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IN THE SUPREME COURT OF IOWA

SUPREME COURT NO. 18-1158

EERIEANNA GOOD,
Petitioner-Appellee,
v.

IOWA DEPARTMENT OF HUMAN SERVICES,
Defendant-Appellant.

CAROL BEAL,
Petitioner-Appellee,

v.

IOWA DEPARTMENT OF HUMAN SERVICES,
Respondent-Appellant.

APPEAL FROM THE IOWA DISTRICT COURT
FOR POLK COUNTY
HONORABLE ARTHUR E. GAMBLE

BRIEF OF AMICI CURIAE THE AMERICAN MEDICAL ASSOCIATION, THE IOWA MEDICAL SOCIETY, THE AMERICAN COLLEGE OF PHYSICIANS, MENTAL HEALTH AMERICA, NATIONAL ASSOCIATION OF SOCIAL WORKERS, AND GLMA: HEALTH PROFESSIONALS ADVANCING LGBT EQUALITY*

***conditionally filed in final form**

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STATEMENT REQUIRED BY IOWA R. APP. P. 6.906(4)(D)

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INTERESTS OF *AMICI CURIAE*[1]

Amici Curiae represent the interests of leading medical and mental-health professionals dedicated to providing the proper healthcare and treatment for all individuals in need. *Amici* offer this brief to explain that the exclusion of medically necessary transition-related surgeries from Iowa's Medicaid coverage impinges upon medical and mental-health professionals' ability to provide medically necessary care to each Iowan patient with gender dysphoria. *Amici* represent well-recognized organizations that promulgate the leading standards of care in the field and individual medical professionals charged with ensuring proper treatment for their patients.

The American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Iowa.

[1] This statement is made pursuant to Iowa Supreme Court Rule 6.906.

The Iowa Medical Society ("IMS") is the statewide professional association for Iowa physicians, residents and medical students. IMS helps professionals develop their skills and further their careers by providing access to unique and relevant content and exclusive member services. IMS also works to protect the health of Iowans through a variety of projects and activities at the state and national levels. Today, IMS exists to assure the highest quality healthcare in Iowa through its role as physician and patient advocate.

The AMA and IMS join this brief on their own behalves and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

The American College of Physicians is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. ACP membership includes 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults

across the spectrum from health to complex illness.

Mental Health America is committed to the principle that people with mental health and substance use conditions are entitled to those health care and other services and legal protections which will enable them to maximize their abilities and be fully integrated into all aspects of life. More specifically this includes the preservation of liberty and personal autonomy, presumption of competency, freedom from seclusion and restraints, protection of privacy, as well as specific consumer needs for employment, housing, benefits, consumer-driven mental health systems, self-help and peer support services, and ending discrimination. This also includes adherence to the Americans with Disabilities Act, the Individuals with Disabilities Education Act (IDEA), the Rehabilitation Services Act, the Fair Housing Act, and other legislation that protects the rights of people with mental health and substance use conditions. The following statement derives from the principles of choice, empowerment and self-determination and advocates fighting discrimination toward and abuse of people with mental health and substance use conditions. Historically, the treatment of persons with mental health and substance use conditions has been based upon the pervasive, false and seriously harmful assumptions that people with mental health and substance use conditions: (1) are incapable of making a responsible independent judgment about accepting

or refusing treatment and other important aspects of their lives and (2) are substantially more dangerous or violent than other persons. These assumptions ignore the principle fundamental to the preservation of liberty that a person is competent unless legally proven otherwise and the plain fact that most of the more than 25% of Americans facing behavioral health challenges are competent most of the time. While major strides have been made, people with mental health and substance use conditions continue to be denied their full rights as citizens and suffer from stigma and discrimination. Studies continue to show that people with mental health and substance use conditions are only slightly more violent than the general population. But violent acts committed by persons with mental illnesses are frequently highly sensationalized and lead to repeated stigmatization of persons with mental illnesses and threats to their autonomy and privacy in the guise of increasing protection of public safety. Mental Health America is committed to equal justice and protection of legal rights for all persons affected by mental health and substance use conditions, including children, adolescents and their families, and older adults. Mental Health America supports the enactment and enforcement of laws and policies designed to protect the rights of persons with mental health and substance abuse.

GLMA: Health Professionals Advancing LGBT Equality ("GLMA") is

the largest and oldest association of LGBT healthcare professionals. GLMA's mission is to ensure equality in healthcare for LGBT individuals and healthcare professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 in part as a response to the call to advocate for policy and services to address the growing health crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health issues affecting LGBT people and GLMA has become a leader in public policy advocacy related to LGBT health. To advance its mission, GLMA provides cultural competency courses for medical providers, including in transgender health.

