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Supreme Court No. 18–1158
Polk County Case Nos. CVCV054956 & CVCV055470 (cons.)

IN THE SUPREME COURT OF IOWA

EERIEANNA GOOD and CAROL BEAL,

Petitioners–Appellees,

v.

IOWA DEPARTMENT OF HUMAN SERVICES,

Respondent–Appellant.

Appeal from the Iowa District Court for Polk County
Honorable Arthur E. Gamble

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STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

I. Does the Regulation violate ICRA's prohibition against gender-identity discrimination?

Statutes, Rules, and Constitutional Provisions

Iowa Code §§ 17A.19(10)(b), (c) (2017)

A. Is the Regulation discriminatory under ICRA?

Cases

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B. Is DHS a "public accommodation" under ICRA?

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II. Does the Regulation violate ICRA's prohibition against sex discrimination?

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Iowa Code § 216.18(1) (2017)

III. Does the Regulation violate the Iowa Constitution's equal-protection guarantee?

Statutes, Rules, and Constitutional Provisions

Iowa Code § 17A.19(10)(a) (2017)

A. Are transgender and nontransgender Iowans who are eligible for Medicaid similarly situated for equal-protection purposes?

Cases

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C. Should discrimination against transgender people be reviewed under heightened scrutiny?

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ROUTING STATEMENT

Petitioners–Appellees EerieAnna Good ("Ms. Good") and Carol Beal ("Ms. Beal") (collectively, "Petitioners") respectfully ask this Court to retain this case under Sections 6.1101(2)(a), (c), and (f) of the Iowa Rules of Appellate Procedure. Iowa R. App. P. 6.1101(2)(a), (c), & (f).

STATEMENT OF THE CASE

I. Overview

Petitioners are women who are transgender, which means that their gender identity differs from their birth-assigned sex. In the proceedings before the district court, they successfully challenged the legality and constitutionality of Section 441-78.1(4) of the Iowa Administrative Code (the "Regulation"), a provision barring them and other transgender individuals from obtaining Medicaid coverage for medically necessary surgery to treat gender dysphoria, a condition that only affects transgender people.

"Gender identity" is a well-established medical concept referring to a person's internal sense of gender. (App.1 84, ¶ 44; App.1 176, ¶ 44.) All human beings develop this basic understanding of belonging to a gender. (App.1 84, ¶ 45; App.1 176, ¶ 45.) Gender identity is an innate and immutable aspect of personality. (App.2 116, 122; App.2 519, 525.) Typically, people who are designated male at birth based on their external anatomy identify as

boys or men, and people designated female at birth identify as girls or women. (App.1 85, ¶ 47; App.1 176, ¶ 47.)

For transgender people, gender identity differs from the sex assigned at birth. (App.1 85, ¶ 48; App.1 176, ¶ 48; App.2 116; App.2 519.) Women who are transgender, for example, are women who were assigned the "male" gender at birth but have a female gender identity. (App.1 85, ¶ 49; App.1 176, ¶ 49.) The medical diagnosis for the feeling of incongruence between one's gender identity and one's birth-assigned sex is "gender dysphoria" (previously known as "gender-identity disorder" or "transsexualism"). (App.1 85, ¶ 51; App.1 176, ¶ 51; App.2 117; App.2 520.)

This action arises from the Regulation's categorical ban on Medicaid coverage for surgical treatment of "transsexualism," "gender identity disorder," and "sex reassignment," on which DHS relied to deny Petitioners reimbursement for medically necessary surgery to treat their gender dysphoria. The State of Iowa's Medicaid program ("Iowa Medicaid") provides coverage for medically necessary care for a broad range of medical conditions. But the Regulation bars Medicaid coverage for medically necessary gender-affirming surgery to treat gender dysphoria even though Medicaid coverage is provided for the same surgical procedures when they are performed to treat other medical conditions. The Regulation "specifically

exclude[s]" coverage for "[p]rocedures related to transsexualism . . . [or] gender identity disorders." Iowa Admin. Code r. 441-78.1(4)(b)(2) (2017). It also states that "[s]urgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage." Iowa Admin. Code r. 441-78.1(4) (2017).

This discriminatory exclusion from Medicaid coverage has no basis in medical science. It is unlawful and unconstitutional, as the district court recognized below. (App.1 316.) Indeed, exclusions of this sort have been uniformly condemned by leading medical organizations. *See* https://www.lambdalegal.org/sites/default/files/publications/downloads/resource_trans-professional-statements_08-22-2018.pdf.

The Regulation's categorical exclusion of Medicaid coverage for gender-affirming surgery violates the Iowa Civil Rights Act's ("ICRA") express prohibitions against gender-identity and sex discrimination. Iowa Code §§ 216.7(1)(a), 216.2(13)(b) (2018). Under ICRA, it is unlawful for any agent of a "public accommodation," including a "state . . . government unit" such as DHS, to deny services or privileges based on gender identity or sex. Iowa Code §§ 216.7(1)(a), 216.2(13)(b) (2018).

The Regulation's categorical exclusion of Medicaid coverage for gender-affirming surgery also violates the Iowa Constitution's equal-

protection guarantee. Iowa Const. art. I, §§ 1, 6. Under the Regulation, Iowa Medicaid covers medically necessary treatment for nontransgender Medicaid participants but denies coverage for the same or similar medically necessary treatment for transgender Medicaid participants. Because the Regulation does not further an important or compelling government interest, and because there is no plausible policy reason for it, the Regulation fails all levels of constitutional review.

Finally, the Regulation and DHS's denial of Medicaid coverage for medically necessary gender-affirming surgery have had a disproportionate negative impact on the private rights of transgender individuals and are arbitrary and capricious. Petitioners are entitled to relief on these grounds as well. *See* Iowa Code §§ 17A.19(10)(k), (n) (2018).

The district court correctly invalidated the Regulation and reversed DHS's denials of Petitioners' requests for Medicaid coverage. Its judgment should be affirmed.

II. Factual Background

A. Standards of Care for Gender Dysphoria

Gender dysphoria is a serious medical condition codified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-V"), and the International Statistical Classification of Diseases and Related Health Problems, Tenth Edition. (App.2 117–18; App.2 520–21.) The criteria for diagnosing gender dysphoria are set forth in Section 302.85 of DSM-V. (App.1 85, ¶ 53; App.1 176, ¶ 53.)

The undisputed evidence shows that gender dysphoria, if left untreated, can lead to serious medical problems, including clinically significant psychological distress and dysfunction, debilitating depression, and, for some people without access to appropriate medical care and treatment, suicidality and death. (App.2 117–18; App.2 520–21.)

The standards of care for treating gender dysphoria ("Standards of Care" or "Standards") are set forth in the World Professional Association of Transgender Health ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Nonconforming People. *See* The World Professional Association of Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Nonconforming People*,

https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf. (App.2 117–18; App.2 520–21.)

The Standards of Care are widely accepted evidence-based medical protocols that articulate professional consensus to guide health-care providers in medically managing gender dysphoria. (*Id*.) They are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association, among others. (*Id*.) They are, in fact, so well established that federal courts have declared that a prison's failure to provide health care in accordance with the Standards may constitute cruel and unusual punishment under the Eighth Amendment of the US Constitution. *Rosati v. Igbinoso*, 791 F.3d 1037, 1039–40 (9th Cir. 2015); *De'lonta v. Johnson*, 708 F.3d 520, 522–26 (4th Cir. 2013); *Fields v. Smith*, 653 F.3d 550, 553–59 (7th Cir. 2011); *Keohane v. Jones*, No. 4:16CV511a–MW/CAS, 2018 WL 4006798, at *3 (N.D. Fla. Aug. 22, 2018).

For many transgender people, necessary treatment for gender dysphoria may require medical interventions to affirm their gender identity and help them transition from living in one gender to another. (App.2 118–19; App.2 521–22; App.1 85, ¶ 60; App.1 176, ¶ 60.) This transition-related care may include hormone therapy, surgery—sometimes called "gender-confirmation surgery" or "sex-reassignment surgery"—and other medical services to align

a transgender person's body with the person's gender identity. (App.2 118–19; App.2 521–22; App.1 85, ¶ 61; App.1 176, ¶ 61.)

The treatment for each transgender person is individualized to fulfill that person's particular needs. (App.2 118–19; App.2 521–22; App.1 85, ¶ 62; App.1 177, ¶ 62.) The WPATH Standards of Care for treating gender dysphoria address all these forms of medical treatment, including surgery. (App.2 118–19; App.2 521–22.)

By the mid-1990s, there was consensus within the medical community that surgery was the only effective treatment for many individuals with severe gender dysphoria. (App.2 121, 126; App.2 524, 529.) More than three decades of research confirms that surgery to modify primary and secondary sex characteristics and anatomy to align with a person's gender identity is therapeutic, and therefore effective treatment for gender dysphoria. (App.2 122, 125; App.2 525, 528.) For severely gender-dysphoric patients, surgery is, in fact, the only effective treatment. (*Id*.)

Health experts have rejected the myth that these treatments are "cosmetic" or "experimental." (App.2 125; App.2 528; App.1 85, ¶ 67; App.1 177, ¶ 67.) Indeed, all major medical associations—including the American Medical Association, the American Psychological Association, the American Academy of Family Physicians, the American College of Obstetricians and

Gynecologists, and WPATH—agree that gender dysphoria is a serious medical condition and that treatment for gender dysphoria is medically necessary for many transgender people. (App.2 126; App.2 529.)

B. Medicaid Coverage for Gender-Affirming Surgery in Iowa

Twenty-five years ago, DHS contracted with the Iowa Foundation for Medical Care (the "Foundation") to analyze whether to provide Medicaid coverage for treating gender dysphoria. (App.1 84, ¶ 34; App.1 175, ¶ 34.) DHS retained the Foundation because, in *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980), the Eighth Circuit had found that "Iowa[] Medicaid['s] . . . specific[] exclu[sion] [of] coverage for sex reassignment surgery" violated the federal Medicaid Act. *Id.* at 547–48. The exclusion was improper because, "[w]ithout any formal rulemaking proceedings or hearings," DHS created "an irrebuttable presumption that the procedure of sex reassignment surgery [could] never be medically necessary when the surgery [was] a treatment for transsexualism." *Id*. at 549. This ban "reflect[ed] inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated knowledge of the medical community." *Id*. It also violated one of Congress's core objectives in passing the Medicaid Act—that "medical judgments" would "play a primary role in the determination of medical necessity." *Id*.

Following DHS's receipt of the Foundation's report, DHS initiated its normal rulemaking process. (App.1 84, ¶ 35; App.1 175, ¶ 35.) In 1995, after a public meeting of DHS's rulemaking body and review by the Iowa General Assembly's administrative-rules committee, DHS adopted the Regulation in its current form. (App.1 84, ¶ 36; App.1 175, ¶ 36.)

