).

⁴⁸ *Id.* at 865.

basis, for example, in response to changed factual circumstances, or a change in administrations.”⁴⁹

B. 10 U.S.C. § 1079 applies only to dependent care outside DoD facilities.

As explained above, the exclusion in 10 U.S.C. § 1079(a)(11) does not bar medically necessary surgeries for gender dysphoria. It also has another important limitation not recognized by the Department’s proposed rule. Section 1079 applies only to a narrow subset of TRICARE coverage: medical care of dependents provided outside of facilities of the uniformed service. Therefore, even if Section 1079(a)(11) were interpreted to bar coverage of non-cosmetic surgical treatments for gender dysphoria, it would not require the Department to extend that exclusion to the entire TRICARE system. In addition to disregarding contemporary medical science, the proposed rule’s exclusion of transition-related surgeries for all of TRICARE has no statutory basis and goes beyond the limitations imposed by Congress.

Recommendation

The final rule should **entirely delete 32 C.F.R. sections 199.4(e)(8)(ii)(D), 199.4(e)(8)(iv)(R) and 199.4(g)(29) of the proposed rule, and delete the words “or as related to sex gender changes, as prohibited by section 1079 of title 10, United States Code” in section 199.4(e)(8)(iv)(Q).**

Conclusion

In accordance with the requirements of federal law and contemporary medical science, the Department should revise the final rule to clarify that any medically necessary treatments for gender dysphoria, including surgical treatments, are covered under TRICARE. Rather than automatically classifying all transition-related surgeries as cosmetic and therefore excluded from coverage, the Department must allow physicians to make an individualized determination of medical necessity for any TRICARE recipient based on well-established medical principles and diagnostic standards.

⁴⁹ *Nat’l Cable & Tel. Ass’n v. Brand X Internet Servs.*, 545 U.S. 967, 981 (2005) (internal quotation marks, citations, and ellipses omitted).