The National Association of Social Workers ("NASW"), founded in 1955, is the largest association of professional social workers in the United States with 120,000 members in 55 chapters. The Iowa Chapter of NASW has 1,000 members. The NASW National Committee on LGBT Issues develops, reviews, and monitors programs of the Association that significantly affect LGBT individuals. NASW recognizes the considerable diversity in gender expression and identity among our population. NASW asserts that

discrimination and prejudice directed against any individuals on the basis of gender identity or gender expression, are damaging to the social, emotional, psychological, physical, and economic well-being of the affected individuals, as well as society as a whole. NASW *Code of Ethics* for professional social workers require that all people – including those who are transgender – should be afforded the same respect and rights regardless of gender identification. NASW reaffirms a commitment to human rights and freedom and opposes all discrimination on the basis of gender identity and of gender expression regardless of assigned sex at birth. NASW encourages the passage of legislation protecting the rights, legal benefits, and privileges of all gender identities and expressions and the repeal of laws and discriminatory practices that impede individuals in their identification with, and their expression of, the gender that matches their sense of themselves in all areas of the public arena, especially employment, health care, education, and housing.[2]

The Endocrine Society is the largest global community—18,000 strong—energized by the promise of unraveling the mysteries of hormone disorders to care for patients and cure disease. It is devoted to advancing hormone research, excellence in the clinical practice of endocrinology,

[2] NASW Policy Statements: Transgender and Gender Identity Issues in Social Work Speaks 302, 305-06 (10th ed. 2015).

broadening understanding of the critical role hormones play in health, and advocating on behalf of the global endocrinology community. The Endocrine Society's Clinical Practice Guideline on gender dysphoria/gender incongruence provides the standard of care for treating transgender individuals. The guideline establishes a framework for the appropriate treatment of these individuals and standardizes terminology to be used by healthcare professionals.

SUMMARY OF THE ARGUMENT

Gender dysphoria is a recognized medical condition that causes an individual great distress due to the incongruence between the individual's sex or gender assigned at birth biological gender and their strongly felt gender identity. Gender dysphoria is a serious medical condition that can be life-threatening if untreated. The internationally recognized standards of care for gender dysphoria, established by renowned medical and mental-health professional organizations, recognize that surgeries to treat gender dysphoria (also known as sex-reassignment surgeries, or SRS), are clinically effective and medically necessary, in some cases, to treat severe gender dysphoria and sometimes may be a patient's only effective treatment option. For this reason, courts have recognized that blanket prohibitions on surgical treatments for gender dysphoria can result in significant harm.

The standards of care for gender dysphoria require individualized assessment of the medically necessary care for each patient and emphasize the need for continuity of care. These standards are based on the fundamental principle that medical and mental-health professionals must make a case-by-case assessment and treatment plan for each patient to identify the severity of, and to treat, each patient's condition. By imposing a blanket exclusion of medically necessary surgery to treat gender dysphoria

from Iowa Medicaid coverage, the Iowa Department of Human Services ("DHS" or "Defendant") denies patients with the most serious levels of gender dysphoria, like Petitioners Eerieanna Good and Carol Beal, medically necessary care, placing them at substantially greater risk of serious physical and emotional trauma.

ARGUMENT

I. Gender Dysphoria is a Serious Medical Condition that Can Result in Death or Serious Harm.

A. Gender Dysphoria is a Serious Medical Condition.

Gender dysphoria is a medical condition experienced only by transgender people. "Transgender" is an "adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth."[3] Transgender individuals have a "gender identity"—a "deeply felt, inherent sense" of their gender—that is not aligned with their sex assigned at birth.[4] This inherent sense is more than a mere feeling; it is "a person's internal, personal sense of being a man or a woman (or boy or

[3] Am. Psychol. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832-864 (2015) [hereinafter Am. Psychol. Ass'n Guidelines].
[4] *Id.* at 832, 834.

girl)."[5] Recent estimates suggest that there are around 1.4 million[6] transgender adults in the United States, though that estimate is thought to underreport the true population.[7] Transgender individuals are a diverse group of people with various races and ethnicities.[8] They participate in everyday life like any other individual: they live in every state, are active members of the workforce, and raise children.

The healthcare profession's understanding of gender has significantly advanced in the last 50 years. Throughout the twentieth century, gender-nonconforming individuals were often viewed as "perverse" or "deviant," which doctors attempted to "correct" by forcing them to live as their birth-assigned gender.[9] This practice not only failed, it also caused significant

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[5] glaad, *Transgender FAQ: What Does Transgender Mean?*, https://www.glaad.org/transgender/transfaq (last visited Sept. 26, 2018).
[6] Andrew R. Flores et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?* 2 (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.
[7] Am. Psychol. Ass'n Guidelines, *supra* note 3, at 832.
[8] *Id.*
[9] Am. Psychol. Ass'n, *Report of the APA Task Force on Gender Identity and Gender Variance* (2008), https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf [hereinafter *APA Task Force*]; *see also* Substance Abuse & Mental Health Servs. Admin., *Ending Conversion Therapy: Supporting and Affirming Transgender LGBTQ Youth* 25-26 (2015), https://store.samhsa.gov/shin/content/SMA15-4928.pdf [hereinafter *Ending Conversion Therapy*].

harm to the transgender individuals subjected to it.[10] Today, healthcare professionals recognize that being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[11]

The medical community is not certain why some people are transgender. Some research suggests that there may be biological influences,[12] including, for example, exposure of natal females to elevated levels of testosterone in the womb.[13] Brain scans and neuro-anatomical

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[10] *APA Task Force*, *supra* note 9, at 26-27; *Ending Conversion Therapy*, *supra* note 9, at 25-26.

[11] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012), https://psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Transgender-Gender-Variant-Discrimination.pdf.

[12] *See* Am. Acad. of Pediatrics, *Gender Non-Conforming & Transgender Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Non-Conforming-Transgender-Children.aspx; Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1895 (2008).