In *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001), the Eighth Circuit found that DHS's revised regulatory exclusion on coverage for "[p]rocedures related to gender identity disorder" did not violate the Medicaid Act. *Id*. at 760. The court reasoned that the Foundation's report provided DHS with "evidence . . . questioning the efficacy of and the necessity for sex reassignment surgery, given other treatment options." *Id*. at 761.

The Regulation remains in effect. Since its promulgation more than two decades ago, it has not been updated or modified to reflect medical developments in the research or treatment of gender dysphoria. (App.1 84, ¶ 42; App.1 176, ¶ 42.) Nor have any studies been commissioned to revisit the validity of the medical research or conclusions on which it was based. (App.1 84, ¶ 43; App.1 176, ¶ 43.)

C. Ms. Good

Ms. Good is a twenty-seven-year-old woman who is transgender and has known that she is female since the age of seven. (App.2 190.) She was

diagnosed with gender dysphoria in 2013. (*Id*.) As part of her treatment for gender dysphoria, Ms. Good has lived full time as a woman in every aspect of her life for several years. (*Id*. 190–91.) *See* Standards of Care at 9–10, https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.

In 2014, Ms. Good began hormone therapy. (App.2 191.) In 2016, she legally changed her name, birth certificate, driver's license, and social-security card to reflect her female identity. (*Id*.)

Ms. Good's gender dysphoria exacerbates her depression and anxiety. (*Id*. 190.) She is distressed and very uncomfortable with her genitalia, which does not align with her gender identity. (*Id*. 191–22.) To better present as female, she tucks her genitals into her body and wears a girdle for up to twelve hours or more each day. (*Id*.) These measures help her present outwardly as female in conformity with her gender identity but are very painful and uncomfortable. (*Id*.)

Ms. Good's health-care providers have uniformly concluded that surgery is necessary to treat her gender dysphoria. (App.2 205–07, 209–21.) Ms. Good's surgeon, Dr. Bradley Erickson, for example, concluded that "Ms. Good's gender dysphoria would be significantly improved by undergoing an orchiectomy." (*Id*. 218–21.) He noted that Ms. Good's managed-care

organization ("MCO"), AmeriHealth Caritas Iowa ("AmeriHealth"), "covers orchiectomy procedures for other medical conditions, such as testicular cancer, pain and torsion," and opined that an orchiectomy procedure "is an equally necessary and proper treatment for transgender women with gender dysphoria, including for Ms. Good." (*Id*.)

D. Ms. Beal

Ms. Beal is a forty-two-year-old woman who is transgender and has known that she is female since roughly the age of five. (App.2 531–32.) She has expressed her female identity in various ways since the age of ten, at which time she decided, with her family's support, to transition to living as female full time. (*Id*.)

In 1989, Ms. Beal was diagnosed with gender dysphoria and began hormone therapy. (*Id*. 532.) In 2014, Ms. Beal legally changed her name, birth certificate, driver's license, and social-security card to reflect her female identity. (*Id*. 532–33.) Like Ms. Good, Ms. Beal's gender dysphoria causes her to experience depression and anxiety. (*Id*. 532.) She is distressed and very uncomfortable with her genitalia, which do not align with her gender identity and intensify her depression and anxiety. (*Id*. 533.)

Ms. Beal's health-care providers have uniformly concluded that surgery is necessary to treat her gender dysphoria. (App.2 504–17.) For

example, Ms. Beal's surgeon, Dr. Loren Schechter, has opined that she "satisfie[s] the criteria for medical necessity" established by WPATH and that, in his experience, "it would be highly unusual for an insurance company to deny coverage for each of the procedures [at issue] for medical conditions other than gender dysphoria such as post-oncologic reconstruction, post-traumatic reconstruction, post-infectious reconstruction, or for reconstruction of congenital defects or anomalies." (*Id.* 511–13.) According to Dr. Schechter, "[t]hese are equally necessary and proper treatments for transgender women with gender dysphoria, including for Ms. Beal." (*Id.* 512.)

III. Procedural History

A. Administrative Proceedings

As set forth in the district court's opinion (App.1 283–85), Petitioners requested Medicaid preapproval of expenses for gender-affirming surgery from their MCOs, AmeriHealth and Amerigroup of Iowa Inc. (App.1 83, ¶ 19; App.1 175, ¶ 19.) Both MCOs denied coverage based on the Regulation. (App.1 83, ¶ 20; App.1 175, ¶ 20; App.2 288–90; App.2 391–93.) After internal appeals within each MCO (App.2 157–92, 334–37; App.2 653–705), and hearings before administrative-law judges ("ALJs") (App.2 138–44, 342–45; App.2 537–43, 711–51), DHS adopted the decisions denying coverage (App.2 69–71, 74–134; App.2 443–47, 480–533).

Significantly, neither the MCOs nor DHS submitted any evidence contradicting the affidavits presented by Ms. Good or Ms. Beal. (App.2 228–33; App.2 544–50, 552–55.) Petitioners' evidence that the surgical procedures they requested are medically necessary was unrebutted. (App.2 99–114; App.2 507–17, 531–33.) So, too, was their evidence pertaining to the Standards of Care applicable to gender dysphoria. (App.2 115–127; App.2 518–30.)

B. The District Court

Each Petitioner filed a petition for judicial review in the Polk County District Court. (App.1 5–30; App.1 93–119.) After evaluating the extensive administrative record, conducting a hearing, and considering the parties' briefs, the district court issued a well-reasoned ruling invalidating the Regulation and reversing DHS's denials of Petitioners' requests for Medicaid coverage. The district court concluded that the Regulation violates ICRA's prohibition against gender-identity discrimination (App.1 287–95), violates the Iowa Constitution's equal-protection guarantee under both intermediate scrutiny and rational-basis review (*id.* at 295–309), imposes a disproportionate negative impact on the rights of transgender Medicaid recipients (*id.* at 309–10), and is arbitrary and capricious (*id.* at 310–12).

ARGUMENT

I. The Regulation violates ICRA's prohibition against gender-identity discrimination.

The district court correctly concluded that the Regulation violates the plain meaning of ICRA by discriminating against transgender individuals on the basis of their "gender identity." (App.1 at 290–95.) *See* Iowa Code §§ 17A.19(10)(b), (c) (2018). This issue is subject to de novo review and has been properly preserved for appeal. (Br. 19–20, 30–31.)

A. The Regulation is discriminatory under ICRA.

"The intent of the legislature is the polestar of statutory construction and is primarily to be ascertained based on the language employed in the statute." *Univ. of Iowa v. Dunbar*, 590 N.W.2d 510, 511 (Iowa 1999). "Precise, unambiguous language will be given its plain and rational meaning in light of the subject matter." *Carolan v. Hill*, 553 N.W.2d 882, 887 (Iowa 1996).

The plain language of ICRA expressly states that it is "unfair or discriminatory" for any "employee or agent" of a "public accommodation" to deny services based on "sex [or] gender identity." Iowa Code § 216.7(1)(a) (2018).

As "agent[s]" of DHS, the MCOs were expressly prohibited by the terms of ICRA from discriminating against Petitioners on the basis of gender

identity. (App.1 83, ¶¶ 17–18; App.1 175, ¶¶ 17–18.) And as "employee[s] or agent[s]" of DHS, the agency's director and his staff were expressly prohibited from implementing the MCOs' discriminatory decisions. (App.1 83, ¶ 14; App.1 174, ¶ 14.) Yet that is what the MCOs, the director, and the director's staff did when they denied expense reimbursement for Petitioners' gender-affirming surgery, a medically necessary treatment for gender dysphoria. (App.2 118; App.2 521; App.1 85, ¶ 60; App.1 176, ¶ 60.)

Indeed, the Regulation expressly singles out transgender Iowans for discriminatory treatment by denying Medicaid-eligible individuals coverage for medically necessary treatment solely because they are transgender. It does so since transgender people are the only individuals who have a medical need for surgical procedures related to "transsexualism" or "gender identity disorders," the procedures categorically banned by the Regulation. Discrimination against transgender people is, by its very nature, discrimination on the basis of gender identity because people who are transgender face discrimination due to the failure of their birth-assigned gender to accord with their gender identity. (App.2 116; App.2 519.)

DHS does not dispute that the Regulation categorically prohibits surgical treatment for gender dysphoria. (Br. 20–30.) Instead, DHS takes the position that the Regulation is nondiscriminatory because its exclusion

encompasses "cosmetic, reconstructive, or plastic surgery" that is "performed primarily for psychological purposes," thereby precluding nontransgender and transgender individuals alike from obtaining Medicaid reimbursement for such surgeries. (*Id*.) This argument fails for several reasons.

First, DHS did not deny Medicaid coverage for the surgeries at issue here because of the Regulation's "psychological purposes" exclusion, but instead because they were "[p]rocedures related to transsexualism . . . [or] gender identity disorders" and "[s]urgeries for the purposes of sex reassignment." (App.2 69–71, 144, 334–35; App.2 443–47, 539–40, 654.)

Second, the Regulation categorically bans coverage for gender-affirming surgery for transgender individuals by precluding coverage for surgery related to "transsexualism" or "gender identity disorders" and "[s]urgeries for the purposes of sex reassignment." Iowa Admin. Code r. 441-78.1(4). The Regulation draws a distinction between "cosmetic, reconstructive, or plastic surgery," which includes "surgery . . . to improve physical appearance or . . . primarily for psychological purposes," on the one hand, and surgery that "primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance," on the other. *Id.* Coverage for the former is barred; coverage for the latter is allowed. Cosmetic surgery "to improve appearance of . . . part of the body" that would

be considered "normal" for a person's "age or ethnic or racial background" is therefore not covered, while surgery for "[c]orrection of a congenital anomaly; . . . [r]estoration of body form following an accidental injury; or . . . [r]evision of disfiguring and extensive scars resulting from neoplastic surgery" is covered. Iowa Admin. Code r. 441-78.1(4)(d)(1); 441-78.1(4)(d)(11). The Regulation, however, makes it irrelevant whether surgical treatment of gender dysphoria is for "psychological purposes" or for restoration of "bodily function" since "[s]urgeries for the purposes of sex reassignment" are *categorically defined* as "not . . . restoring bodily function" and "excluded from coverage." *Id.* (emphasis added).

Third, gender-affirming surgery is not primarily for "psychological purposes" and therefore cannot be excluded on that basis. Rather, the purpose of the surgery is to alter or reconstruct a person's "primary and/or secondary sex characteristics" in order to "create body congruence and eliminate anatomical dysphoria." (App.2 125; App.2 528.) "The idea that gender dysphoric patients [are simply] 'demonstrating psychotic mechanisms'" has been "discredited by the weight of research," and the notion that gender dysphoria can be "cured" through "psychoanalysis" has been thoroughly "debunked." (App.2 120; App.2 523.) Indeed, current research indicates that a person's gender identity "has a strong biological basis." (App.2 122; App.2

525.) Gender dysphoria "is based on a realistic perception that one's body habitus does not align with one's gender identity." (App.2 117; App.2 520.)

