Medical Censorship in Tennessee

Doctors, Minor Trans Patients, and Insurance

Tennessee Public Chapter 748

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The Issue

Medical professionals understand why establishing trust with their LGBTQ minor patients is essential for health promotion, safety, and to protect public health. It requires open and honest communication to normalize these conversations and to provide the recommended screenings for LGBTQ adolescents. It also creates an opportunity to understand what life is like at home and how they can also support their patients' best interest. And LGBTQ minors in Tennessee without insurance, without support at home, or limited access to health care in rural areas may find physicians as their one and only safe space.

Laws, litigation, and the court of public opinion targeting transgender people have upended access to life saving care. A recent Tennessee law, Public Chapter 748, doubles down on limiting access. It prohibits medical providers and insurers, excluding licensed mental health and pastoral providers, from asking or collecting information about a minor patient's gender identity, without parental consent. This unprecedented censorship of clinical practices not only interrupts routine prevention, it also establishes a practical and moral conflict for clinical standards of care and ethics. It threatens regulatory compliance, accreditation, and quality assurance measures, and weakens our understanding of LGBTQ health. Tennessee should anticipate litigation from patients, families, providers, and insurers.

Key Points

Asking minor patients about gender identity is not a coercive or a causative factor for transgender and gender nonconforming identities.

Clinical standards and government issued screening tools for LGBTQ adolescents address sexuality and gender in clinical settings.

Existing Tennessee laws provide explicit permissions to treat mature minors for specific health conditions without parent permission.

Insurers collecting demographic data on patients' sex and gender are necessary for payment, accreditation and quality assurance, public health research, and compliance with existing state and federal laws.

Transgender, gender nonconforming, and intersex patients are legally protected from medical and insurance discrimination by numerous civil rights laws.

Physicians and clinics who treat transgender minor patients have reported experiencing fear, threats to their life, moral distress, and burnout.

Asking minor patients gender identity questions does not cause, influence, or coerce them to identify as LGBTQ.

Public Chapter 748, Medical Censorship

Sponsors of Public Chapter 748, SB 1664/HB1665, argued that asking minor patients questions about gender identity in clinical settings is upsetting and confuses or influences them into being transgender. No empirical evidence supports these claims. The law usurps "gender identity," a neutral term in medical and social sciences, with stigmatizing language and the inflammatory terms "gender confusion" and "perceived gender normalcy." Medical providers, excluding licensed mental health and pastoral providers, are prohibited from initiating confidential conversations about gender related questions without parents' written consent, specifically: "Whether the minor feels normal in the minor's body; (2) Whether the minor believes the minor is the correct gender; (3) Whether the minor identifies as a gender different from the minor's sex; or (4) An inquiry intended to elicit statements about gender confusion, or gender dysphoria."

Physicians are only authorized to respond to patient-initiated questions related to gender identity or to suspicions of brutality, abuse, or neglect. Insurance companies are prohibited from asking or requiring providers to collect responses to the prohibited questions for any reason, including payments for services, reimbursement, quality scoring, compliance, or participation. Physician violations will be referred to licensing boards as professional misconduct. (See Appendix A for a copy of Public Chapter 748).

LGBTQ Minors in Tennessee

Even though the number of out young LGBTQ persons has increased, less than 1% of Tennessee's 13-17 year old adolescents are transgender. "LGBTQ" refers to the diverse community of individuals who identify as lesbian, gay, bisexual, transgender, queer, and questioning identities. Intersex persons may or may not identify with LGBTQ, but are frequently targeted in anti-trans laws. The community is typically referred to as a singular group, but significant differences between group experiences and health outcomes are widely documented. Health and wellness for Tennessee's LGBTQ children and youth has been understudied and underreported, but a wealth of research demonstrates how LGBTQ youth can thrive with acceptance, inclusion, and active affirmation from their parents and families, their peers, and their schools (Poquiz et al., 2020; Ryan et al., 2020).

Note on terminology

For brevity, "LGBTQ" and "trans," as an umbrella term, are used in this report, but not intended to conflate or erase any person or group. Visit National LGBTQIA+ Health Education Center for a comprehensive glossary of terms referenced in medical literature and research, https://www.lgbtqiahealtheducation.org/glossary/.

44% trans & gender-expansive youth have not disclosed their gender identity to parents.

Trevor, 2023 Report

LGBTQ Youth in Crisis

Tennessee ranks poorly on every youth mental health measure: 42nd for mental health overall, 49th for access to mental health services, and 45th for completed suicides. In recent years, the Tennessee Department of Health has reported substantial increases in suicidal ideation (24%) and self-injuries, death (47%), and death by firearms (80%), (Tennessee Department of Health [TDH], 2025). The risk does not end at 18: suicidal ideation and traumatic experiences in childhood confer an added suicide risk into adulthood (Copeland et al., 2017; Tran et al., 2022).