[13] Arianne B. Dessens et al., *Gender Dysphoria and Gender Change in Chromosomal Females With Congenital Adrenal Hyperplasia*, 34 Arch. Sexual Behav. 389, 395 (2005). *See also* Psychology Today, *Gender Dysphoria,* https://www.psychologytoday.com/us/conditions/gender-dysphoria (last visited Sept. 26, 2018). Specifically, medications that increase hormones in a mother's system may have an impact, or the fetus could also have androgen insensitivity syndrome, whereby the hormones don't work properly in the womb. NHS, *Overview: Gender Dysphoria*, https://www.nhs.uk/conditions/gender-dysphoria/ (last visited Sept. 26, 2018). It may also be the result of a rare condition like congenital adrenal hyperplasia, where higher levels of testosterone are produced in a female fetus. *Id.*

studies of transgender individuals may also support these biological explanations.[14]

The medical community's advancement in understanding gender dysphoria has led to a clearer understanding of the severity of condition in the transgender community. Studies have shown that transgender individuals have a significantly lower quality of life than the general population.[15] This is due in large part to their high rates of depression, suicide attempts, and substance abuse.[16] The suicide-attempt rate among transgender individuals has been estimated to be between 32% and 50%.[17] By comparison, the suicide-attempt rate of the general population has been estimated at around

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[14] *See, e.g.*, Francine Russo, *Is There Something Unique About the Transgender Brain?*, Sci. Am. (Jan. 1, 2016), https://www.scientificamerican.com/article/is-there-something-unique-about-the-transgender-brain/.

[15] *See generally* Joz Motmans, et al., *Female and Male Transgender Quality of Life: Socioeconomic and Medical Differences*, J. of Sexual Medicine (2012), http://transgenderinfo.be/wp-content/uploads/2013/01/QOL_Motmans.pdf.

[16] Walter Bockting, et al., *Adult Development and Quality of Life of Transgender and Gender Nonconforming People*, Current Opinion in Endocrinology, Diabetes and Obesity (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4809047/ (manuscript version); Collier M. Cole., et al., *Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses*, http://new-gallery-of-art.com/pdf/TScomorbidity.pdf (unpublished).

[17] H.G. Virupaksha et al., *Suicide and Suicidal Behavior among Transgender Persons*, Indian J. Psychol. Med. (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5178031/ (manuscript version).

.05% for adults 18 years and older.[18] In a recent survey of transgender individuals, 41% reported suffering from depression, while 33.2% reported struggling with anxiety.[19] Meanwhile, depression and anxiety rates among the general population are 6.7% and 18.1% respectively.[20] Similarly, "it is estimated that between 20 percent to 30 percent of gay and transgender people abuse substances, compared to about 9 percent of the general population."[21] These risks are exacerbated when a transgender individual is diagnosed with gender dysphoria.[22]

Many transgender individuals are diagnosed with gender dysphoria, a condition that involves an often debilitating "conflict between a person's physical or assigned gender and the gender with which he/she/they identify."[23] Every person has a "gender identity": their internal sense of

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[18] Am. Foundation for Suicide Prevention, *Suicide Statistics*, https://afsp.org/about-suicide/suicide-statistics/ (last visited Sept. 26, 2018).
[19] *Id.*
[20] Anxiety & Depression Ass'n of Am., *Facts & Statistics*, https://adaa.org/about-adaa/press-room/facts-statistics (last visited Sept. 26, 2018) (stating statistics for adults 18 years or older).
[21] Jerome Hunt, *Why the Gay and Transgender Population Experiences Higher Rates of Substance Use*, Ctr. For Am. Progress, https://www.americanprogress.org/issues/lgbt/reports/2012/03/09/11228/why-the-gay-and-transgender-population-experiences-higher-rates-of-substance-use/ (March 9, 2012 9:00 AM).
[22] *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 452-53 (5th ed. 2013) (hereinafter DSM-5).
[23] Am. Psychiatric Ass'n, *What is Gender Dysphoria?*, https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-

being male, female, or another gender.[24] A person's gender identity is not ascertainable at birth,[25] and many children do not develop a stable gender identity until they are three or four.[26] Importantly, gender identity cannot be altered voluntarily.[27] Most individuals are cisgender, meaning that their gender identities are congruent with their bodies.[28] For example, a cisgender female is born anatomically female and also identifies as female. But individuals with gender dysphoria experience a degree of incongruence that is often severe, distressing, long-standing, and debilitating.[29] People suffering from gender dysphoria "are cruelly imprisoned in a body

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gender-dysphoria (last visited Sept. 26, 2018) (hereinafter *What is Gender Dysphoria?*).

[24] Am. Psychol. Ass'n, *Answers to Your Questions About TransGender People, Gender Identity, and Gender Expression* 1 (2014), http://www.apa.org/topics/lgbt/transgender.pdf; Caitlin Ryan, Family Acceptance Project, *Supportive Families, Healthy Children: Helping Families With Lesbian, Gay, Bisexual, & Transgender Children*, 17 (2009), http://familyproject.sfsu.edu/sites/default/files/FAP_English%20Booklet_pst.pdf.

[25] Am. Psychol. Ass'n Guidelines, *supra* note 3, at 862.

[26] *Id.* at 841.

[27] Colt Meier & Julie Harris, Am. Psychol. Ass'n, *Fact Sheet: Gender Diversity And Transgender Identity in Children* 1, http://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pdf; *see also* Am. Acad. of Pediatrics, *Gender Identity Development in Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Identity-and-Gender-Confusion-In-Children.aspx.

[28] *What is Gender Dysphoria?*, *supra* note 23.