Unlike elective cosmetic surgery that a person undergoes for aesthetic reasons, medically necessary gender-affirming surgery is intended to alter a person's body to conform to the person's gender identity in order to address the life-altering—and, at times, life-threatening—consequences of gender dysphoria. The undisputed medical evidence in the record shows that gender-affirming surgical treatment may prevent social dysfunction, physical pain, and even death. (App.2 117–18; App.2 520–21.) If left untreated, gender dysphoria often causes acute distress and isolation, impedes healthy personality development and interpersonal relationships, and destroys a person's ability to function effectively in daily life. (App.2 118, 125; App.2 521, 528.) Suicidality and death are common among persons who are unable to access gender-dysphoria treatment, with an attempted-suicide rate of 41% to 43% for those individuals, as compared to a baseline rate of 4.6% in North America for the overall population. (App.2 118; App.2 521.)

For some, like Ms. Good, surgery also alleviates acute physical issues. The gender-affirming orchiectomy for which Ms. Good requested Medicaid coverage, for example, would relieve the extreme pain and discomfort she currently experiences by tucking and wearing a girdle for up to twelve or more

hours each day to better present as female. (App.2 99–102.) And for both Ms. Good and Ms. Beal, gender-affirming surgery would reduce the risks they face from their hormone treatment by allowing them to reduce their hormone dosages to safer levels. (App.2 205–07; App.2 504–06.)

DHS argues that the purpose of gender-affirming surgery is "psychological" because gender dysphoria is a mental-health diagnosis, and many other "mental" conditions may have biological causes and result in the same kinds of physical effects as untreated gender dysphoria. (Br. 25–30.) This argument is badly flawed. With two exceptions—gender dysphoria and body dysmorphic disorder (for which surgery is not an effective treatment)—the Regulation does not classify surgeries as "psychological" based on whether the diagnosis giving rise to the treatment relates to mental health. (App.2 117; App.2 520.) Moreover, surgery is not a treatment for the other mental conditions identified by DHS. The record evidence shows that surgical treatment of gender dysphoria is the only medically necessary surgery banned by the Regulation. DHS's argument that the ban on coverage for surgery to treat gender dysphoria should be upheld because it is part of a larger ban on surgery to treat mental-health conditions fails.

Fourth, the Regulation categorically prohibits transgender individuals from receiving Medicaid coverage for surgical care that is available to

nontransgender individuals for conditions other than gender dysphoria. These surgeries include treatment for testicular cancer, pain, and torsion; postoncologic reconstruction; posttraumatic reconstruction; postinfection reconstruction; reconstruction of congenital defects or anomalies; and scar removal. (App.2 218–21; App.2 512.) *See, e.g.*, Iowa Admin. Code r. 441-78.1(249A) (2017) (approving reimbursement for surgeries to correct "congenital anomol[ies]," for "restoration after injury," and for "[r]evision of disfiguring and extensive scars resulting from neoplastic surgery."). Reconstructive surgery "is performed to treat structures of the body affected *aesthetically* or *functionally* by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally done to improve function and ability, but *may also be performed to achieve a more typical appearance of the affected structure*." American Society of Plastic Surgeons, *Reconstructive Procedures*, http://www.plasticsurgery.org/reconstructive-procedures (emphasis added); *see also id.*, *Breast Reconstruction*, https://www.plasticsurgery.org/reconstructive-procedures/breast-reconstruction ("Breast reconstruction is achieved through several plastic surgery techniques that attempt to restore a breast to near normal shape, appearance and size following mastectomy."); *see also id.*, *Scar Revision*, http://www.plasticsurgery.org/reconstructive-procedures/scar-revision ("Scar

revision surgery will attempt to minimize a scar so that it is less conspicuous and blends in with the surrounding skin tone and texture.").

Fifth, the history behind the language of the Regulation explicitly barring coverage for surgical treatment for "transsexualism" and "gender identity disorder" clearly illustrates that the Regulation's purpose is to exclude coverage for gender-dysphoria treatment, rather than to uniformly bar coverage for surgeries for psychological treatment. In November 1994, DHS began rulemaking to "exclude[] Medicaid coverage for sex reassignment surgery." (App.2 280.) It did so following the Eighth Circuit's decision in *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980), finding that "sex reassignment was an effective treatment for transsexualism and the only effective treatment available." (*Id*. 281.) After that decision, a 1991 claim for coverage for "sex reassignment procedures" was "initially denied based on the state administrative rule's general exclusion of cosmetic, reconstructive, or plastic surgery for psychological purposes" but then was *allowed* after "determin[ing] that the intent of the current rule was to allow payment for sex reassignment." (*Id.*) The addition of explicit language to deny coverage for "sex reassignment procedures" and "gender identity disorders" resulted from DHS's 1994 rulemaking to "reevaluat[e] . . . its policy on sex reassignment surgery"—an unambiguous effort to circumvent *Pinneke*. (*Id.*)

DHS's assertion that the Regulation's exclusion of surgical treatment for gender dysphoria is the result of a generally applicable test excluding care for "psychological purposes" is thus belied by (1) the actual basis on which the Regulation was applied to Petitioners; (2) the Regulation's explicit ban on coverage for surgery to treat gender dysphoria; (3) the evidence showing that (a) gender identity and gender dysphoria are immutable and may have biological bases, and (b) gender-affirming surgery addresses the ways in which a person's body fails to conform with his or her gender identity to lessen or cure the dysfunction, pain, and even death that can result from untreated gender dysphoria; (4) the Regulation's allowance of various other surgeries "for psychological purposes"; and (5) the history of the Regulation. All of this is included in the record; DHS has failed to challenge it by offering any contrary evidence.

B. DHS is a "state . . . government unit," and therefore a "public accommodation," under ICRA.

DHS's proposed interpretation of the Act is based on the false premise that a "public accommodation" can only be a physical place, establishment, or facility. (Br. 30–40.) This restrictive reading of the Act ignores its plain language and disregards well-established principles of statutory construction. And it also ignores the physical involvement of DHS's Des Moines office in

denying Petitioners' requests for Medicaid coverage. The district court correctly rejected DHS's reading of the Act. (App.1 287–90.)

1. The term "unit" does not denote a physical facility.

An undefined statutory term, such as "state . . . government unit," must be afforded its "plain and rational meaning." *Carolan v. Hill*, 553 N.W.2d 882, 887 (Iowa 1996). To do so, Iowa courts frequently look to an undefined term's dictionary definition. *See, e.g.*, *State v. Pettijohn*, 899 N.W.2d 1, 16 (Iowa 2017).

Merriam–Webster's online dictionary defines "unit," in most relevant part, as "a single thing, person, or group that is a constituent of a whole" or "a piece or complex of apparatus serving to perform one particular function." *Dictionary by Merriam–Webster*, http:/www.merriam-webster.com/dictionary/unit. This definition encompasses individual government agencies or entities such as DHS. An agency is "a single thing . . . that is a constituent of a whole" state government. *Id*. It is also "a piece" of the "apparatus" of state government that "serv[es] to perform [the] particular function" of administering the programs and services that fall within its purview. *Id*.

Of the eleven possible definitions of "unit" offered by Merriam–Webster's online dictionary, only one—"an area in a medical facility and

especially a hospital that is specially staffed and equipped to provide a particular type of care," such as "an intensive care unit"—implies a physical facility of any kind. *Id*. Interpreting "state . . . government unit[s]" under Section 216.2(13)(b) of ICRA to include only physical facilities would require reading a limitation into the statutory language that is not supported by the plain meaning of the words chosen by the legislature. This is impermissible. *Cubit v. Mahaska County*, 677 N.W.2d 777, 782 (Iowa 2004) (courts have "no power to read a limitation into [a] statute that is not supported by the words chosen by the general assembly"); *Miller v. Marshall County*, 641 N.W.2d 742, 748 (Iowa 2002) (same).

Other references to the word "unit" within different parts of ICRA are irrelevant. (Br. 35–37.) ICRA does not define "unit"; it simply uses the term to describe the meaning of a "[c]overed multifamily dwelling." Iowa Code § 216.2(4) (2018). Nothing about this usage informs or limits the definition of "government unit," a separate and independent term utilized in a different section of the Act. *See* Iowa Code § 216.2(13)(b) (2018) (defining "public accommodation" to include a "state . . . government unit"); *State ex rel. Claypool v. Evans*, 757 N.W.2d 166 (Iowa 2008) (utilizing the term "unit" relative to a housing-discrimination claim under ICRA, not ICRA's public-accommodation provisions).

2. The doctrine of *noscitur a sociis* supports Petitioners' interpretation of "unit."

The doctrine of *noscitur a sociis*, properly applied, further supports interpreting "unit" as something broader than a physical facility. Under that doctrine, which Iowa courts often invoke in ascertaining a term's plain meaning, "the meanings of particular words may be indicated or controlled by associated words." *Porter v. Harden*, 891 N.W.2d 420, 425 (Iowa 2017); *Des Moines Flying Serv., Inc. v. Aerial Servs., Inc.*, 880 N.W.2d 212, 221 (Iowa 2016).

Here, Section 216.2(13)(b) of ICRA states that "public accommodation" includes "each state and local government *unit* or tax-supported *district*." Iowa Code § 216.2(13)(b) (2018) (emphasis added). The term "district" denotes, in relevant part, "a territorial division" or "an area, region, or section with a distinguishing character." *Dictionary by Merriam–Webster*, http:/www.merriam-webster.com/dictionary/district. Contrary to DHS's contention (Br. 34–35), a "district" is not a physical facility; it is a more generalized "division" or "section," such as a division or section of government administered by the state or one of its localities. By association with the word "district," the word "unit" should be interpreted as something broader than a physical facility.

3. Even under a restrictive interpretation of ICRA, DHS qualifies as a "public accommodation."

In any event, even if "state . . . government unit[s]" were limited to physical facilities, DHS would still qualify as a "public accommodation."

First, DHS has multiple physical offices across the State of Iowa. *See* Iowa Dep't of Human Servs., *DHS Offices Map*, https://dhs.iowa.gov/dhs_ _office_locator. At least one of those offices was involved in denying Medicaid benefits to Petitioners. (App.1 83, ¶ 14; App.1 174, ¶ 14; App.2 69–71; App.2 443–47.) Petitioners were therefore subject to a discriminatory practice by an agent or employee of DHS operating out of a DHS facility—i.e., a "state . . . government unit"—when DHS denied them Medicaid coverage based on their gender identity. These circumstances satisfy even DHS's proposed restrictive definition of "public accommodation" under Section 216.2(13)(b) of ICRA.