Tennessee LGBTQ high school youth have reported high rates of suicidal ideation, self-injury, and suicide attempts that required medical treatment compared to their heterosexual/cisgender peers. Similar experiences are reported by cisgender peers in same-sex and both-sex relationships (CDC, TN YRBS). Overall, mental health for trans and gender nonconforming youth is worse off compared to their same-age cisgender peers and cisgender LGB peers (Becerra-Culqui et al., 208). They are nearly five times more likely to attempt suicide and more likely to use any substances, with the highest risk for cocaine use (Carney et al., 2023; Gonzales & Deal, 2022; Johns et al., 2019, 2020). Large studies have reported similarly high rates of suicidal thoughts (42% LGBT and 50% trans/nonbinary), suicide attempts (12%), and anxiety symptoms (69% LGBT and 73% trans/nonbinary), and depression (57%) (Nath et al., 2025).

Cumulative experiences with stigma, discrimination, negative messages, fear, and persistent anticipation of negative events lead to serious mental health consequences for LGBTQ adolescents. Health inequities widen at the intersections of marginalized race and ethnicities (Chodzen et al., 2019; Hendricks, 2012; Meyer, 2003; Mustanksi et al., 2016; Russell & Fish, 2016; Wittlin et al., 2023). Trans and gender questioning youth report striking rates of relationship violence, including rape and sexual and physical violence. High-risk same-sex and both-sex behaviors, including unprotected sex, poly-substance drug use, and lack of consent, are more likely for LGBTQ adolescents. Many parents of cisgender and heterosexual adolescents who engage in same-sex and both-sex behaviors are unaware of these risks (Raspberry et al., 2018). Entry into foster care and experiences with housing and food instability are common for LGBTQ youth (DeChants et al., 2021; Ormiston, 2022). With Tennessee's mental health workforce shortages and limited access to insurance and health services, rural physicians and local public health clinics are the only health care providers for LGBTQ youth experiencing distress and suicidal ideation.

Additional Considerations

Youth suicide prevention is a high priority for Tennessee, with over 1,000 lives lost each year to suicide, higher than the national average,(TDH, 2025). Tennessee should examine risk and protective factors for trans minors in comprehensive prevention programming "2024 National Strategy for Suicide Prevention."

Family Acceptance

Parent Support

Supportive parents are critical to the provision of LGBTQ affirming health care services. As shared decision-makers with health care providers who display openly supportive behaviors and pride are known protective factors for self-esteem, social support, and general health, and for depression, substance abuse, and suicidal ideation and self harm (Ryan et al., 2010; Wittlin et al., 2023). Unfortunately, supportive parents in Tennessee with limited resources or no insurance struggle to find knowledgeable and affirming physicians.

Supportive parents of trans minors are attentive to the many ways gender identity fundamentally impacts their child's engagement with health care. A multidisciplinary team is necessary for comprehensive health care into young adulthood, regardless of the type, timing, or sequence of medical or mental health care. Higher levels of family support with an additional one to two years of gender-affirming medical care not only reduced gender dysphoria, mental illness, and victimization for trans minors, but reduced physical health problems that limited activities at school and with friends (Chelliah et al., 2024; Gadomski et al., 2023). But most Tennessee parents find the costs, legal barriers, and institutional restrictions make affirming health care inaccessible.

Additional Considerations

Affirming, inclusive, and protective educational environments; family acceptance; peer, and social support; social affirmation; access to affirming health care, and publicly coming out are protective factors for LGBTQ youth mental health.

Health Care Preferences

Pediatricians, physicians, specialists, and other clinicians with a pediatric and adolescent focus, hereafter referred to as physicians, provide direct medical care for the whole child. Generally, LGBTQ adolescent patients prefer nonjudgmental physicians with good interpersonal skills, followed by general knowledge and the willingness to refer out for more specialized care. They play an important role in sexual health education, too, with patients' highest preferences for help with decision–making and knowledge about HIV (Hoffman et al., 2009). Patients prefer clinical settings that offer screening and treatment for STIs, HIV, and provide confidential care that "allows me to come out to my parent/guardian," as high priorities. In other words, clinically safe spaces.

Contrary to the political rhetoric, many trans children and youth only seek social transition at home, school, or both, i.e. name change or preference, pronoun usage, and safe restroom access. Parents shared many of the same concerns with their trans minors regarding the medical aspect of transitioning and school experiences. Parents are also concerned about family acceptance, acute mental health, safety at school, and general resources for varied ages and sex assigned birth. Notably, Lawlis et al. (2017), found that a top concern of trans minor patients were legal issues.

Only **13%** of mental health **18%** substance abuse facilities have LGBTQ programs.
Williams & Fish, 2020

Trans-affirming parents in Tennessee who want access to gender-affirming medications are struggling under the state ban with the lack of access to medical professionals within the state. Even though the numbers of out trans and gender nonconforming children have increased, medical transition is exceptionally rare (<0.1%) (Hughes et al., 2025; Respaut & Terhune, 2022) and rarer in Tennessee. For those who can travel to states without bans, resource demands to follow the standards of care are significant and unsustainable for many families (Coleman et al., 2022; Hembree et al., 2017; Parents, personal communications, 2023-2026).

Questionnaires & Assessments

The American Academy of Pediatrics (AAP) emphasizes the importance of structured time for adolescents to meet without family members present and with consideration for families, individuals, and cultures. Patient-doctor confidentiality for sensitive questions and the limits of disclosure should be discussed with patients.