[29] DSM-5, *supra* note 22, at 454-55; *What is Gender Dysphoria?*, *supra* note 23.

incompatible with their subjective gender identity."[30]

Prior to treatment, individuals with gender dysphoria "live in a dissociated state of mind and body,"[31] where "[t]he mind is of one gender, and the body is of the other."[32] If untreated, gender dysphoria can cause debilitating distress, depression, impairment of function, substance abuse, self-mutilation, and suicide, among others.[33] As the Seventh Circuit Court of Appeals has recognized, "[a] person with [gender dysphoria] often experiences severe anxiety, depression, and other psychological disorders. Those with [gender dysphoria] may attempt to commit suicide or to mutilate their own genitals." *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011). Gender dysphoria can so impair the well-being of an individual that at least one court has held that it constitutes a disability within the meaning of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (2013) (amended 2008) ("ADA"). *Blatt v. Cabela's Retail, Inc.*, No. 5:14-cv-04822, 2017 WL

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[30] *Merck Manual of Diagnosis and Therapy* 1568 (Robert S. Porter et al. eds., 19th ed. 2011) (hereinafter *Merck Manual*).

[31] David Seil, *The Diagnosis and Treatment of Transgendered Patients*, 8 J. Gay & Lesbian Psychotherapy 99, 115 (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001).

[32] *Id.*

[33] *See, e.g.*, DSM-5, *supra* note 22, at 455, 458; George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. Transgenderism 31, 31-39 (2010).

2178123, at *4 (E.D. Pa. May 18, 2017).

Without proper treatment, gender-dysphoric individuals may resort to medically dangerous self-help. For example, some male-to-female individuals suffering from gender dysphoria resort to treating themselves with hormones or, in more extreme cases, attempt their own castration or penectomy, which can be life-threatening.[34] Further, individuals with severe gender dysphoria are at an increased risk for suicidal ideation, suicide attempts, and suicide prior to gender reassignment.[35] It is not uncommon for gender-dysphoric individuals to take, or attempt to take, their own lives because their gender dysphoria was not properly assessed and treated, with some studies finding that as many as one in four male-to-female individuals and one in five female-to-male individuals attempt suicide before treatment.[36]

B. There is a General Medical Consensus on Diagnostic Criteria for Gender Dysphoria.

While all transgender individuals experience a degree of incongruence between their birth-assigned sex and their gender identity,

[34] DSM-5 at 454; Brown, *supra* note 34, at 33–35.
[35] DSM-5, *supra* note 22, at 452-53.
[36] *See, e.g.*, Brown, *supra* note 34, at 31-39; Bram Kuiper & Peggy Cohen-Kettenis, *Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals*, 17 Archives Sexual Behav. 439, 451 (1988).

gender dysphoria is marked by a clinically recognized level of distress as a result of the incongruence. Gender dysphoria is "manifested in a variety of ways, including strong desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender."[37]

Critical to assessing gender dysphoria is an individual's persistent cross-gender identification and discomfort and distress that result from his or her gender incongruence. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") recognizes the following diagnostic criteria for gender dysphoria in adolescents and adults:

> A) A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
>
> (1) A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
>
> (2) A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
>
> (3) A strong desire for the primary and/or secondary sex characteristics of the other gender.
>
> (4) A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
>
> (5) A strong desire to be treated as the other gender (or some alternative gender different from one's

[37] Am. Psychiatric Ass'n, *Gender Dysphoria*, 1,1 (2013).

> assigned gender).
> (6) A strong conviction that one has the typical feelings and reactions of the other gender…. and
> B) The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.[38]

Similarly, the World Health Organization ("WHO") has recognized that gender dysphoria "is characterized by a marked and persistent incongruence between an individual's experienced gender and the assigned sex."[39] According to WHO, gender dysphoria is manifested by at least two of the following characteristics

> 1) a strong dislike or discomfort with the one's primary or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender; 2) a strong desire to be rid of some or all of one's primary and/or secondary sex characteristics (in adolescents, anticipated secondary sex characteristics) due to their incongruity with the experienced gender; 3) a strong desire to have the primary and/or secondary sex characteristics of the experienced gender. The individual experiences a strong desire to be treated (to live and be accepted) as a person of the experienced gender.[40]

The deep discomfort felt by gender-dysphoric individuals is not one of mere inconvenience. Untreated gender dysphoria can have severe, life-threatening

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[38] DSM-5, *supra* note 22, at 452-53.
[39] World Health Org., *International Classification of Disease*, F64.2 (2018) (11th ed.), https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f90875286-).
[40] *Id.*

consequences, as discussed above.

II. Surgery is a Clinically Effective, Medically Necessary Treatment for Certain Patients for Whom Psychotherapy and Hormone Therapy are not Sufficient to Treat Gender Dysphoria.

A. There are Established Standards of Care for Medical Treatment of Gender Dysphoria.

Mental-health practitioners once attempted to treat gender nonconformity by forcing transgender and gender-dysphoric individuals to be more gender conforming.[41] There is no evidence that this approach prevented individuals from being transgender and, in fact, evidence shows that it can "often result in substantial psychological pain by reinforcing damaging internalized attitudes."[42] In recent decades, treatment for gender dysphoria has shifted to providing gender-dysphoric individuals access to gender-affirming psychological and medical support.[43]

For more than 30 years, the generally accepted treatment protocols

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[41] Am. Acad. of Child & Adolescent Psychiatry, *Conversion Therapy* (2018), https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx; Am. Psychol. Ass'n Guidelines, *supra* note 3, at 835; Jack Drescher, *Queer Diagnoses: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual*, 39 Arch. Sexual Behav. 427, 436-40 (2010).