Second, DHS satisfies the definition of "public accommodation" set forth in Section 216.2(13)(a) of the Act. Under that provision, "public accommodation[s]" expressly include "facilit[ies] . . . that offer services to . . . nonmembers [of any organization or association] gratuitously . . . if the accommodation receives governmental support or subsidy." Iowa Code § 216.2(13)(a) (2018).

DHS operates "facilities" throughout the State of Iowa that "offer services" to members of the public "gratuitously," such as Medicaid. (App.1 83, ¶ 14; App.1 174, ¶ 14.) And those facilities "receive[] governmental support or subsidy" in that they are funded by the State of Iowa. (App.1 83, ¶ 15; App.1 174, ¶ 15.) Therefore, even under Section 216.2(13)(a)'s definition of "public accommodation," the director of DHS and his staff, as "employee[s] or agent[s]" of DHS, were prohibited from discriminating based on gender identity in administering the Iowa Medicaid program from an office of the Iowa state government. *Cf.* Letter from Attorney General, 1972 WL 262259 (Feb. 2, 1972) (even private club may become "public accommodation" if it receives government support or subsidy).

It is, moreover, immaterial that Petitioners were not denied physical access to DHS's office facility. Section 216.2(13)(a) covers the denial of *services* administered by a public facility, as multiple courts have acknowledged. *Torres v. N. Fayette Cmty. Sch. Dist.*, 600 F. Supp. 2d 1026, 1031 (N.D. Iowa 2008) (public-accommodation discrimination involves denial of "the use of a public facility *or the services or privileges of a public facility*") (emphasis added); *Kirt v. Fashion Bug #3253, Inc.*, 479 F. Supp. 2d 938, 963 (N.D. Iowa 2007) (prima facie case exists if plaintiff "sought to enjoy the accommodations, advantages, facilities, *services, or privileges* of a 'public

accommodation'") (emphasis added). DHS's conduct falls within the scope of Section 216.2(13)(a).

DHS argues that it is "a state agency that . . . is not confined to or defined by a physical locale." (Br. 34.) This argument misconstrues the record and Petitioners' interpretations of Sections 216.2(13)(a) and (b) of ICRA. This is not, as DHS mistakenly contends, a situation where the alleged discrimination is untethered to a "physical locale." (*Id*.) On the contrary, it is evident, that DHS's Des Moines office, and personnel from that office, were involved in Petitioners' Medicaid denials. (App.1 83, ¶ 14; App.1 174, ¶ 14; App.2 69–71; App.2 443–47.) So, too, for that matter, were the ALJs who recommended the denials to DHS from their state offices in Des Moines. (App.2 138–44; App.2 535–43.) These decisions did not simply materialize from thin air; they were made and implemented at discrete, tangible locations. (App.2 70 (decision issued from "1305 E. Walnut Street, Des Moines, IA"); App.2 138 (decision issued from "Wallace State Office Building, Des Moines, Iowa").) Although DHS seeks to distance itself from physical, onsite involvement in discriminatory conduct, it cannot do so.

4. DHS's interpretation of ICRA violates other well-established principles of statutory construction.

DHS's interpretation of "public accommodation" is problematic for several other reasons as well.

a. DHS's interpretation of ICRA renders key statutory language superfluous.

DHS's interpretation of "public accommodation" focuses on Section 216.2(13)(a) of ICRA, which states that "'public accommodation' means each and every place, establishment, or facility of whatever kind, nature, or class that . . . offers services" to the public. Iowa Code § 216.2(13)(a) (2018). (Br. 31–33.) Emphasizing this component of the public-accommodation definition to the exclusion of the provision that includes "state . . . government unit[s]" renders the latter superfluous. Iowa Code § 216.2(13)(b) (2018). Specifically, if, as DHS suggests, Section 216.2(13)(b) of ICRA merely functions as a subset of Section 216.2(13)(a), then Section 216.2(13)(b) has no independent meaning.

As this Court has repeatedly emphasized, courts must "not construe a statute to make any part of it superfluous." *In re Chapman*, 890 N.W.2d 853, 857 (Iowa 2017); *Civil Serv. Comm'n v. Iowa Civil Rights Comm'n*, 522 N.W.2d 82, 86 (Iowa 1994). On the contrary, they must "presume the legislature included all parts of the statute for a purpose . . . [to] avoid reading the statute in a way that would make any portion of it redundant or irrelevant." *Chapman*, 890 N.W.2d at 857 (quotation marks omitted); *Ramirez-Trujillo v. Quality Egg, LLC*, 878 N.W.2d 759, 770 (Iowa 2016). DHS's interpretation of "public accommodation" is improper.

b. DHS fails to broadly construe ICRA.

Additionally, DHS's interpretation of "public accommodation" runs afoul of the clear statement of legislative intent that ICRA "shall be broadly construed to effectuate its purpose." Iowa Code § 216.18(1) (2018). This Court has held that "[a]n Iowa court faced with competing legal interpretations of . . . [ICRA] must keep in mind the legislative direction of broadly interpreting the Act when choosing among plausible legal alternatives." *Pippen v. State*, 854 N.W.2d 1, 28 (Iowa 2014); *see also Probasco v. Iowa Civil Rights Comm'n*, 420 N.W.2d 432, 435 (Iowa 1988) (remedial legislation is to "be construed liberally").

Here, for the reasons discussed above, the only plausible interpretation of "public accommodation" includes DHS, a "state . . . government unit." Yet, even assuming DHS's restrictive interpretation of Section 216.2(13)(b) of the Act were a "plausible legal alternative[]" (which it is not), Petitioners' interpretation must be adopted to ensure that the Act is "broadly construed." Iowa Code § 216.18(1) (2018); *Pippen*, 854 N.W.2d at 28.

c. DHS misreads ICRA's legislative history.

Finally, DHS misreads ICRA's legislative history, which supports Petitioners' reading of the Act. (Br. 38–39.)

When ICRA was enacted in 1965, it replaced a previous Iowa civil-rights statute that contained language similar to the federal Civil Rights Act of 1964. Under the federal Civil Rights Act, the definition of "public accommodation" is significantly narrower and much more focused on discrimination regarding the goods, services, and facilities provided at certain specific physical locations. *See* 42 U.S.C. § 2000a(b).

Under ICRA's predecessor, as under the federal Civil Rights Act, all persons within the State of Iowa were "entitled to the full and equal enjoyment of the accommodations, advantages, facilities, and privileges of inns, restaurants, chop-houses, eating houses, lunch counters, and all other places where refreshments are served, public conveyances, barbershops, bathhouses, theaters, and all other places of amusement." Iowa Code § 735.1 (1962) (current version at Iowa Code § 216.7 (2018)).

ICRA's old language was similar to the federal statute in that it listed facilities constituting public accommodations instead of defining "public accommodation" in general terms. *Compare id. with* 42 U.S.C. § 2000a(b). This language, however, was abandoned by the Iowa legislature, which opted for the provision now in effect because of a concern that the prior provision would be interpreted narrowly to exclude all establishments not explicitly listed in the statute, such as banks, gas stations, and doctor's offices. The

legislature chose less restrictive language. *See U.S. Jaycees v. Iowa Civil Rights Comm'n*, 427 N.W.2d 450, 454–55 (Iowa 1988). ICRA's legislative history therefore supports a *broader* interpretation of "public accommodation," not a narrower one.

DHS's reference to the portion of Professor Arthur Bonfield's article cited in the *Jaycees* case does not support concluding that DHS is not a "public accommodation." (Br. 33–34, 38–39.) That case addressed an entirely different question—namely, whether a private-membership organization itself qualifies as a "public accommodation" under ICRA. *Id*. at 453. The private-membership organization at issue in *Jaycees* bore no relation to the state agency at issue here. It was not a division of the state government. Nor was it connected in any way to a physical location. *Id*. ("The issue here is whether this membership organization is a 'public accommodation' and not whether a public accommodation can be operated by a membership organization.").

II. The Regulation violates ICRA's prohibition against sex discrimination.

For the same reasons set forth above, the Regulation violates ICRA's prohibition against sex discrimination.

This issue falls within the purview of Sections 17A.19(10)(b) and 17A.19(10)(c) of the Iowa Administrative Procedure Act ("IAPA"). Iowa

Code §§ 17A.19(10)(b), (c) (2018). It involves the interpretation of a statute and is therefore subject to de novo review. *Thoms v. Iowa Pub. Employees Ret. Sys.*, 715 N.W.2d 7, 10–11 (Iowa 2006); *City of Des Moines v. Employment Appeal Bd.*, 722 N.W.2d 183, 192 (Iowa 2006).

The issue was properly preserved for review since it was briefed and argued both before DHS and the district court. (App.2 69–70; App.2 443–47; App.1 290–92.) *See Meier v. Senecaut*, 641 N.W.2d 532, 540 n.1 (Iowa 2002) ("A prevailing party may support the district court judgment on any ground contained in the record, provided that the affirmance on that ground does not alter the rights of the parties established in the judgment.").

Although the district court found Petitioners' sex-discrimination claim "compelling," it considered itself "bound" by this Court's decision in *Sommers v. Iowa Civil Rights Commission*, 337 N.W.2d 470, 474 (Iowa 1983), and therefore denied the claim. (App.1 291.) This Court should abrogate *Sommers*, which is now outdated, and find that ICRA's prohibition against sex discrimination encompasses discrimination based on transgender status.

Discrimination based on transgender status constitutes sex discrimination, as dictated by nearly three decades of federal case law, which guides Iowa courts' interpretation of ICRA. *Vivian v. Madison*, 601 N.W.2d

872, 873 (Iowa 1999) (noting that because "ICRA was modeled after Title VII of the United States Civil Rights Act, Iowa courts turn to federal law for guidance in evaluating . . . ICRA"); *Wright v. Winnebago Indus., Inc.*, 551 F. Supp. 2d 836, 845 (N.D. Iowa 2008) (same).

In *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), the United States Supreme Court held that sex discrimination encompasses discrimination based on a person's failure to conform to stereotypical gender norms—the type of discrimination to which transgender individuals are subjected. *Id.* at 250–52, 258. Since *Price Waterhouse* was decided, numerous federal courts have recognized that discrimination against transgender persons is sex discrimination. *See EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560, 571–580 (6th Cir. 2018), *cert. petition filed*, No. 18–107 (July 24, 2018); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1048 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312, 1316–17 (11th Cir. 2011); *Barnes v. City of Cincinnati*, 401 F.3d 729, 736–38 (6th Cir. 2005); *Smith v. City of Salem*, 378 F.3d 566, 572–75 (6th Cir. 2004); *Rosa v. Park W. Bank & Trust*, 214 F.3d 213, 215–16 (1st Cir. 2000); *Schwenk v. Harford*, 204 F.3d 1187, 1198–1203 (9th Cir. 2000). The Eighth Circuit recently has shown a similar inclination. *Tovar v. Essentia Health*, 857 F.3d 771, 775 (8th Cir. 2017) (assuming, for purposes of appeal, "that the prohibition on sex

based discrimination under Title VII . . . encompasses protection for transgender individuals").

