

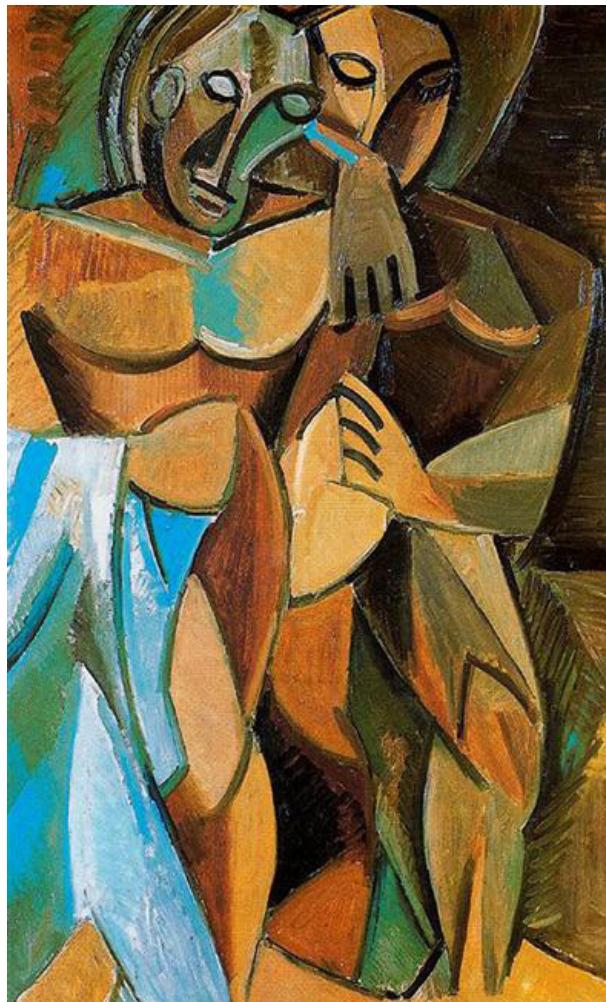
Safeguarding Gender- Affirming Care in an Era of Uncertainty: Lessons from Massachusetts

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At Harvard Medical School, we often hear how fortunate we are to learn medicine in Massachusetts. The Commonwealth Fund's most recent health system performance scorecard ranked the state number one overall and highest in insurance coverage, health care affordability, and health care access (1). For many, Massachusetts functions as a medical safe haven – a place where patients travel to receive care unavailable or under threat elsewhere in the country.

Gender-affirming care (GAC) plays a significant role in this narrative. Massachusetts requires state-regulated insurance plans to cover medically necessary GAC, and state laws protect clinicians from professional discipline or civil liability for providing it (2). In July 2025, the legislature passed the Shield Act 2.0, which strengthens legal protections for patients and providers of reproductive health services and GAC (3). On paper, transgender patients in Massachusetts



perhaps appear insulated from the escalating national restrictions that have curtailed or eliminated access to GAC in many states.

Yet in October 2025, the fragility of this assumed protection became clear. Fenway Health – a nationally recognized leader in LGBTQIA+ care – announced it would no longer provide GAC to patients under 19 (4). As a Federally Qualified Health Center (FQHC), Fenway relies heavily on federal funding to sustain operations. New federal regulations – which would “deprioritize” organizations that provide GAC to minors – could jeopardize Fenway’s FQHC status and the associated funds if they were to continue such care. Fenway’s announcement stunned many in Massachusetts who hoped state policy would continue to shield access regardless of federal shifts.

Unfortunately, Fenway was the first, but not the last. Outer Cape Health Services, another

FQHC, subsequently announced it also would discontinue GAC for minors; the organization cited the same federal constraints as Fenway did (5). Reporting conflicts have made it unclear how many FQHCs remain able or willing to continue this care (5-6). As more clinics close, remaining clinics likely will experience greater strain. Patients who previously received timely, geographically accessible care now funnel into fewer systems with longer waitlists, more complex referral pathways, and substantial travel burdens. Notably, this contraction of access occurred despite Massachusetts' strong legal and political commitment to transgender health care.

For medical students who train in one of the most supportive environments in the country, these developments carry a sobering lesson.

Many of us viewed Fenway as a model institution for LGBTQIA+ healthcare – one immune to the political and administrative pressures that disrupt GAC elsewhere. Yet recent events underscore that no institution is fully protected. Federal policy can alter access with a speed and reach that state legislation may struggle to counteract.

In light of this reality, the question becomes: what can medical students do?

First, we must resist complacency. We cannot assume that Massachusetts' reputation as a health care safe haven will be permanent. Federal policy changes can rapidly override state-level protections, and the events of 2025 demonstrate how quickly access can shift. As trainees, we must approach our education with an awareness that rights—and health care access—preserved today may require active defense tomorrow.

Second, we must advocate within our institutions. Medical students hold positions on curriculum committees, governance boards, and community partnerships that allow us to shape institutional priorities in meaningful ways. We can push for robust training in gender-affirming care across specialties, help sustain student-run or embedded

clinical programs that serve transgender patients, and support faculty who provide this care. Broad internal backing—including from students—can strengthen clinics' ability to maintain services or seek alternative funding mechanisms when external pressures threaten access.

Third, we can support community organizations and patients directly. Sudden clinic closures often leave families confused and distressed, with limited understanding of where to seek care. Students can assist through patient navigation programs, hotline staffing, pro bono advocacy, and collaboration with legal and community groups working to preserve access. These efforts provide immediate support to affected patients while reinforcing the broader ecosystem required to sustain GAC across the state.

Ultimately, we must situate these events within the long arc of public health history. Political structures have always shaped health care access. Local ideals and statutory protections, while essential, do not fully safeguard Massachusetts from the consequences of national policy shifts. If we want this state to remain not only a provider of GAC, but also a refuge for it, we must actively defend the systems that make such care possible.

Massachusetts leads the nation in health system performance, but leadership does not confer invulnerability. Recent events serve as a reminder that protections for GAC—even in dedicated and ostensibly safe environments—can erode quickly. **As future physicians, we bear a responsibility not only to care for patients, but also to safeguard the conditions that enable that care.** The work of ensuring access does not end at the state border; it begins with recognizing that threats can—and have—arrived here, and with our willingness to respond.

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Author's Update:

Since the completion of this article, the policy landscape described here has evolved. In December 2025, the federal government announced proposed regulatory actions intended

to restrict access to gender-affirming medical care for minors nationwide. These proposals include revision of Medicare/Medicaid participation requirements for hospitals to prohibit enrolled facilities from providing certain gender-affirming treatments to patients under 18 and a separate rule to prohibit the use of federal Medicaid and Children's Health Insurance Program (CHIP) dollars to pay for such care (7). Because Medicare/Medicaid participation underwrites reimbursement across a broad range of hospital services—not solely gender-affirming care—these proposals pose significant financial risk for institutions that continue to offer these services and represent a substantial practical constraint on the continued provision of care. Although these policies remain in the proposal stage and are subject to ongoing legal challenges by multiple states, their announcement already has introduced significant uncertainty for providers and patients, including in states such as Massachusetts that currently maintain statutory protections for access to gender-affirming care.

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