Answers to confidential clinical questions about sexuality and gender identity can be life saving for LGBTQ adolescents. Follow up screenings and honest conversations are also important tools to promote health and protect public health. Although these topics may make some heterosexual and cisgender minor patients and parents uncomfortable, the majority of parents, adolescents, and health care professionals find questions about sexual orientation and gender identity acceptable in routine screenings, intake forms, and direct conversations during confidential appointments (Ross et al., 2025; Rullo et al., 2018). Adolescent patients under 18 and medical providers prefer in-person questions and conversations, while young people over 18 prefer filling out electronic forms in advance (Hillier et al., 2025; Pourian et al., 2025).

For parents of the youngest patients, ages 3-12, the large majority (79.6%) found questions about gender identity and gender expression acceptable, not confusing, offensive, or uncomfortable. Of the less than 7% with strong negative feelings, most reported that their children had cross-gender expression or play. Parents equally preferred to obtain permission in advance or know the questions in advance (Ross et al., 2025). Similar to other aspects of gender-affirming care, researchers emphasize the need for continued research in this area and why it is of utmost importance to work with parents and families to address any concerns (Hillier et al., 2025).

Family Rejection & Trauma

Physicians may be the only safe place for open and honest conversations about gender and sexuality. Confidential visits are valuable opportunities to learn more about life at home and school. Family rejection comes in many forms, such as suppressing children's identities at home and publicly, kicking them out, and subjecting them to physical and emotional abuse or conversion therapies. These adverse childhood experiences (ACEs) are known lifetime suicide risk factors; strongly associated with worse lifetime outcomes.

ACEs are common for LGBTQ adolescents, with 83% of LGBTQ adults in Tennessee reporting childhood sexual and emotional abuse (Swedo et al., 2024; Tran et al., 2022). Nearly 90% of trans and gender-questioning adolescents have reported emotional abuse, with 1 in 5 reporting sexual abuse because of parents' transphobic beliefs and behaviors (Kreski & Keyes, 2025). The Tennessee Department of Health (TDH) reported the most common risk factors of suicidal ideation and self-harm for its youth are depression, anxiety, substance misuse, post-traumatic stress disorder (PTSD), and parental abuse, the state does not report these rates (TDH, 2025).

Additional Considerations

Tennessee LGBTQ Youth Abused. Nearly fifty-nine percent (58.6%) of LGBT high school students in reported that a "parent or an adult in the home: "always or most of the time insulted or put them down" and nearly 21% "most of the time or always hit, beat, kicked, or physically hurt them in any way". (CDC YRBS)

Conversion Therapy

Many families threaten, coerce, or force different treatment therapies to change or suppress their children's LGBTQ identities, thoughts, and behaviors, to a "normative" heterosexual and cisgender state. This "conversion therapy" is extremely harmful and strongly associated with suicide and lifetime mental illness. It is commonly referred to as reparative or pastoral therapy and sexual orientation and gender identity change efforts. These are typically in-office and pastoral settings, but there are in-patient facilities and camps, including Tennessee. Although every major medical association has unequivocally denounced these dangerous practices, Tennessee now shields abusive parents who subject their children to these treatments by law, see Public Chapter 846, SB1989.

Historically, survivors have reported a wide range of abuses, from talk therapy to isolation, solitary confinement, physical violence, sexual assault, and other horrific abuses (Blosnich et al., 2020). Symptoms associated with PTSD have also been reported, including new or worse depression, anxiety, self-harm, suicidal ideation, nightmares, somatic symptoms, relationship issues, and self-isolation (American Psychological Association, 2009; Blosnich et al., 2020; Turban et al., 2019). Suicide is twice as likely for the majority of LGBTQ youth subjected to conversion therapy and 2.5 times more likely to make multiple attempts in the past year (Green et al., 2020). Trans persons subjected

to conversion therapy before the age of 10 were over four times more likely to attempt suicide and more likely to use illicit drugs (Turban et al., 2019). The consequences are economically tangible, with an annual U.S. $9.23 billion and average $98,000 cost per person due to substance abuse, depression, anxiety, suicide attempts, and medical treatments (Forsythe et al., 2022).

Additional Considerations

Conversion Therapy Survey in Tennessee. Seventy-six percent (76%) reported being subjected to repress or change their sexual orientation (51%) or gender identity (12%), or both (32%), as children under 18. They were pressured (42%), forced (8%), or chose (15%) to undergo conversion therapy, most commonly from parents (58%) and family members and religious and spiritual leaders (37%). Nearly every survivor (94%) believed that it should be an illegal practice for minors and felt that it was extremely harmful (Chinn et al., 2023)

A Physician's Role

Pediatric physicians are highly trained and tasked with normalizing developmentally and age-appropriate conversations, including sexuality and gender. Done well, they create a safe space for LGBTQ minor patients that also allows for screening for risk and protective factors at home and school, treating specific health conditions, and working with parents to access mental health services. Specialized trans health care requires an even higher level of knowledge, diagnostic skills, and abilities to work with minor patients and parents. They must prioritize shared-decision making and manage the coordination of comprehensive health care. But no physician in Tennessee is legally able to properly care for or treat trans minors (Providers, personal communications, 2023-2025).