As courts have recognized, "discrimination on the basis of transgender and transitioning status" is by its very nature sex discrimination. *R.G.*, 884 F.3d at 574–75. It is "analytically impossible" to make a decision based on an individual's "status as a transgender person without being motivated, at least in part, by the [person's] sex." *Id*. at 575. "There is no way to disaggregate discrimination on the basis of transgender status from discrimination on the basis of gender non-conformity . . . ." *Id*. at 576–77.

This Court's decision in *Sommers* is based on a constricted definition of "sex" borrowed from federal case law that has been superseded by intervening decisions. In *Sommers*, the Court held that ICRA's prohibition against sex discrimination did not encompass discrimination based on "transsexualism." *Sommers*, 337 N.W.2d at 473–74. But *Sommers* was predicated on a narrow definition of "sex" based on the Eighth Circuit's decision in *Sommers v. Budget Marketing, Inc.*, 667 F.2d 748 (8th Cir. 1981), as well as other federal decisions that have been "eviscerated by *Price Waterhouse*." *See Smith*, 378 F.3d at 573.

In light of the superseding federal case law postdating that on which *Sommers* was based, this Court should overrule its decision in *Sommers* and

find that the Regulation and DHS's denials of Petitioners' requests for Medicaid coverage violate ICRA's prohibition against sex discrimination. *McElroy v. State*, 703 N.W.2d 385, 395 (Iowa 2005) (noting that "stare decisis does not prevent the court from reconsidering, repairing, correcting or abandoning past judicial announcements when error is manifest, including error in the interpretation of statutory enactments") (quotation marks and citations omitted).

The Regulation discriminates based on sex by restricting coverage for necessary medical treatment to a class of persons based on their failure to conform to stereotypical gender norms and the fact of their transition from one gender to another, both of which amount to sex discrimination. It denies Medicaid coverage for medically necessary procedures to conform a person's body to a gender that is different from that assigned at birth while affording coverage for comparable procedures for other medically necessary purposes.

DHS argued below that if ICRA explicitly prohibits gender-identity discrimination, then it would be redundant to interpret its prohibition against sex discrimination to encompass discrimination based on gender identity as well. (App.1 207–08.) This argument contravenes the principle, reflected in ICRA itself, that remedial statutes must be construed liberally to effectuate their purpose. Iowa Code § 216.18(1) (2018); *Pippen v. State*, 854 N.W.2d 1,

28 (Iowa 2014); *Probasco v. Iowa Civil Rights Comm'n*, 420 N.W.2d 432, 435 (Iowa 1988). Here, a liberal construction of ICRA requires interpreting its prohibition against sex discrimination to encompass gender-identity discrimination.

This Court's case law supports this reading of the Act. In *Deboom v. Raining Rose, Inc.*, 772 N.W.2d 1 (Iowa 2009), the Court considered whether a jury properly entered a defense verdict for an employer sued for sex and pregnancy discrimination under ICRA. *Id*. at 4. In noting that Section 216.2(d) of the Act "deals with pregnancy *directly*," the Court implicitly acknowledged that the Act's "general provisions," which include its prohibition against "sex" discrimination, deal with pregnancy, too. *Id*. at 6–7 (emphasis added). Dual coverage is thus permissible under the Act and necessary to effectuate its remedial purpose.

Indeed, legislatures often enact more specific laws to clarify existing laws of a general nature. *See R.G.*, 884 F.3d at 578–79 (rejecting argument that passage of later federal statute "expressly prohibit[ing] discrimination on the basis of gender identity[]" meant that Title VII failed to prohibit discrimination based on transgender status since "Congress may certainly choose to use both a belt and suspenders to achieve its objectives") (quotation marks and citations omitted); *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp.

3d 509, 527 n.12 (D. Conn. 2016) (where Connecticut legislature added language explicitly protecting gender identity to statute in question, its decision did "not require the conclusion that gender identity was not already protected by the plain language of the statute [prohibiting sex discrimination]"). That is the case here.

III. The Regulation violates the Iowa Constitution's equal-protection guarantee.

The district court correctly concluded that the Regulation violates the Iowa Constitution's equal-protection guarantee. (App.1 295–309.) *See* Iowa Code § 17A.19(10)(a) (2018). This issue is subject to de novo review and has been properly preserved for appeal. (Br. 40.)

A. Transgender and nontransgender Iowans eligible for Medicaid are similarly situated for equal-protection purposes.

The Iowa Constitution contains a two-part equal-protection guarantee. Iowa Const. art. I, §§ 1, 6. Although this Court looks to federal courts' interpretation of the US Constitution in construing parallel provisions of the Iowa Constitution, it "jealously reserve[s] the right to develop an independent framework under the Iowa Constitution." *NextEra Energy Res., LLC v. Iowa Utilities Bd.*, 815 N.W.2d 30, 45 (Iowa 2012). This is because, as this Court recently reaffirmed, the rights guaranteed to individuals under the Iowa Constitution have critical, independent importance, and the courts play a

crucial role in protecting those rights. *Godfrey v. State*, 898 N.W.2d 844, 864–65, 869 (Iowa 2017).

Iowa's constitutional promise of equal protection is essentially a direction that all persons similarly situated should be treated alike under the law. *Gartner v. Iowa Dep't of Pub. Health*, 830 N.W.2d 335, 351 (Iowa 2013); *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). More precisely, the equal-protection guarantee requires "that laws treat alike all people who are similarly situated with respect to the legitimate purposes of the law." *Varnum v. Brien*, 763 N.W.2d 862, 882 (Iowa 2009) (quotation marks omitted); *Bowers v. Polk County Bd. of Supervisors*, 638 N.W.2d 682, 689 (Iowa 2002).

Here, as in *Varnum*, and as the district court correctly concluded (App.1 296–97), transgender and nontransgender Iowans eligible for Medicaid are similarly situated for equal-protection purposes. They are the same in all legally relevant ways because Medicaid recipients—transgender or not—share a financial need for medically necessary treatment. *In re Estate of Melby*, 841 N.W.2d 867, 875 (Iowa 2014) ("The Medicaid program was designed to serve individuals and families lacking adequate funds for basic health services . . . ."). Despite medical necessity, DHS has denied Petitioners

and other transgender individuals coverage for health care based on nothing more than the fact that they are transgender. (App.2 69–71; App.2 443–47.)

B. The Regulation is discriminatory under the Iowa Constitution's equal-protection guarantee.

As discussed above, and as the district court recognized (App.1 292–95, 304–05), the Regulation discriminates against transgender Medicaid recipients.

The Regulation is facially discriminatory against transgender Medicaid recipients because it singles out transgender recipients, such as Petitioners, by denying them coverage expressly because they are transgender. Specifically, it denies them coverage for gender-affirming surgery to treat gender dysphoria, a condition only affecting transgender persons, and withholds necessary medical treatment that is inextricably tied to the fact of a person's transgender status. Iowa Admin. Code r. 441-78.1(4) (2017) (excluding coverage for "[p]rocedures related to transsexualism . . . [or] gender identity disorders" and "[s]urgeries for the purposes of sex reassignment").

Varnum v. Brien, 763 N.W.2d 862 (Iowa 2009), is instructive. In *Varnum*, the "benefit denied by the marriage statute—the status of civil marriage for same-sex couples—[was] so closely correlated with being homosexual as to make it apparent the law [was] targeted at gay and lesbian people as a class." *Id*. at 885 (quotation marks omitted). Here, gender

transition through social transition and medical interventions, such as surgical treatment for gender dysphoria, "is so closely correlated with being [transgender] as to make it apparent" that the Regulation, which bans such treatment, "is targeted at [transgender] people as a class." *See id.* (quotation marks omitted). The Regulation's disparate treatment of transgender Medicaid recipients is a sufficient basis to support Petitioners' equal-protection claim.

C. Discrimination against transgender people should be reviewed under heightened scrutiny.

This Court should affirm the district court's determination that heightened scrutiny applies to classifications that discriminate against transgender individuals. First, the factors this Court relies on to decide whether a heightened level of review should apply to an identifiable group strongly support applying intermediate or strict scrutiny to transgender Iowans. Second, discrimination against transgender Iowans is a form of gender-based discrimination, which this Court reviews under intermediate scrutiny.

1. Iowa's four-factor test for ascertaining the appropriate level of equal-protection scrutiny mandates applying heightened scrutiny.

The highest and most probing level of scrutiny under the Iowa Constitution—strict scrutiny—applies to classifications based on race,

alienage, or national origin and those affecting fundamental rights. *Varnum v. Brien*, 763 N.W.2d 862, 880 (Iowa 2009); *Sherman v. Pella Corp.*, 576 N.W.2d 312, 317 (Iowa 1998). Under this approach, classifications are presumptively invalid and must be "narrowly tailored to serve a compelling state interest." *In re S.A.J.B.*, 679 N.W.2d 645, 649 (Iowa 2004).

A middle level of scrutiny called "intermediate scrutiny" exists between rational-basis review—discussed below—and strict scrutiny. *Varnum*, 763 N.W.2d at 880. Intermediate scrutiny requires the party seeking to uphold a classification to demonstrate that it is "substantially related" to achieving an "important governmental objective[]." *Sherman*, 576 N.W.2d at 317 (quotation marks omitted). The justification for the classification must also be "genuine" and must not depend on "overbroad generalizations." *United States v. Virginia*, 518 U.S. 515, 533 (1996). This Court's decisions confirm that intermediate scrutiny applies to classifications based on gender, illegitimacy, and sexual orientation. *Varnum*, 763 N.W.2d at 895–96; *NextEra Energy Res., LLC v. Iowa Utilities Bd.*, 815 N.W.2d 30, 46 (Iowa 2012).

Iowa courts apply a four-factor test to determine the appropriate level of scrutiny under the Iowa Constitution's equal-protection guarantee. *Varnum*, 763 N.W.2d at 886–87. The factors include "(1) the history of invidious discrimination against the class burdened by [a particular

classification]; (2) whether the characteristics that distinguish the class indicate a typical class member's ability to contribute to society; (3) whether the distinguishing characteristic is immutable or beyond the class members' control; and (4) the political power of the subject class." *Id.* at 887–88.

In *Varnum*, the Court cautioned against using a "rigid formula" to determine the appropriate level of equal-protection scrutiny and refused "to view all the factors as elements or as individually demanding a certain weight in each case." *Id*. at 886–89. Although no single factor is dispositive, the first two "have been critical to the analysis and could be considered as prerequisites to concluding a group is a suspect or quasi-suspect class," and the last two "supplement the analysis as a means to discern whether a need for heightened scrutiny exists" beyond rational basis. *Id*. at 889.