[42] Am. Psychoanalytic Ass'n, *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression* (2012), http://www.apsa.org/content/2012-position-statement-attempts-change-sexual-orientation-gender-identity-or-gender.

[43] Am. Psychol. Ass'n Guidelines, *supra* note 3, ay 835; World Prof'l Ass'n

for transgender and gender-dysphoric people have aimed at alleviating the distress associated with the incongruence between gender identity and birth-assigned sex. These protocols are laid out in the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Verison 7)* ("Standards of Care"), developed by the World Professional Association for Transgender Health ("WPATH"). According to the Standards of Care:

> The number and type of interventions applied and the order in which these take place may differ from person to person. Treatments options include the following:
>
> > • Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
> >
> > • Hormone therapy to feminize or masculinize the body; Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
> >
> > •Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
> >
> > •Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender

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for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Verison 7)*, https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf (hereinafter *Standards of Care*) at 8.

> dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.[44]

These standards have been embraced by many of the major medical and mental-health groups internationally and in the United States, including the American Psychological Association[45] and the American Medical Association,[46] and they represent the consensus of appropriate treatment for transgender and gender-dysphoric people.[47] They are, in fact, so well established that federal courts have declared that a prison's failure to provide healthcare consistent with these standards may constitute cruel and unusual punishment under the Eighth Amendment. *See, e.g., 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); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 231–32 (D. Mass. 2012).

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[44] *Standards of Care*, *supra* note 43, at 8-9.
[45] Am. Psychol. Ass'n, *APA Adopts Guidelines For Working With Transgender, Gender Nonconforming People* (Aug. 6, 2015), http://www.apa.org/news/press/releases/2015/08/working-transgender.aspx.
[46] Am. Med. Ass'n, *Policy Forum: Transgender Rights As Human Rights*, 18 J. of Ethics 1128 fn.12 (2016), https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/pfor3-1611.pdf (citing the WPATH *Standards of Care*).
[47] *See, e.g.*, APA Task Force, *supra*, at 9; *see also Merck Manual*, *supra* note 30 at 1570 (recognizing that WPATH's *Standards of Care* are "the internationally accepted standards of care for the treatment of gender identity disorders").

Consistent with these standards, the recommended treatment for gender-dysphoric transgender people begins with an assessment and counseling. From there, depending on the individual's need, it can include a social transition, hormone therapy, and surgical procedures to align an individual's body with his or her gender identity.[48] The needs of each person differ, and the Standards of Care emphasize the importance of individualized treatment plans for this reason.[49]

1. Surgery to Treat Gender Dysphoria is a Widely Accepted, and Medically Necessary, Treatment for Many Individuals with Gender Dysphoria.

Medical and mental-health professionals agree that for some gender-dysphoric individuals, surgery is a medically necessary treatment. These healthcare providers widely recognize that for some individuals, especially those with severe gender dysphoria, it is impossible to manage their distress with psychotherapy and/or hormone therapy alone.[50] Research has shown that many of those seeking treatment for gender dysphoria are

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[48] APA Task Force Report, *supra* note 9, at 32-39; Am. Psychiatric Ass'n Workgroup on Treament of Gender Dysphoria, *Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists* 16-18 (2016).

[49] APA Task Force Report, *supra* note 9, at 32; *Standards of Care*, *supra* note 43, at 11.

[50] *See* Seil, *supra* note 32, at 114-16; Walter O. Bockting & Eli Coleman, *A Comprehensive Approach to the Treatment of Gender Dysphoria*, 5 J. Psychol. & Human Sexuality, 131, 150 (1993).

repulsed by their genitals and sexual features and are desperate to remove them.[51] For these patients, "relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity."[52]

The well-established protocols for assessing and treating gender dysphoria specifically recognize the medical necessity and therapeutic importance of SRS for certain individuals. "While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria."[53] According to WPATH, such medically necessary procedures include "complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation," among others.[54] For some individuals, these surgeries may be "the *only* effective treatment for the condition, and for some people genital surgery is essential and life-saving."[55]

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[51] Brown, *supra* note 34, at 32.
[52] *Standards of Care*, *supra* note 43, at 54-55.
[53] *Id.* at 54.
[54] World Prof'l Ass'n for Transgender Health, *WPATH Policy Statements: Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.,* https://www.wpath.org/newsroom/medical-necessity-statement (last visited Aug. 23, 2018) (hereinafter *WPATH Policy Statement*).
[55] *Id.* (emphasis in original).

The decision to undergo surgery to treat gender dysphoria "is not taken lightly."[56] "Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient's needs."[57] In other words, "[g]enital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures."[58] They are medically necessary treatments for gender dysphoria to be undertaken only after "assessment of the patient by qualified mental health professionals" to determine whether the patient has "met the criteria for a specific surgical treatment."[59]

Even where psychotherapy and/or hormone therapy have a positive impact on a gender-dysphoric individual, surgery is often a key component to treatment: it is the combination of psychotherapy, hormone therapy, and SRS that "is often curative when the disorder is appropriately diagnosed and clinicians follow the internationally accepted standards of care."[60]

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[56] Hilary Daniel & Renee Butkus, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians*, 163 Annals of Internal Med. 135 (2015), http://annals.org/aim/article/2292051/lesbian-gay-bisexual-transgender-health-disparities-executive-summary-policy-position.
[57] *Id.*
[58] *See Standards of Care*, *supra* note 43, at 55.
[59] *Id.*
[60] *Id.*