86% pediatric providers want more training for trans & gender-expansive youth to be better clinicians.

Gruschow et al., 2018

Clinical Skills

Earning patient trust and normalizing factual conversations about gender identity, sexuality, and sexual health can be life-saving. Because Public Chapter 748 exempts licensed mental health providers, pediatric guidelines for physicians treating LGBTQ minors are the focus of this report. Updated mental health competencies for screening, treatment, and referrals to treatment have been recommended for pediatricians, highlighting the phenomenal rise in mental illness and the need for physicians to respond where access to mental health care is limited (Foy et al., 2025). Confidential appointments are an opportunity to screen for these risks and provide accurate and nonjudgmental sex education.

Affirming health care centered around transgender children and youth requires a high level of clinical competencies- and the willingness to dedicate the time, attention, and compassion to care for the unique needs of these minors and their families. But the reality is that a small number of professionals have the expertise or abilities to competently treat LGBTQ minors, and the majority are not aware of the specific treatment guidelines for trans and gender nonconforming children (Fitzgerald et al., 2023; Gruschow et al., 2018; Hadland et al., 2016; Levine, 2013).

Additional Considerations

"Establishing and safeguarding confidentiality with youth is a critical element of a safe and viable treatment relationship, concomitantly with maintaining collaborative relationships that include developmentally appropriate privacy from adult parents and guardians, school personnel, colleagues, and other important adults in the youth's life, is critical in the care of all youth, but especially for LGBTQ youth." (Hadland et al., 2016).

The Social Determinants of Health

Clinical guidelines for physicians working with LGBTQ minor patients are evolving with an increasing consideration of the contextual influence of social determinants of health (SDOH). These non-medical factors include access to high-quality health care, social community, education, housing and food stability, income, and built and policy environments. Minority stress is an established framework for understanding health disparities in marginalized populations, driven by the SDOH. Some examples of the routine processes that power minority stress involve: discrimination and threats (hostile LGBT legislation), vigilance and anticipation of a negative event will occur (rejection, victimization), and internalized beliefs and messages (homophobia and transphobia) (Meyer, 2003; Hendricks & Testa, 2012; Russell & Fish, 2016; Wittlin et al., 2023). Embedding social theories in general medical curricula and during clinical skills training in pediatric medicine is critical for LGBTQ minors. They do not exist in isolation.

Clinical Guidelines

Without LGBTQ patient-centered prevention services for minors, the risks from stigma, lack of inclusive sex education, and screening for certain sex behaviors lead to higher rates of substance abuse, unplanned pregnancies, and exposures to sexually transmitted and blood-borne infections (STBBIs), such as Hepatitis B/C, HIV, and bacterial pathogens (Johns et al., 2017, 2019; Charlton et al., 2013; Cronin & Stockdale, 2021; Goldberg et al., 2016; Valente et al., 2024). Physicians can also provide sexual health prevention for any other minors who engage in same-sex and both-sex behaviors, particularly minors unsure of their gender identity or sexuality.

Bright Futures **"Recommendations for Preventive Pediatric Health Care and Promoting Health Development of Sexuality and Gender Identity"** AAP Recommendations outline developmentally and age-appropriate discussions for all ages of children and adolescents. It offers guidance to work with parents and families, and tools to create LGBTQ welcoming practices. Numerous guidelines emphasize the importance of establishing a trusted space for conversations with LGBTQ minor patients (Hadland, et al., 2016; Levine, 2013; Salas-Humara et al., 2019). In communities with a limited mental health workforce or parents who don't agree with the idea of mental health care, physicians and public health clinics may be minor patients' only contact with mental and behavioral health care.

Bright Futures, **"Preventive Pediatric Health Care, Periodicity Schedule and Rationale"** AAP Recommendations include additional developmentally and age-appropriate screenings for LGBTQ adolescents and other known at-risk groups, beginning as early as ages 11 and 12. These also align with the U.S. Prevention Task Force (USPSTF) additional recommendations for higher-risk adolescent populations; considered essential health benefits. For positive results, physicians should follow up with appropriate actions that may include more in-depth screening, treatment, and guided conversations with families about life-saving interventions:

- ★ Behavioral/Social/Emotional Screening
- ★ Tobacco, Alcohol, or Drug Use Assessment; Risks and Sexual Behaviors.
- ★ Depression and Suicide Risk Screening
- ★ Sexually Transmitted Infection Screening
- ★ HIV Screening, Counseling, and Prevention Medication
- ★ Hepatitis B Screening
- ★ Healthy relationships, healthy sexual development
- ★ Consent, intimate partner violence, and sexual abuse.

World Professional Association for Transgender Health (WPATH), "Standards of Care for the Health of Transgender and Gender Diverse People" This authoritative guide to clinical care for transgender, gender nonconforming, and intersex persons strongly emphasizes parent/caregiver involvement with social and medical transition, case-by-case treatment plans, biopsychosocial evaluation, and continuous care into adulthood. Additional assessments for gender identity development, social development, support and intersectionality, potential co-occurring mental health and developmental concerns, and minors' decision-making capacity are recommended (Coleman et al., 2022).