The four-factor *Varnum* test mandates applying at least intermediate scrutiny to classifications that discriminate against transgender Iowans.

a. Factor one, the history of invidious discrimination against a group by the classification, supports heightened scrutiny.

In *Varnum*, the court relied on national statistics, case law from other jurisdictions, and other sources to find that lesbian and gay individuals have experienced a history of invidious discrimination and prejudice. *Varnum v. Brien*, 763 N.W.2d 862, 889–90 (Iowa 2009). The Iowa General Assembly's

enactment of several laws to protect individuals based on sexual orientation was critical to the Court's reasoning in *Varnum*, particularly the General Assembly's decision to add sexual orientation to ICRA as a protected class in 2007. *Id*. at 889–91. These enactments, which included laws to counter bullying and harassment in schools and prohibit discrimination in credit, education, employment, housing, and public accommodations, demonstrated legislative recognition of the need to remedy historical sexual-orientation-based discrimination. *Id*. at 890.

Like sexual orientation, gender identity was added in 2007 as a protected class to both ICRA and the Iowa Anti-Bullying and Anti-Harassment Act. Iowa Code § 216.7(1)(a) (2018); Iowa Code § 280.28(2)(c) (2018). And like discrimination based on sexual orientation, discrimination based on transgender status has been extensively documented. James, S.E., et al., *The Report of the 2015 U.S. Transgender Survey*, Washington, DC: National Center for Transgender Equality (2016), https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF ("Transgender Survey"). Published in 2016, the Transgender Survey describes the discrimination, harassment, and even violence that transgender individuals encounter at school, in the workplace, when trying to find a place to live,

during encounters with police, in doctors' offices and emergency rooms, at the hands of service providers and businesses, and in other aspects of life. *Id.*

In Iowa, widespread discrimination against transgender individuals has been documented by Professor Len Sandler and the University of Iowa College of Law's Rainbow Health Clinic. Len Sandler, *Where Do I Fit In? A Snapshot of Transgender Discrimination in Iowa* (June 16, 2016), https://law.uiowa.edu/sites/law.uiowa.edu/files/Where%20Do%20I%20Fit%20In%20%20A%20Snapshot%20of%20Transgender%20Discrimination%20June%202016%20Public%20Release.pdf. (the "Rainbow Health Clinic Report").

Transgender people nationally and in Iowa continue to face discrimination. And to the extent they have seen progress in protecting their rights, there is considerable backlash against that progress—including, unfortunately, through discriminatory legislation introduced in the most recent Iowa General Assembly. *See Trump's Record of Action Against Transgender People*, National Center for Transgender Equality, https://transequality.org/the-discrimination-administration; Sarah Tisinger, *Branstad Calls Obama's Transgender Policy 'Blackmail,'* WQAD (May 18, 2016), https://wqad.com/2016/05/18/branstad-calls-obamas-transgender-bathroom-policy-blackmail; Jeremy W. Peters et al., *Trump Rescinds Rules*

on Bathrooms for Transgender Students, N.Y. Times (Feb. 22, 2017), https://www.nytimes.com/2017/02/22/us/politics/devos-sessions-transgender-students-rights.html; Brianne Pfannenstiel & Courtney Crowder, *Transgender 'Bathroom Bill' Introduced in Iowa House, Though Support Lags*, Des Moines Register (Jan 31., 2018), https://www.desmoinesregister.com/story/news/politics/2018/01/31/transgender-bathroom-billuiowalgbtq/1077963001/; Iowa H.B. 2164, 87 Gen. Assem. (Jan. 31, 2018) (if passed, law would deprive transgender K through 12 students in Iowa of access to boys' and girls' restrooms consistent with their gender identity); Lee Rood, *Nursing Facility Doors Slam Shut for Transgender Iowan*, Des Moines Register (May 18, 2016), https://www.desmoinesregister.com/story/news/investigations/readers-watchdog/2016/05/18/nursing-facility-doors-slam-shut-transgender-iowan/84490426. These examples illustrate the long, troubling history of invidious discrimination against transgender individuals in Iowa and elsewhere. *Varnum*, 763 N.W.2d at 889–90.

b. Factor two, the relationship between transgender status and the ability to contribute to society, supports heightened scrutiny.

The second *Varnum* factor examines whether the class members' characteristics are related in any way to their ability to contribute to society. *Varnum v. Brien*, 763 N.W.2d 862, 890 (Iowa 2009). In *Varnum*, the test was

satisfied by (1) the lack of any holding by any court that lesbian, gay, or bisexual people are unable to contribute to daily life and (2) the existence of ICRA's protections against sexual-orientation discrimination. *Id*. at 890–91.

A person's gender identity or transgender status is irrelevant to the person's ability to contribute to society. The fact the Iowa General Assembly has outlawed discrimination based on gender identity shows that it recognizes transgender Iowans' ability to contribute to society. *Id*. at 891 (finding that the Iowa legislature's prohibition against sexual-orientation discrimination sets forth "the public policy . . . that sexual orientation is not relevant to a person's ability to contribute to a number of societal institutions"). The same is true of various letters that Iowa corporations submitted to the Iowa Civil Rights Commission in support of the 2007 ICRA amendments. Rainbow Health Clinic Report at 10. Those letters, which attest to the need for a state law protecting lesbian, gay, bisexual, and transgender ("LGBT") Iowans against discrimination, illustrate the high premium Iowa employers place on their LGBT employees. (*Id*.) Additionally, the evidence in the record includes unrebutted expert testimony that "[m]edical science recognizes that transgender individuals represent a normal variation of the diverse human population" and that "transgender people are fully capable of leading healthy, happy and productive lives." (App.2 122; App.2 525.) "Being transgender

does not affect a person's ability to be a good employee, parent, or citizen." (*Id.*)

Consistent with *Varnum*, these sources support a finding that gender identity or transgender status, like sexual orientation, has no bearing on a person's ability to contribute to society. *Varnum*, 763 N.W.2d at 890.

c. Factor three, the immutability of the trait at issue, supports heightened scrutiny.

The third *Varnum* factor is satisfied when a trait is "so central to a person's identity that it would be abhorrent for the government to penalize a person for refusing to change [it]." *Varnum v. Brien*, 763 N.W.2d 862, 893 (Iowa 2009) (quotation marks omitted).

Gender identity, like sexual orientation, is a trait central to a person's identity. (App.2 116, 122; App.2 519, 525.) The WPATH Standards of Care and other medical literature in the record demonstrate that gender identity is not subject to change through outside influence. (App.2 116, 119–22; App.2 519, 522–25.) *See also* Standards of Care at 16, https://www.wpath.org/media.cms/Documents/SOC%20v7/SOC%20V7_English.pdf ("Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success . . . . Such treatment is no longer considered ethical.").

d. Factor four, the political powerlessness of the class, supports heightened scrutiny.

The last *Varnum* factor is whether people experience political powerlessness as a result of being the members of a similarly situated class. *Varnum v. Brien*, 763 N.W.2d 862, 887–88 (Iowa 2009). The "touchstone" of this analysis is whether a group "lacks sufficient political strength to bring a prompt end to . . . prejudice and discrimination through traditional political means." *Id*. at 894 (quotation marks omitted).

Varnum identified two considerations that help define the boundaries of political powerlessness. First, "absolute political powerlessness" is not required for a class to be subject to intermediate scrutiny because, for example, "females enjoyed at least some measure of political power when the Supreme Court first heightened its scrutiny of gender classifications." *Id.*

Second, "a group's current political powerlessness is not a prerequisite to enhanced judicial protection." *Id*. "[I]f a group's *current* political powerlessness [was] a prerequisite to a characteristic's being considered a constitutionally suspect basis for differential treatment, it would be impossible to justify the numerous decisions that continue to treat sex, race, and religion as suspect classifications" in the face of growing political power for women, racial minorities, and others. *Id*. (emphasis in original) (quotation marks

omitted). As a result, increased political standing or power does not prevent a court from utilizing heightened scrutiny.

Applying these principles here strongly supports a finding that transgender Iowans are politically weak, if not powerless. Although the transgender community does not suffer from "absolute political powerlessness," transgender individuals cannot overturn discriminatory laws and policies, such as the Regulation, through the legislative process. Transgender Iowans lack the political power to bring a "prompt end to the prejudice" that they experience because of the community's small population size and the enduring societal prejudices against transgender people. *Id*. (quotation marks omitted).

2. Jurisdictions across the country support applying heightened scrutiny to classifications that discriminate against transgender individuals.

A growing number of courts have found that intermediate or strict scrutiny is appropriate to examine classifications based on transgender status. For example, in *Adkins v. City of New York*, 143 F. Supp. 3d 134 (S.D.N.Y. 2015), the court found that discrimination against transgender individuals is subject to heightened scrutiny since transgender people have suffered a history of discrimination and prejudice, a person's identity as transgender has nothing to do with the person's ability to contribute to society, and transgender

people represent a discrete minority class that is politically powerless to bring about change on its own. *Id*. at 139–40.

Many other courts have reached the same conclusion. *See*, *e.g.*, *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015) (discrimination against transgender people subject to intermediate scrutiny); *Marlett v. Harrington*, No. 1:15–cv–01382–MJS (PC), 2015 WL 6123613, at *4 (E.D. Cal. 2015) (same); *Bd. of Educ. of the Highland Local Sch. Dist. v. United States Dep't of Educ.*, 208 F. Supp. 3d 850, 874 (S.D. Ohio 2016) (same); *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017) (same); *Doe 1 v. Trump*, 275 F. Supp. 3d 167, 208–09 (D.D.C. 2017) (same); *A.H. v. Minersville Area Sch. Dist.*, 290 F. Supp. 3d 321, 331 (M.D. Pa. 2017) (same); *Stone v. Trump*, 280 F. Supp. 3d 747, 768 (D. Md. 2017) (same); *Grimm v. Gloucester County Sch. Bd.*, 302 F. Supp. 3d 730, 748–50 (E.D. Va. 2018) (same); *M.A.B. v. Bd. of Educ. of Talbot County*, 286 F. Supp. 3d 704, 718–22 (D. Md. 2018) (same); *F.V. v. Barron*, 286 F. Supp. 3d 1131, 1142–45 (D. Idaho 2018) (same); *Karnoski v. Trump*, No. C17–1297–MJP, 2018 WL 1784464, at *1 (W.D. Wash. Apr. 13, 2018) (finding that "any attempt to exclude [transgender people] from military service will be looked at with . . . 'strict scrutiny'").

In addition, heightened scrutiny applies since discrimination against transgender people is a form of sex discrimination. *Varnum v. Brien*, 763 N.W.2d 862, 880 (Iowa 2009) (intermediate scrutiny applies to gender classifications); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017) (same); *Glenn v. Brumby*, 663 F.3d 1312, 1318 (8th Cir. 2011) (same).