Empirical studies reflect the importance of the interplay among treatments, finding that hormone therapy in conjunction with psychotherapy and, for some, surgery, to be necessary elements of treating severe levels of gender dysphoria.[61]

2. Surgery Improves the Health of Many Gender-Dysphoric Individuals.

Further bolstering the importance of surgery, research shows that surgery helps significantly improve the well-being of gender-dysphoric individuals. Surgery to treat gender dysphoria can fill a significant gap in treatment left by other treatment options. As medical and mental-health professionals have recognized, gender identity cannot be changed through psychotherapy. "However, the body can be changed, and when a proper transition to the other gender has been completed, the dissociation" of gender dysphoria may be lessened.[62]

Research has demonstrated that surgery is a safe and effective treatment for gender dysphoria and can improve the quality of life for gender-dysphoric individuals. "Many studies have shown that the vast majority of transsexuals are satisfied with the outcome of sex

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[61] *See* Gianna E. Israel & Donald E. Tarver II, *Transgender Care: Recommended Guidelines, Practical Information & Personal Accounts* 56-73 (1997).

[62] Seil, *supra* note 32, at 115.

reassignment," with one study finding that "satisfaction rates ranged from 87% for male-to-females to 97% for female-to-males."[63] One study in particular found that "a review of quality of life after hormone therapy and transition indicated that the majority (80%) showed improvement, including more stable relationships, better psychosocial adjustment, overall happiness and contentment. Perceived financial, professional, and employment status also improved."[64]

In sum, while some transgender individuals may find successful treatment without surgery, for others, such as Petitioners, "surgery is essential and medically necessary to alleviate their gender dysphoria."[65] In short, surgery is an effective and medically necessary treatment for certain patients, like Ms. Good and Ms. Beal, for whom psychotherapy and

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[63] APA Task force, *supra* note 9; *see also Seil*, *supra* note 32, at 55 ("Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes."); E. Colman et al., *Standards Of Care For The Health Of Transsexual, Transgender, And Gender-Nonconforming People*, 7 Int'l J.of Transgenderism 13(4):165-232 (2012) (reporting that 80% of individuals were highly satisfied with the surgery while only 2% regretted it); Ana Sandoiu, *Transgender Surgery Can Improve Life For Most, Study Confirms*, https://www.medicalnewstoday.com/articles/321258.php (March 19, 2018) (reporting that 71 percent of transgender individuals who had a sex reassignment surgery an average of more than six years prior reported "feeling very satisfied with the 'optical and functional results' of the surgery").

[64] Bockting, et al., *supra* note 16.

[65] *Id.* (internal citation omitted).

hormone therapy are insufficient treatments for their gender dysphoria.[66]

III. The Blanket Ban on Surgery Imposed by Defendant Violates the Standards of Care for Treating Gender Dysphoria and Threatens the Well-being of Transgender Iowans.

Blanket bans on SRS—such as DHS's—violate the clearly established standards of care for treating transgender individuals suffering from severe gender dysphoria, thereby endangering their lives. The overwhelming medical consensus is that gender-dysphoric patients require individualized care and continuity of care and that SRS is a medically necessary treatment option. Despite this clear guidance, DHS's blanket ban flouts these standards.

A. DHS's Blanket Ban on Surgery to Treat Gender Dysphoria Denies the Widely Recognized Need for Individualized Care.

Not all patients require the same therapeutic care; medical and mental-health professionals must make treatment decisions on a case-by-case basis. As the Standards of Care emphasize, treatment for gender dysphoria "is individualized: [w]hat helps one person alleviate gender dysphoria might be very different from what helps another person."[67] Major medical and mental-health organizations, the courts, and the federal government all recognize the importance of individualized treatment.

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[66] Good Pet. ¶ 74; Joint Pet. at 24.

[67] *Standards of Care*, *supra* note 43; *see also* DSM-5, *supra* note 22, at 452-53. ("It is important to state that all transsexuals are not the same, and thus are not part of a uniform group").

Recognizing the importance of individualized care for transgender patients, courts have recognized the harm that can result from blanket prohibitions on treatments for gender dysphoria. For example, in *Fields*, the Seventh Circuit affirmed the district court's decision striking down on Eighth Amendment grounds a Wisconsin statute that prohibited the Wisconsin Department of Corrections from providing transgender inmates with hormone therapy and SRS. 653 F.3d at 559. The Seventh Circuit recognized the dangers of untreated gender dysphoria, and then observed that "[s]ome [gender-dysphoric] patients are able to manage the discomfort, while others become unable to function without taking steps to correct the disorder." *Id.* at 553.

The Seventh Circuit held that Wisconsin's blanket ban on certain gender-dysphoria treatments was unacceptable because "[t]he feelings of dysphoria can vary in intensity," and "[t]he accepted standards of care dictate a gradual approach to treatment." *Id.* at 553-54. Thus, the court stated, "[f]or some number of patients," psychotherapy "will be effective in controlling feelings of dysphoria," but for others, "a doctor can prescribe hormones, which have the effect of relieving the psychological distress." *Id.* at 554. Following this individualized course of treatment depending on an individual's needs, the Seventh Circuit recognized that "[i]n the most severe

cases, sexual reassignment surgery may be appropriate." *Id.*; *see also Fields v. Smith*, *Amicus* Br. of Medical and Mental Health Professionals 12-16 (arguing case-by-case assessment is necessary for prisoners with gender dysphoria).