Endocrine Society and other trans-focused clinical experts recommend strategies for welcoming clinical environments and additional screenings for treatment and specialty referrals, including: anxiety and depression, eating and mood disorders, tobacco, alcohol, and substance misuse, and trauma (Hembree et al., 2017; Salas-Humara et al., 2019).

Additional Considerations

Major medical associations affirmatively support developmentally and age-appropriate gender-affirming care for trans, gender nonconforming, and intersex minors on a case-by-case basis with parents. See, American Academy of Pediatrics, Endocrine Society, American Medical Association, American Psychological Association, American College of Obstetricians and Gynecologists, GLMA, World and U.S. Professional Association for Transgender Health.

Burnout & Moral Distress

Contemporary politics, anti-transgender stigma, and anti-trans health care restrictions have led to threats, doxxing, and moral distress for physicians and mental health providers. In Tennessee and other states with anti-trans health care legislative efforts, 95% of pediatric gender-affirming care specialists reported moral distress, or their personal experiences with distress and "morally-charged issues of patient care." (Stamm et al., 2025). Frustration and guilt, fear, and exhaustion are frequently reported. They reported that the most common sources of moral distress included their role and responsibility, legal and ethical dilemmas, and the institutional constraints that delay care. Parents of trans minors in Tennessee have reported the chilling effect of legislation and experiences with physicians who express strong feelings of guilt and frustration with legislators, plus their institutions' overcompliance with laws or in anticipation of litigation. Pediatricians have called parents and met with families in tears, saying their hands are tied because they could lose their medical license or be sued. For some families, this meant a loss of any health care because their pediatricians were even prohibited from making referrals to providers out of state (Providers, personal communications, 2023-2025).

95%

of trans affirming providers report moral distress in states with trans health care bans.

Stamm et al., 2025

Medical and mental health providers have reported harassment, threats, and bomb threats on social media, phone calls, emails, letters, and reports to medical boards. Their clinics have also been the target of these threats. Behavioral health professionals experienced the most harassment, compared to nurse practitioners and physicians (Hughes et al., 2023). In response, providers have negotiated safety measures with their institutions to avoid violence and intimidation. They have adapted their clinical practice, public presence, and turned to advocacy.

Reflecting the reports from Tennessee parent experiences, pediatric endocrinologists have also reported their institutions' pressure and practice restrictions, dismissal of existing patients, and refusal to accept or even refer out new inquiries from parents (Gupta et al., 2023; Hughes et al., 2023, 2026).

Additional Considerations

Tennessee Provider Feedback. Tennessee's shortage of mental health providers and culturally competent programs that support LGBT minors is at risk of worsening. Mental health providers have shared extreme concerns that practicing under laws censoring their ability to treat LGBT minors will prevent them from doing their job on a daily basis, enforcing noncompliance with well-established standards of practice that violates their professional code of conduct. They have indicated that not only will they leave the state, but they would encourage other providers to move out of state, ultimately harming every minor needing mental health services in Tennessee (Providers, personal communications, Feb. 2026).

Insurance

Health insurance is one of the most heavily regulated, complex, and data-driven industries in the nation. Health insurance access substantially influences an individual's physical and mental health. For population health, insurance access is considered one of the main drivers of the SDOH. The Tennessee Department of Commerce and Insurance maintains administrative oversight of insurers operating in the state, including licensure and compliance with state and federal laws. Approximately 49% of Tennesseans under 19 are insured through employer-sponsored programs, followed by Medicaid (43%), private insurance (6%), and up to 5% are uninsured (Spears, 2020; Tennessee Division of TennCare, 2026).

Seventeen-thousand privately insured Tennessee youths' insurance plans exclude mental health services, a serious concern for LGBTQ youth in areas already underserved (Reinert et al., 2025). Efforts are underway to increase the number of rural school-based mental health professionals to fill the gap in coverage (Burris, 2025). Serious policy makers interested in protecting all children should expand insurance access, increase the mental health workforce, and increase access to the evidence-backed preventive services.

Data Collection

High-quality data on sexual orientation and gender identity (SOGI) are critically essential to address health care inequities. The Institute of Medicine (IOM) issued a scoping report in 2021 with detailed recommendations for understanding and improving LGBTQ health, emphasizing the necessity to collect high-quality data (Institute of Medicine [IOM], 2011). Since the IOM report, various directives, executive orders, initiatives, and federal guidance on SOGI data collection have been issued and rescinded under various administrations. Not until 2023 did the Centers for Medicaid and Medicare Services

(CMS) issue guidance to adopt three optional questions on insurance applications for ages 12 and older: sexual orientation, sex assigned at birth, and gender identity. The mandatory binary question on "sex" remained (CMS, 2024; Gipson, 2024; Grasso, et al., 2019). Tennessee did NOT adopt these questions on TennCare or CoverKids applications. It is unknown if and how many private and group insurers adopted similar questions.