DHS's argument that heightened scrutiny is inapplicable because the Regulation does not classify Medicaid beneficiaries based on transgender status (*see* Br. 41–43) fails for the reasons discussed above.

DHS's only other argument is that "[n]o evidence was submitted pertaining to the political powerlessness of the class." (Br. 43.) However, evidence of political powerlessness is a legislative fact, not an adjudicative fact. *Varnum*, 763 N.W.2d at 881 (noting the "distinction between 'adjudicative' and 'legislative' facts" and stating that the former involve admissible evidence, while the latter may "may be presented either formally or informally"). "Legislative facts are relevant in deciding . . . constitutional issues because courts must normally analyze 'whether there exist circumstances which constitutionally either legitimate the exercise of legislative power or substantiate the rationality of the legislative product.'" *Id.* (quoting 2 John W. Strong, McCormick on Evidence § 328, at 370 (5th ed.

1999)). Here, in addition to the evidence in the record supporting the second and third elements giving rise to heightened scrutiny, the Court may also consider evidence outside the record to support a finding of political powerlessness and a history of discrimination.

D. The Regulation cannot survive intermediate or strict scrutiny.

Of the two forms of heightened scrutiny, intermediate scrutiny requires a party seeking to uphold a classification to demonstrate that the "classification is substantially related to the achievement of an important governmental objective." *Varnum v. Brien*, 763 N.W.2d 862, 880 (Iowa 2009). It is the government's burden to justify the classification based on specific policy or factual circumstances that it can prove, rather than broad generalizations. *Id*. "Classifications subject to strict scrutiny are presumptively invalid and must be narrowly tailored to serve a compelling governmental interest." *Id.*

DHS cannot meet these standards, as the district court correctly acknowledged. (App.1 301–05.) There is no "compelling governmental interest" or "important governmental objective" advanced by excluding transgender individuals from Medicaid reimbursement for medically necessary procedures. Gender dysphoria is a serious medical condition. (App.1 85, ¶ 67; App.1 177, ¶ 67; App.2 117–18; App.2 520–21.) And

surgical treatment for gender dysphoria is medically necessary and effective. (App.1 85, ¶¶ 60–61, 67; App.1 176–77, ¶¶ 60–61, 67; App.2 118–26; App.2 521–29.) Therefore, denying coverage cannot be justified on medical grounds. Nor, under intermediate or strict scrutiny, can it be justified as a cost-savings measure. *Varnum*, 763 N.W.2d at 902–04 (cost savings could not justify exclusion of same-sex couples from marriage).

DHS fails to offer any evidence to satisfy its burden under heightened scrutiny, relying instead on its incorrect assertion that the Regulation involves a classification regarding surgery to treat psychological conditions rather than a ban on coverage for care needed only by transgender persons. (Br. 45.) The federal cases DHS cites—which involved rational-basis review, *not* heightened scrutiny—likewise do not support its argument. (Br. 44–45.)

E. The Regulation cannot survive rational-basis review.

The Regulation also cannot withstand rational-basis review. Rational-basis review requires a "plausible policy reason for the classification." *Varnum v. Brien*, 763 N.W.2d 862, 879 (Iowa 2009) (quotation marks omitted). It also requires that "the legislative facts on which the classification is apparently based rationally may have been considered to be true by the governmental decisionmaker" and that "the relationship of the classification

to its goal is not so attenuated as to render the distinction arbitrary or irrational." *Id*. (quotation marks omitted).

Although the rational-basis test is "deferential to legislative judgment, it is not a toothless one in Iowa." *Racing Ass'n of Cent. Iowa v. Fitzgerald* ("*RACI*"), 675 N.W.2d 1, 9 (Iowa 2004) (quotation marks omitted). In addition, rational-basis scrutiny does not protect laws that burden otherwise unprotected classes when the reason for a distinction is based purely on animus. *U.S. Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973).

The district court correctly concluded that the Regulation cannot withstand rational-basis review. (App.1 305–09.) For the reasons discussed above, there simply is no plausible policy reason advanced by, or rationally related to, excluding transgender individuals from Medicaid reimbursement for medically necessary procedures. Surgical treatment for gender dysphoria, a serious medical condition, is necessary and effective. (App.1 85, ¶¶ 60–61, 67; App.1 176–77, ¶¶ 60–61, 67; App.2 117–26; App.2 520–29.) And Medicaid coverage is crucial to ensuring the availability of that necessary treatment.

Moreover, under rational-basis review, the Regulation's surgical ban cannot be justified as a measure to save money since there is no reasonable distinction between transgender and nontransgender individuals with regard

to their need for Medicaid coverage for medically necessary surgical care. Both groups need financial assistance for critically necessary medical treatments. Costs savings are insufficient to justify the arbitrary distinction the Regulation creates between transgender persons and nontransgender persons in need of necessary medical care. *RACI*, 675 N.W.2d at 12–15 (even under rational-basis review, there must be some reasonable distinction between the group burdened with higher taxes, as compared to the favored group, to justify the higher costs); *see also Diaz v. Brewer*, 656 F.3d 1008, 1014 (9th Cir. 2011); *Bassett v. Snyder*, 59 F. Supp. 3d 837, 854–55 (E.D. Mich. 2014).

Varnum further supports this conclusion. While *Varnum* held that intermediate scrutiny applied to Iowa's marriage statute, the Court's explanation for rejecting cost savings as a rationale for the discriminatory treatment of same-sex couples applies equally well to rational-basis review: "Excluding any group from civil marriage—African–Americans, illegitimates, aliens, even red-haired individuals—would conserve state resources in an equally 'rational' way. Yet, such classifications so obviously offend our society's collective sense of equality that courts have not hesitated to provide added protections against such inequalities." *Varnum*, 763 N.W.2d at 903.

In contrast, the decision in *Kantrowitz. v. Weinberger*, 388 F. Supp. 1127, 1131 (D.D.C. 1974), on which DHS relies, involved a federal constitutional challenge in which the court concluded that it was rational to prefer the elderly (i.e., because they "are the least able of the categorical grant recipients to bear the hardships[] of an inadequate standard of living") and the young (i.e., as "a compassionate, sound investment to restore mentally ill children amenable to treatment to constructive citizenship"). Unlike the arbitrary distinction between transgender Medicaid recipients in need of surgical treatment for gender dysphoria and nontransgender recipients in need of treatment for other medical conditions, the distinction in *Kantrowitz* was not one made on "purely arbitrary grounds." *Id.*

Additionally, DHS's assertion that surgical treatments for gender dysphoria have an "excessive cost" has no factual basis at all, and none was offered as evidence. (Br. 45.) Publicly available data shows otherwise. *See* Herman, Jody L., *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* (Williams Institute, Sept. 2013) ("Herman Study"). In fact, there are medical costs associated with denying transgender people access to medically necessary transition-related care since, with the availability of care, their overall health and well-being improve, resulting in significant reductions in suicide attempts, depression, anxiety, substance abuse, and self-administration of hormone injections. Cal.

Dep't of Ins., *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (Apr. 13, 2012), https://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.

Quoting *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001), DHS asserts that the "nature and diagnosis of gender identity disorder" is "evolving" and that there is "disagreement regarding the efficacy of sex reassignment surgery." (Br. 47–50.) But the facts in the record plainly show otherwise. Dr. Randi Ettner, one of the leading experts in the country on transgender issues, states definitively that there is no disagreement among mainstream medical professionals regarding the appropriateness and necessity of this surgical care. (App.2 126; App.2 529.) That is why leading medical groups all endorse the Standards of Care, which include surgery as one of the medically necessary treatments for gender dysphoria. (App.2 118–19, 126; App.2 521–22, 529.)

That some health-care providers have personal objections to performing surgery to treat gender dysphoria fails to undermine the community consensus that such surgeries are medically necessary, as DHS suggests. (Br. 48). *See* Standards of Care at 55, https://www.wpath.org/medi

a/cms/Documents/SOC%20v7/SOC%20V7_English.pdf. DHS's argument regarding personal objections does not distinguish these surgeries from other forms of medical treatment, such as care involving contraception. Similarly, DHS wrongly suggests that the difference of opinion "as to what degree" certain surgical procedures, such breast augmentation and facial-feminization surgery, "can be considered purely reconstructive"—as opposed to a mixture of reconstructive and cosmetic—supports its argument that there is controversy regarding the efficacy of gender-affirming surgery. (Br. 48 (citing Standards of Care at 58).) The difference of opinion does no such thing even as to those surgeries. And it fails to justify the Regulation's blanket ban on coverage for any surgery.

DHS's assertion that "the medical consensus at the time the Regulation was made was not substantially different from that posited by Petitioners today" is nonsense. (Br. 49.) Additional studies have confirmed that the surgery is medically necessary, and the medical consensus regarding its efficacy has strengthened since 1995. (App.2 120–21; App.2 523–24.) While a number of private insurers still exclude coverage for these surgeries (Br. 48), that number is significantly smaller than it used to be. *See* Herman Study at 2.

And Medicare and at least seventeen states have ended exclusions on coverage for this treatment.[1]

[1] *See* Dep't of Health & Human Servs. Dept'l Appeals Bd. Decision No. 2576 (May 30, 2014), https://www.hhs.gov/sites/default/files/static/dab/dec https://www/hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf; Cal. Dep't of Health Care Servs., *Ensuring Access to Medi-Cal Services for Transgender Beneficiaries* (Oct. 6, 2016), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL/APL16-013.pdf; 10 Colo. Code Regs. § 2505-10 8.735; Conn. Gen. Stat. § 46a-71(a); Del. Dep't of Ins., *The Gender Identity Nondiscrimination Act of 2013* (March 2016) Bulletin 86, https://insurance.delaware.gov/wp-content/uploads/sites/15/2016/11domestic-foreign-insurers-bulletin-no86.pdf; Dep't of Health Care Finance, *DHCF Issues Policy Clarifying Medicaid Coverage of Gender Reassignment Surgery* (Sept. 2016), https://dhcf.dc.gov/release/dhcf-issues-policy-clarifying-medicaid-coverage-gender-reassignment-surgery.pdf; Haw. Rev. Stat. §§ 431:10A-118.3(a), 432:1-607.3, 432D-26.3 (2016); Maryland Dep't Health & Mental Hygiene, *Managed Care Organizations Transmittal No. 110* (March 2016), https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_37_16.pdf; MassHealth, *Guidelines for Medical Necessity Determination for Gender Reassignment Surgery* (2015), https://www.mass.gov/files/documents/2016/07/ow/mg-genderreassignment.pdf; Minn. Dep't Human Servs., *Provider Manual* (2017), https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-297587; Mont. Dep't Pub. Health & Human Servs., Healthcare Programs Notice (May 2017), https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2017/provnoticenondiscriminationgendertransition05252017.pdf; Web Announcement 1532 (2018), https://www.medicaid.nv.gov/Downloads/provider/web_annoucement_1532_20180223.pdf; 2017 NJ Sess. Law Serv. Ch. 176 (ASSEMBLY 4568) (WEST); 18 N.Y.C.R.R. 505.2; Ore. Health Auth., *Oregon Health Plan Handbook* 13 (March 2017), https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he9035.pdf; Penn. Dep't Human Servs., Medical Assistance Bulletin 99-16-11 (July 2016), http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_233793.pdf; R.I. Exec. Office Health & Human Servs., *Gender*

(Footnote continued on next page)

More to the point, even if the medical consensus were the same today as when *Smith* was decided, *Smith*'s rejection of a federal Medicaid challenge to the Regulation has no relevance to whether the Regulation violates Iowa's equal-protection guarantee. The fact that not everyone with gender dysphoria needs surgery (Br. 49) cannot possibly justify a blanket prohibition on its coverage for persons, such as Petitioners, for whom it is medically necessary treatment.