Similarly, in *De'lonta v. Johnson*, 708 F.3d 520 (4th Cir. 2013), the Fourth Circuit reversed the district court's dismissal of a transgender prisoner's Eighth Amendment claim based on the prison's refusal to refer the plaintiff for assessment for SRS because she was already receiving counseling and hormone therapy to treat her gender dysphoria. The Court observed that "the [WPATH] Standards of Care . . . indicate that [SRS] may be necessary for individuals who continue to present with severe [gender dysphoria] after one year of hormone therapy." *Id.* at 525; *see also Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1118 (N.D. Cal. 2015) (plaintiff, who was an inmate, stated an Eighth Amendment claim for denial of SRS, characterizing it as "necessary medical treatment" for this inmate); *cf. O'Donnabhain v. Commissioner*, 134 T.C. 34, 65-70 & n.45 (2010) (SRS is "well-recognized and accepted treatment[] for severe" gender dysphoria). It further stated that just because the prison provided the prisoner "with *some* treatment consistent with the [] Standards of Care, it does not follow that they have necessarily provided her with *constitutionally*

adequate treatment." *Delonta*, 708 F.3d at 525.

More recently, and particularly relevant here, the Western District of Wisconsin granted transgender plaintiffs a preliminary injunction preventing Wisconsin from enforcing its ban on Medicaid coverage for sex-affirming surgery. *Flack v. Wis. Dep't of Health Servs.*, No. 18-CV-309-WMC, 2018 WL 3574875, at *1 (W.D. Wis. July 25, 2018). In *Flack*, two transgender individuals challenged Wisconsin Medicaid's express exclusion of coverage for "transsexual surgery," which it stated was "medically unnecessary." *Id.* at *3. In granting the plaintiffs a preliminary injunction, the court recognized that gender dysphoria is a serious medical condition whose symptoms could be mitigated through "appropriate individualized medical care." *Id.* at *1. It noted that sex reassignment surgery was, in the plaintiffs' cases, medically necessary treatment and "meets the prevailing standards of care." *Id.* at *8. Thus, the court held, plaintiffs were at a risk of irreparable harm if they were not given access to the surgeries they sought. *Id.* at *9.

Notably, in *Smith v. Rasmussen*,[68] upon which DHS relies, the Eighth Circuit ignored the fact that the 1993 report by the Foundation for Medical Care, which DHS uses to justify its ban on gender-affirming surgeries, did not reflect the scientific and medical communities' consensus at the time it

[68] *See generally* 249 F.3d 755, 760 (8th Cir. 2001).

was drafted, as the district court in the same case correctly noted. *Smith v. Rasmussen*, 57 F. Supp. 2d 736, 758–59 (N.D. Iowa 1999), *aff'd in part, rev'd in part*, 249 F.3d 755 (8th Cir. 2001). Given scientific and medical advances in the last 25 years, the report is even less relevant now.

Indeed, major medical and mental-health organizations have called for an end to blanket exclusions in health-insurance coverage for treatment of gender dysphoria:

- The American Medical Association ("AMA") "supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician."[69]
- "The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries."[70]
- In its Standards of Care, WPATH "urges health insurance companies and other third-party payers to cover the medically

[69] Am. Med. Ass'n, *Removing Financial Barriers to Care For Transgender Patients*, https://policysearch.ama-assn.org/policyfinder/detail/Removing%20Financial%20Barriers%20to%20Care%20for%20Transgender%20Patients%20H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml (last visited Sept. 26, 2018).

[70] Daniel & Butkus, *supra* note 57, at 135-36.

necessary treatment to alleviate gender dysphoria."[71]

- "The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder."[72]
- The American Psychiatric Association "[a]dvocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment" and "[o]pposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician."[73]
- The American Psychological Association "recognizes the efficacy, benefit, and necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments."[74]

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[71] *Standards of Care*, *supra* note 43, at 33.

[72] Am. Coll. of Obstetricians & Gynecologists, Committee Opinion of the Committee on Healthcare for Underserved Women, No. 512, *Health Care for Transgender Individuals* (Dec. 2011).

[73] Am. Psychiatric Ass'n, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012), https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-transgender-gender-variant- access-care.pdf.

[74] Am. Psychol. Ass'n, *Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination* (Aug. 2008),

The U.S. Department of Health and Human Services ("HHS") has also recognized the need for individualized assessment and treatment: HHS recently overturned a blanket ban on providing Medicare coverage for SRS.[75] In May 2014, the HHS Appeals Board (the "Board") found that SRS "is an effective treatment option in appropriate cases."[76] The Board also found that the Standards of Care have "attained widespread acceptance."[77] These Standards of Care include "criteria for the use of" SRS.[78] Thus, the Board determined that the blanket denial of "Medicare coverage of all transsexual surgery as a treatment for transsexualism" failed the Board's "reasonableness standard."[79]

Research also supports the need for individualized care. Empirical studies of individuals who have undergone the full treatment prescribed by medical and mental-health professionals for their diagnosis further demonstrate that gender dysphoria "is not a homogenous phenomenon" and

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http://www.apa.org/about/policy/transgender.pdf.

[75] *See In re NCD 140.3, Transsexual Surgery*, DAB Dec. No. 2576, Docket No. A-13-87 (HHS, Appeals Bd., May 30, 2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

[76] *Id.* at 15.

[77] *Id.* at 23.

[78] *Id.* at 15 n.22.