Minor patient's SOGI information and treatment are protected health information (PHI) and individually identifiable health information (IIHI). Information from PHI and IIHI identifies, or can be used to infer an identity, and must be handled within patient privacy laws and regulations. De-identified gender identity data may be aggregated and used for quality measures, program effectiveness, third-party accreditation standards, regulatory compliance, and research. Despite the gains in research on these topics, questions on gender identity have been removed from dozens of federal surveys and questionnaires, including the Youth Risk Behavior Survey. Politicizing one of the most powerful public health tools to understand the LGBTQ adolescent population benefits no one (Bouton & Redfield, 2026).

Addressing Disparities

Health care professionals, community-based health programs, and public health practitioners understand that high-quality data is critical to objectively examine health disparities. Without data, there is no way to evaluate population-based programs and initiatives. Insurers that can ask SOGI questions can also better understand the health disparities of all Tennessee minors. All three of TennCare managed care organizations are accredited by the National Committee for Quality Assurance (NCQA) and its Health Equity Accreditation. The NCQA HEA uses data to dig deeper into health disparities, targeted programs, and quality improvement efforts. Again, the intersection of recent TennCare laws and regulations banning coverage and the provision of health care, combined with federal inconsistencies, will be detrimental to addressing health inequities.

Prevention medicine and gender-affirming care are known economic benefits for public health, with nominal costs for substantial reductions in suicide, substance abuse, and self-medication (Baker & Restar, 2022; Padula et al., 2016). Health insurance coverage for gender-affirming care has been shown to be cost-effective. It provides overall improvements in mental health and HIV prevention, resulting in medium and long-term cost-savings by reducing mental illness, suicide attempts, and substance abuse (American Medical Association, 2025). For example, HIV prevention is a specific socioeconomic benefit, given the high cost of HIV treatment and the lifetime mental health costs (Padula et al., 2016). The per-person medical cost-savings for preventing HIV infection in just one person range from $229,800 to as much as $338,400 for earlier intervention (Schackman et al., 2015). This should be a priority concern in Tennessee, considering Memphis has one of the highest rates of new HIV infections (Nabors, 2025). Adding restrictions to youths' access to targeted prevention services and treatment through policy could widen this health disparity and threaten public health.

Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) greatly expanded access to health care for trans persons, although most policies lack gender inclusive language and service coverage widely differs (Baker & Restar, 2022; Bond et a., 2022). Although ACA Section 1557 provides the strongest statutory nondiscrimination protections for LGBTQ access to health care, it has been inconsistently interpreted across administrations and in the courts, see HHS Finalizes Rule Addressing Section 1557 of the ACA's Incorporation of Title IX. (2026, April 30). Discrimination based on race, color, national origin, sex, age, and disability in health care programs and activities that receive federal dollars is prohibited. It has been interpreted to include non-discrimination protections for people with limited English proficiency (national origin) and pregnancy status, pregnancy-related conditions, sexual orientation, gender identity, sex stereotypes, sex characteristics, and intersex traits (sex). A final CMS rule was issued on May 6, 2024, to address protected categories and religious exemptions from health care services and insurance, but rules are subject to politically biased interpretations (Office of the Federal Register, 89 FR 37522).

Essential Health Benefits (EHB), defined in ACA Section 2713, are mandated no-cost sharing screenings recommended by the USPSTF. Additional recommendations for higher-risk adolescents, including LGBTQ adolescents, are found in the ACA Preventive Services Coverage Requirement (2026, April 30) and the AAP *Bright Futures* screenings. Specific health services for trans persons are not considered EHB in Tennessee, although the recent passage of Tennessee SB676/HB754 would require the state to certify "detransition services" as EHB, which are also transition services. Once implemented, Public Chapter 748 should be a serious concern for trans minors missing out on appropriate EHB. The intersections of state and federal healthcare policies directly or indirectly aimed at transgender persons increase the imaginable risks for physicians who cannot comply.

Laws & Politics Restrict Access

Tennessee has codified two systems of health care based on rudimentary understandings of sex and gender. The addition of Public Chapter 748 to other anti-LGBTQ and anti-trans legislation from the last ten years effectively removes any access to specialized health care for minors. Not only have these fractured objective clinical practices and the public health systems designed to prevent disease and lessen health disparities, but it has generally restricted access to permissible preventive care. This collective legislation pushes transgender people beyond the margins, out of the record, and will widen disparities across the board.

The current executive branch has targeted transgender, gender nonconforming, and intersex persons through executive orders and agency directives to erase or prohibit data on gender identity and rulemaking targeting Medicaid and Medicare coverage and the

hospitals providing their care. Major hospitals and specialty clinics reacted by abandoning trans minors and their families. At this time, the number of trans minors seeking or receiving any specialized health care in Tennessee is unknown.

Additional Considerations

Political hostility and anti-trans laws caused a 72% spike in youth suicide attempts. Students in schools with anti-trans bathroom policies are more likely to experience sexual assault (Lee et al., 2024, Murchison et al., 2019). Adults in states with anti-LGBT laws report constant worry, hypervigilance, hopelessness, and concern about their freedom and future laws and restrictions (Last et al., 2026).

Litigation

Prohibiting any health care provider from asking gender identity questions on applications, surveys, intake forms, or during physician-initiated conversations with minor patients will likely lead to litigation. Issues around discrimination, malpractice, health care access under the ACA, compliance with related health care laws, and religious freedoms and free speech are some of the possibilities. The state should anticipate legal challenges from parents and patients, providers and professional associations, hospitals, and insurance companies.