DHS's argument that there is nothing "in the record to support" the district court's conclusion that "'DHS has not reviewed or studied the language regarding sex reassignment surgery in the [Regulation] since its original adoption'" makes no sense. (Br. 50.) Had DHS reviewed the Regulation, it stands to reason that DHS would have informed the district court. And even if it had reviewed the Regulation, its review would not have changed the Regulation's irrationality.

DHS's argument that the Regulation is focused on surgeries for psychological purposes (Br. 45, 47) is addressed above. The Regulation is a

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Dysphoria/Gender Nonconformity Coverage Guidelines (2015), http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/Physician/gender_dysphoria.pdf; Wash. Admin. ence%20Guides/Physician/gender_dysphoria.pdf; Wash. Admin. Code § 182-531-1675; Dep't of Vt. Health Access, *Gender Reassignment Surgery* (2016), http://dvha.vermont.gov/for-providers/gender-reassignment-surgery-w-icd-10-coded-111616.pdf.

targeted ban on surgeries to treat gender dysphoria, while the surgeries themselves address a person's nonconformity with the person's gender identity, are life-saving, and make it possible for persons with gender dysphoria to function in daily life. Other surgeries covered for Medicaid recipients are not more, and are possibly even less, restorative of function than surgical treatments for gender dysphoria. The relationship between the ban on surgical treatment for gender dysphoria and a purpose of restoring function fails rational-basis review because it is "so weak that the classification must be viewed as arbitrary." *McQuistion v. City of Clinton*, 872 N.W.2d 817, 831 (Iowa 2015) (quotation marks omitted)

As DHS concedes, justification for a classification must be "credible as opposed to specious." (Br. 49.) A rational basis must be "realistically conceivable" and have some "basis in fact." *RACI*, 675 N.W.2d at 7–8; *Residential & Agric. Advisory Comm. v. Dyersville City Council*, 888 N.W.2d 24, 50 (Iowa 2016). DHS baldly asserts that the justification for the Regulation "is buoyed by the record" (Br. 49.) But the record itself directly contradicts this assertion.

IV. The Regulation has a disproportionate negative impact on private rights.

The district court correctly found that the Regulation has a disproportionate negative impact on the private rights of transgender

individuals. (App.1 309.) *See* Iowa Code § 17A.19(10)(k) (2018). This issue is subject to de novo review and has been properly preserved for appeal. (Br. 51.)

Petitioners have rights under ICRA and the Iowa Constitution's equal-protection guarantee that have been violated in this case. DHS acknowledges that Petitioners "ha[ve] a right to be treated in accordance with the provisions of . . . ICRA and the Iowa Constitution." (App.1 90, ¶ 148; App.1 181, ¶ 147.)

Petitioners' disproportionality claims, which arise from these rights, are straightforward. An unlawful, unconstitutional administrative regulation, such as the one at issue here, is not only "not required"; it is forbidden. The Regulation causes a disproportionate negative impact on the private rights of transgender individuals such as Petitioners by categorically prohibiting them from receiving Medicaid coverage for medically necessary surgical treatment of gender dysphoria. (App.2 118; App.2 521.) And there is no public interest served by denying Medicaid coverage for medically necessary and effective treatment. (App.1 85, ¶ 60; App.1 176, ¶ 60; App.2 121–22, 125–26; App.2 524–25, 528–29.) In light of this, the Regulation, and the decisions based on it, cannot stand.

V. The Regulation is arbitrary and capricious.

The district court correctly concluded that DHS's denials of Petitioners' requests for Medicaid coverage were arbitrary and capricious and must be overturned. (App.1 310–12.) *See* Iowa Code § 17A.19(10)(n) (2018). This issue is subject to de novo review and has been properly preserved for appeal. (Br. 19–20, 30–31.)

An agency action is considered arbitrary or capricious "when it is taken without regard to the law or facts of the case" pending before the agency. *Soo Line R.R. Co. v. Iowa Dep't of Transp.*, 521 N.W.2d 685, 688–89 (Iowa 1994); *Hough v. Iowa Dep't of Personnel*, 666 N.W.2d 168, 170 (Iowa 2003). An agency "of course cannot act unconstitutionally, in violation of a statutory mandate, or without substantial support in the record" *Stephenson v. Furnas Elec. Co.*, 522 N.W.2d 828, 831 (Iowa 1994). Although an "agency is entitled to reconcile competing evidence," it is not entitled to "ignore competing evidence." *JBS Swift & Co. v. Hedberg*, 873 N.W.2d 276, 281 (Iowa Ct. App. 2015).

DHS blindly applied the Regulation without regard for ICRA, the Iowa Constitution's equal-protection guarantee, or the unrefuted evidence that the surgical procedures requested by Petitioners are medically necessary and consistent with modern standards of care.

DHS's reliance on *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001), is unjustified. As the district court noted, that case "did not involve a challenge to the Regulation under the Equal Protection Clause of the Iowa Constitution or . . . ICRA" and was also "decided *before* the 2007 amendment to . . . ICRA prohibiting gender-identity discrimination." (App.1 302 (emphasis added).) *See* Acts 2007 (82 G.A.) ch. 191, S.F. 427, §§ 5, 6 (inserting references to "gender identity"). Nor did *Smith* "consider or decide challenges to the Regulation or application of the Regulation to the facts under the []IAPA." (*Id.* 302–03.) "The medical facts alleged [by Petitioners]," the district court correctly observed, "are not the same as the facts considered by the Court in *Smith*." (*Id.*)

Smith involved a Section 1983 challenge to DHS's denial of Medicaid coverage based on rights conferred by the federal Medicaid Act rather than a challenge based on ICRA, the Iowa Constitution, or the US Constitution. *Smith*, 249 F.3d at 758. The ICRA and Iowa constitutional claims at issue in this case were not asserted or adjudicated in *Smith*. Additionally, the *Smith* court concluded that, in 1994, the evidence before DHS reflected disagreement in the medical community "regarding the efficacy of sex reassignment surgery" and that this surgery was also excluded from coverage under Medicare. *Smith*, 249 F.3d at 761. Even if this were true at the time, it

is true no longer. In the seventeen years since *Smith* was decided, the medical community has reached a clear consensus that transition-related care—including surgery—is safe and effective and that discriminatory exclusions of transition-related care have no basis in medical science. (App.2 117–126; App.2 520–29.) Moreover, the federal Medicare regulations no longer prohibit Medicare coverage for gender-affirming surgery. *See* Dep't of Health & Human Servs. Dept'l Appeals Bd. Dec. No. 2576 (May 30, 2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

DHS argues that, because it was "obligated" to enforce the Regulation, its decision to do so cannot be considered arbitrary or capricious. (Br. 58.) If this were true, then an agency could insulate itself from an arbitrary-and-capricious challenge to its application of an illegal, unconstitutional regulation simply by asserting that it applied the regulation as written. This is not the law. *Soo Line*, 521 N.W.2d at 688–89; *Hough*, 666 N.W.2d at 170. Here, as mentioned, DHS applied the Regulation without any regard for ICRA, the Iowa Constitution's equal-protection guarantee, or the unrefuted evidence that the surgical procedures requested by Petitioners are medically necessary and consistent with modern standards of care. Its decision to do so was improper.

When laws change and regulations fail to be amended to conform with those changes, the regulations become unlawful and unenforceable; when the regulations nevertheless continue to be enforced, the enforcing agency has violated the law. *Exceptional Persons, Inc. v. Iowa Dep't of Human Servs.*, 878 N.W.2d 247, 252 (Iowa 2016) ("When a statute directly conflicts with a rule, the statute controls."). In *Exceptional Persons*, the very same agency whose actions Petitioners challenge here argued as much—successfully—to this Court when defending its decision not to apply a 2009 rule that failed to conform with a subsequently enacted law, arguing that it must apply the law over prior, nonconforming rules. *Id.*

Indeed, Iowa administrative agencies regularly review all administrative rules to ensure consistency with changing law for this very reason, reviewing each rule no less than every five years. This is typically referred to by each agency as its "five-year regular-review" process. *See* Iowa Code 17A.7(2) (2018); State of Iowa, Understanding Administrative Rules in Iowa State Government, https://rules.iowa.gov/info/rulemaking-petition.

The specific legislative history of the Regulation shows that it was reviewed by DHS in 2010, 2012, 2013, 2015, 2015, and 2016. Iowa Admin. Bulletin ARC 2371C (Jan. 1, 2016), https://www.legis.iowa.gov/docs/aco/bu

lletin/01-20-2016.pdf; Iowa Admin. Bulletin ARC 2164C (Sept. 30, 2015), https://www.legis.iowa.gov/docs/aco/arc/2164C.pdf; Iowa Admin. Bulletin ARC 1297C (Feb. 5, 2014), https://www.legis.iowa.gov/docs/aco/arc/1297C.pdf; Iowa Admin. Bulletin ARC 1052 (Oct. 2, 2013), https://www.legis.iowa.gov/docs/aco/bulletin/10-02-2013.pdf; Iowa Admin. Bulletin ARC 0305C (Sept. 5, 2012), https://www.legis.iowa.gov/docs/aco/arc/0305C.pdf; Iowa Admin. Bulletin ARC 8714B (May 5, 2010), https://www.legis.iowa.gov/docs/aco/arc/8714B.pdf. Despite this review, DHS has failed to put an end to the Regulation's discrimination against transgender Iowans in violation of ICRA and the Iowa Constitution.

CONCLUSION

The Regulation's categorical exclusion of Medicaid coverage for gender-affirming surgery violates ICRA's express prohibitions against gender-identity and sex discrimination and the Iowa Constitution's equal-protection guarantee. It also has a disproportionate negative impact on the private rights of transgender individuals and is arbitrary and capricious.

Petitioners respectfully ask this Court to affirm the district court's ruling invalidating the Regulation and reversing DHS's denials of Petitioners' requests for Medicaid coverage.

REQUEST FOR ORAL ARGUMENT

Petitioners respectfully request oral argument.

Respectfully submitted,

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