[79] *Id.* at 1.

that it requires "a more varied treatment approach."[80]

Accordingly, DHS's blanket ban on SRS—which has no basis in medicine or science—is contrary to the overwhelming consensus that gender-dysphoric patients require individualized care. In denying coverage for SRS, DHS limits Iowans with gender dysphoria, like Ms. Beal and Ms. Good, to a one-size-fits-all treatment despite evidence that such an approach is ineffective in treating severe gender dysphoria.

B. DHS' Blanket Ban on Surgery to treat Gender Dysphoria Disregards the Medical Necessity of the Treatment and Denies Continuity of Care.

For patients with severe gender dysphoria, surgery may be vital to their health. Psychotherapy and hormone therapy may fail to address the medical needs of individuals with severe gender dysphoria, like Ms. Good and Ms. Beal, threatening their health and well-being. Further, denying access to this medically necessary treatment disrupts the continuity of care, which the Standards of Care advise healthcare providers is an important part of a patient's treatment.[81]

Continuity of care is an important principle in the Standards of Care,

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[80] P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 J. Psychosomatic Res. 315, 328 (1999) (reviewing empirical studies on those with gender dysphoria).
[81] *Standards of Care*, *supra* note 43, at 65.

which state that "[h]ealth professionals should stress the importance of post-operative care with their patients and offer continuity of care."[82] Without coverage for SRS, transgender Iowans may receive coverage for some of their pre- and post-operative treatment but go without critical SRS until they can afford it. This disruption in the continuity of their care runs contrary to the Standards of Care for treating gender dysphoria and puts the health of transgender Iowans, like Ms. Good and Ms. Beal, at risk.

Ms. Good was diagnosed with gender dysphoria in 2013.[83] For years she has struggled with depression and anxiety as a result of her gender dysphoria.[84] She first began seeking hormone therapy to treat her gender dysphoria in 2014.[85] Despite this therapy, she continues to feel distressed and uncomfortable with her genitalia.[86] To combat her gender dysphoria, she requested Medicaid coverage for an orchiectomy (testicle removal) in 2017.[87] Four healthcare providers agreed that the surgical procedure was medically necessary to treat her gender dysphoria.[88] Despite this consensus among the medical providers treating her, Defendant DHS denied Ms. Good Medicaid

[82] *Id.*
[83] Good Pet. ¶ 11.
[84] *Id.* at ¶ 73.
[85] *Id.* at ¶ 71.
[86] *Id.* at ¶ 74.
[87] *Id.* at ¶ 3.
[88] *Id.*

coverage for the surgery.[89] Four years since she was first diagnosed with gender dysphoria, Ms. Good still has not received the medically necessary treatment she needs, denying her continuity of care and relegating her to ineffective hormone treatment.

Ms. Beal was diagnosed with gender dysphoria in 1989.[90] She began hormone therapy that same year.[91] Despite years of hormone therapy, Ms. Beal has experienced decades of depression and anxiety as a result of her gender dysphoria, and she continues to be distressed and uncomfortable with her genitalia.[92] To treat her gender dysphoria, in 2017, she requested Medicaid coverage for a vaginoplasty, penectomy, bilateral orchiectomy, clitoroplasty, urethroplasty, labiaplasty, and perineoplasty.[93] Four healthcare providers agreed that these surgical procedures were medically necessary to treat her gender dysphoria.[94] Despite this consensus, Defendant DHS denied Ms. Beal Medicaid coverage for the surgeries.[95] After decades of suffering, Ms. Beal still has not received the medically necessary treatment she needs, disrupting the continuity of her care.

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[89] *Id.*
[90] Joint Pet. at 24.
[91] *Id.*
[92] *Id.*
[93] *Id.* at 16.
[94] *Id*. at 13.
[95] *Id*.

Blanket denials of medically necessary surgery, such as that of DHS, and the attendant denial of continuity of care, can have serious consequences for severely gender-dysphoric individuals like Ms. Good and Ms. Beal. Iowans with severe gender dysphoria are at an increased risk of serious harm and suicide prior to receiving SRS.[96] Even a delay in treatment can have a long-term impact on an individual. One study found that gender-dysphoric individuals "who were operated on relatively soon after diagnosis were socially more active and showed less neuroticism than those who were kept on a waiting list for at least 2 years.[97] Without the needed surgery, gender-dysphoric Iowans are forced to continue to grapple with a lower quality of life that threatens their health and well-being.

These consequences can be mitigated by access to surgery. "Gender affirming/confirming surgery . . . plays an undisputed role in contributing toward favorable outcomes."[98] Surgery has been shown to "improve[] mental health, socioeconomic status, relationships, and sexual satisfaction."[99] In a study of outcomes of SRS, the surgery also significantly improved anxiety, depression, and hostility.[100] In short, surgery to treat

[96] DSM-5, *supra* note 22, at 452-53.
[97] APA Task Force, *supra* note 9.
[98] *WPATH Policy Statement*, *supra* note 55.
[99] *Id.*
[100] *See* Yolanda L.S. Smith, et al., *Adolescents with Gender Identity*

gender dysphoria is not an elective, cosmetic procedure, as DHS's regulations state.[101] DHS's blanket ban prevents medical and mental-health professionals from prescribing the proper treatment and it denies some gender-dysphoric Iowans much-needed relief while placing them at a substantially greater risk of physical and emotional harm.

CONCLUSION

For all of these reasons, *amici curiae* respectfully submit that the Court affirm the district court's ruling.

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Respectfully submitted,

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Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study, 40 J. Am. Academy Child & Adolescent Psychiatry 475-77 (2001).

[101] Iowa Admin. Code r. 441.78.1(4).

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