Clinically, minors will receive suboptimal care if open and honest conversations with physicians are interrupted. Prohibiting or delaying care will impact lifetime health. It is also a missed opportunity for shared decision-making with supportive parents or finding ways to support minors rejected at home. Patients and parents may have to rely on the courts to address discrimination and malpractice. The burden of proof for abuse would be on the minor victims subjected to legally permissible conversion therapies in Tennessee.

Physicians censored from asking basic questions about gender identity cannot follow standards of care, including the USPSTF-recommended EHB for adolescents, or treatment for mature minors under certain circumstances allowable under Tennessee laws. For example, the Supreme Court's 2025 *Kennedy v. Braidwood Management, Inc*., ruled that no cost-sharing for ACA 2713 HIV PreP medication is a justified net-benefit for required coverage in qualified health plans. Physicians may find it difficult to comply with prohibitions on providing trans health care services. It could also restrict providers' ability to refer out for their religious rights to refuse treatments. Physicians and their member associations, such as the AAP, Endocrine Society, and USPATH, may turn to the courts on behalf of their professional members' rights to speech and standard practices.

Prohibiting insurers and hospitals from collecting gender identity questions could lead to sex-based discrimination and eliminate coverage for recommended EHB for LGBTQ and higher-risk minors. Similarly, it could compromise their compliance with Tennessee's health care bans and TennCare prohibition on coverage for certain health services. It is unclear how insurers could demonstrate compliance in audits or investigations, threatening accreditations, quality assurance measures, and funding for targeted programming.

Temperamental politics and federal directives, executive orders, and rulemaking that target trans health care access compromise hospitals' and clinics' abilities to provide equal access to the federally recommended EHB. Previous landmark rulings, *Bostock v. Clayton County* and the *United States v. Skrmetti*, have already led to ongoing litigation in *Pritchard v. Blue Cross Blue Shield of Illinois*. They argue that categorical exclusion of gender-affirming care from insurance coverage is Section 1557 discrimination, by-proxy. Numerous allegations of violations of civil rights protections and ACA Sections 2713 and 1557 are winding their way through the courts. Follow KFF tracking for up-to-date information on federal actions regarding transgender discrimination in health care, https://www.kff.org/lgbtq/overview-of-president-trumps-executive-actions-impacting-lgbtq-health/.

Conclusions

Tennessee's statutory slate of anti-transgender discrimination in health care is consequential to pediatric and adolescent standards of medical care, health outcomes, and poses a serious threat to public health. Persistent exposures to stigma, discrimination, and social rejection are known risk factors for health inequities and severe mental distress for young trans people. The careful collection and presentation of demographic data contributes to our understanding of the resilience, risk and protective factors, disparities, and the unique needs of these populations.

Trans, gender nonconforming, and intersex minor patients' autonomy, health status, and safety are under threat when physicians are censored from asking straightforward questions. Discussing gender identity and expression, sexuality, and behaviors in a protected clinical setting is materially relevant to advancing their lifelong physical and mental health. Physicians' critical role in screening, treatment, and support for these minors cannot be overstated.

Public Chapter 748 will be another failed attempt to erase the existence of gender minority persons from the written record. Misleading and stigmatizing statutory language is indefensible and irresponsible. It is a lose-lose for patients, parents, physicians, and society. Tennessee should expect costly and protracted litigation because of the law's complex threats to patients and parents, medical professionals and their associations, hospitals, and insurance companies.

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State of Tennessee

PUBLIC CHAPTER NO. 748

HOUSE BILL NO. 1665

By Representatives Maberry, Reneau, McCalmon, Moody, Howell, Grills, Hawk, Todd

Substituted for: Senate Bill No. 1664

By Senators Rose, Bailey, Bowling

AN ACT to amend Tennessee Code Annotated, Title 4; Title 33; Title 47; Title 56; Title 63; Title 68 and Title 71, relative to the protection of minors in healthcare settings.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

56-7-1022. Prohibition on insurance-driven questionnaires.

(a) A health insurance issuer, managed care organization, or an entity providing reimbursement for healthcare services shall not require or request a healthcare provider or facility to ask the following questions for any purpose, including as a condition of payment, credentialing, quality scoring, compliance, or participation:

(1) Whether a minor feels normal in the minor's body;

(2) Whether a minor believes the minor is the correct gender;

(3) Whether a minor identifies as a gender different from the minor's sex; or

(4) An inquiry intended to elicit statements from a minor about gender confusion or gender dysphoria.

(b) A health insurance issuer, managed care organization, or any entity providing reimbursement for healthcare services shall not deny or reduce payment, impose penalties, or otherwise disadvantage a provider for failing to ask such questions.

(c) This section does not apply to questions regarding a female's menstrual period.

(d) As used in this section, "minor":

(1) Means a person who has not attained eighteen (18) years of age; and

(2) Does not include a person who:

(A) Is emancipated pursuant to title 29, chapter 31;

(B) Needs emergency treatment pursuant to § 63-6-222;

(C) Is or was previously a member of the armed forces of the United States or a member of a reserve or national guard unit; or

(D) Is the parent of a minor child and has full custody of that minor child.

SECTION 2. Tennessee Code Annotated, Title 63, Chapter 1, is amended by adding the following as a new part:

63-1-1001. Legislative findings.

The general assembly finds and declares that:

(1) A parent has the right to make all physical and mental healthcare decisions for the parent's minor child and consent to all physical and mental health care on the child's behalf, as described in § 63-1-176;

(2) Minors are increasingly being asked questions by healthcare providers regarding gender identity, perceived gender normalcy, or whether the minor identifies as the minor's true or right gender without parental knowledge or consent;

(3) Some healthcare providers and facilities have reported that insurance companies or third-party payors require the inclusion of such questions for data collection or reimbursement;

(4) Such questions may introduce confusion, influence minors, or conflict with the values and beliefs of families in this state; and

(5) This state has a compelling interest in ensuring that healthcare providers do not solicit sensitive information from a minor that is unrelated to legitimate medical purposes and that a parent remain fully informed.

63-1-1002. Part definitions.

As used in this part:

(1) "Healthcare provider":

(A) Means a healthcare professional, healthcare establishment, or healthcare facility licensed, registered, certified, or permitted pursuant to this title, title 33, or title 68 or regulated under the authority of either the department of health or an agency, board, council, or committee attached to the department of health or by the department of mental health and substance abuse services, and that is authorized to provide health or medical care or mental health services in this state; and

(B) Does not include a psychologist, psychiatrist, licensed professional counselor, marriage and family therapist, licensed clinical pastoral therapist, or a licensed clinical social worker licensed pursuant to this title;

(2) "Minor":

(A) Means a person who has not attained eighteen (18) years of age; and

(B) Does not include a person who:

(i) Is emancipated pursuant to title 29, chapter 31;

(ii) Needs emergency treatment pursuant to § 63-6-222;

(iii) Is or was previously a member of the armed forces of the United States or a member of a reserve or national guard unit; or

(iv) Is the parent of a minor child and has full custody of that minor child; and

(3) "Parent" means as biological, legal, or adoptive parent or an individual who has been granted medical decision-making authority over the child under state law.

63-1-1003. Prohibited conduct.

(a) Except as provided in subsection (b), a healthcare provider shall not knowingly or willfully ask a minor a verbal or written question on the following:

(1) Whether the minor feels normal in the minor's body;

(2) Whether the minor believes the minor is the correct gender;

(3) Whether the minor identifies as a gender different from the minor's sex; or

(4) An inquiry intended to elicit statements about gender confusion or gender dysphoria.

(b) A healthcare provider may ask a question listed in subsection (a) if:

(1) The parent is fully informed and gives written consent to a question listed in subsection (a); and

(2) Such question is directly related to the diagnosis or treatment of a specific medical or psychological condition currently being evaluated.

(c) A healthcare provider shall not include questions relating to gender confusion or gender dysphoria on written intake forms, electronic tablets, or questionnaires directed to a minor unless the requirements of this section are satisfied.

(d) This section does not apply to questions regarding a female's menstrual period.

63-1-1004. Exceptions.

(a) Notwithstanding § 63-1-1003:

(1) If a minor volunteers information related to a question listed in § 63-1-1003(a), then a healthcare provider may ask the minor one (1) or more questions listed in § 63-1-1003(a); and

(2) If a healthcare provider, using reasonable medical judgment, based upon the facts known to the healthcare provider at the time, reasonably believes a minor is a trafficked person or a victim of brutality, abuse, or neglect, and the healthcare provider needs to perform a screening of the minor in order to determine whether the healthcare provider must make a report pursuant to § 37-1-403 or § 37-1-605, then the healthcare provider may privately ask a minor one (1) or more questions listed in § 63-1-1003(a).

(b) This part does not apply to a minor who is receiving medical treatment without parental consent pursuant to a law of this state.

63-1-1005. Parental access.

A parent must have full access to all written forms, questionnaires, or electronic assessments presented to the parent's minor child in a healthcare setting.

63-1-1006. Enforcement and penalties.

A violation of § 63-1-1003 by a healthcare provider constitutes unprofessional conduct subject to discipline by the healthcare provider's licensing board.

63-1-1007. Construction.

This part does not:

(1) Limit mandated reporting obligations for child abuse or neglect pursuant to § 37-1-402 or § 37-1-605;

(2) Restrict emergency medical care, as described in § 63-6-222; or

(3) Prevent a minor from voluntarily reporting concerns of abuse, exploitation, or danger to the minor's self or others.

SECTION 3. If any provision of this act or the application of any provision of this act to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end, the provisions of this act are severable.

SECTION 4. The headings in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 5. This act takes effect October 1, 2026, the public welfare requiring it.

HOUSE BILL NO. 1665

PASSED: March 19, 2026

CAMERON SEXTON, SPEAKER
HOUSE OF REPRESENTATIVES

RANDY MCNALLY
SPEAKER OF THE SENATE

APPROVED this 13th day of April 2026

BILL LEE, GOVERNOR