IN THE IOWA DISTRICT COURT FOR POLK COUNTY

EERIEANNA GOOD, an individual, Petitioner, v. IOWA DEPARTMENT OF HUMAN SERVICES, an independent executive-branch agency of the State of Iowa, Respondent.	Case No. CVCV054956 CVCV055470 (consolidated)
CAROL BEAL, an individual, Petitioner, v. IOWA DEPARTMENT OF HUMAN SERVICES, an independent executive-branch agency of the State of Iowa, Respondent.	**PETITIONERS' REPLY IN SUPPORT OF BRIEF ON JUDICIAL REVIEW**

Rita Bettis, AT0011558
ACLU of Iowa Foundation Inc.
505 Fifth Avenue, Ste. 901
Des Moines, IA 50309-2316
Telephone: 515-207-0567
Facsimile: 515-243-8506
rita.bettis@aclu-ia.org

John Knight, PHV001725
ACLU Foundation
LGBT & HIV Project
150 North Michigan Avenue, Ste. 600
Chicago, IL 60601
Telephone: 312-201-9740
Facsimile: 312-288-5225
jknight@aclu-il.org

F. Thomas Hecht, PHV001733
Tina B. Solis, PHV001311
Seth A. Horvath, PHV001734
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4443
Facsimile: 312-977-4405
fthecht@nixonpeabody.com
tbsolis@nixonpeabody.com
sahorvath@nixonpeabody.com

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COME NOW Petitioners EerieAnna Good ("Ms. Good") and Carol Beal ("Ms. Beal") (collectively, "Petitioners"), by their undersigned counsel, and respectfully submit the following reply in support of their brief on judicial review of the Iowa Department of Human Services' ("DHS") denials of their requests for Medicaid coverage for gender-affirming surgery:

INTRODUCTION

In their initial brief, Petitioners argued that DHS's decisions denying Medicaid reimbursement for medically necessary gender-affirming surgeries, and the regulation on which DHS relied (the "Regulation"), violate the Iowa Civil Rights Act ("ICRA" or "Act"), which expressly prohibits gender-identity discrimination, as well as discrimination on the basis of sex. (Br. at 26–33.)[1] Petitioners also argued that DHS's decisions and the Regulation violate the Iowa Constitution's equal-protection guarantee. (*Id*. at 34–46.) And they asserted that the decisions and Regulation have a disproportionate negative impact on private rights, and are arbitrary and capricious, in violation of the Iowa Administrative Procedure Act ("APA"). (*Id*. at 46–50.)

In response, DHS revisits most of the same arguments it made in its motion to dismiss Ms. Beal's petition for judicial review without addressing the record in the case or responding to the Court's ruling on the motion to dismiss.

First, DHS argues that ICRA is inapplicable to this case as a matter of law because DHS is not a "public accommodation"—an argument this Court has already rejected and for which DHS offers no new authority or evidence. (*Compare* Resp. at 18–26 *with* 11/27/17 Order at 3.)

[1] The citation format throughout this brief is as follows: "Good Pet." refers to Ms. Good's petition for judicial review, "Beal Pet." refers to Ms. Beal's petition for judicial review, "Good Ans." refers to DHS's answer to Ms. Good's petition for judicial review, "Good AR" refers to Ms. Good's administrative record, "Beal AR" refers to Ms. Beal's administrative record, "Br." refers to Petitioners' initial brief, and "Resp." refers to DHS's response.

Second, DHS invokes the Eighth Circuit's decision in *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001), as support for the Regulation, despite the fact this Court has already decided that *Smith* has no bearing on this dispute and is now discredited precedent. (*Compare* Resp. at 26–29 *with* 11/27/17 Order at 3.)

Third, DHS challenges Petitioners' equal-protection claim, arguing, among other things, that DHS's decisions and the Regulation on which they are based survive the rational-basis test because denying Medicaid benefits to transgender people for medically necessary treatment saves the State of Iowa money. (*See* Resp. at 29–37.) This is not a proper justification under the equal-protection guarantee. Moreover, the record before the Court has absolutely no evidence of cost or financial burden to the State of Iowa. In fact, denying treatment for gender dysphoria likely *increases* economic costs since untreated gender dysphoria leads to unemployment, poor health, higher assistance payments, and other social impacts. Although DHS had multiple opportunities to present evidence of cost savings in Petitioners' administrative proceedings, it failed to do so. This is because no such evidence exists.

Fourth, to avoid the consequences of losing, DHS asserts that, if Petitioners are successful, the Court should remand the case to DHS for a determination of medical necessity, limit the scope of its decision, and stay the decision pending further rulemaking. (Resp. at 37–41.) There is no reason for a remand. DHS had a chance to make a record below on medical necessity and did not. There likewise is no reason to limit the scope of, or delay, the relief requested by Petitioners to see if an indeterminate rulemaking process comes about. This is far too speculative.

At the core of DHS's brief, running through all its arguments, is a particularly troubling contention raised for the first time before this Court. Despite the extensive medical testimony in

the record, DHS trivializes gender dysphoria as an "emotional condition" (Resp. at 9) and one that is "psychologically motivated" (*id*. at 31, 41), suggesting that Petitioners' requests for treatment are more concerned with cosmetic appearance than medical necessity. This characterization has no basis in the factual record before the Court. It ignores the *uncontroverted* testimony of Bradley Erickson, MD ("Dr. Erickson"); Loren Schechter, MD ("Dr. Schechter"); Katherine Imborek, MD ("Dr. Imborek"); Jacob Priest, PhD ("Dr. Priest"); Armeda Wojciak, PhD ("Dr. Wojciak"); Randi Ettner, PhD ("Dr. Ettner"); and Elizabeth Graf, PA-C ("Ms. Graf"), described at length in Petitioners' initial brief. And it is directly contradicted by the findings of leading medical groups, including the American Medical Association, the American Psychological Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the National Association of Social Workers, and the World Professional Association of Transgender Health ("WPATH"). (*See* Br. at 18–20.) All agree that gender dysphoria is a serious medical condition and that surgical treatment is medically necessary for transgender people such as Petitioners. By minimizing these medical facts, DHS seeks to avoid the deeply suspect nature of the decisions that gave rise to the petitions before this Court.

Those decisions should be vacated, and DHS should be required to approve Petitioners' requests for Medicaid coverage. Additionally, the Court should enter (1) a declaratory ruling that the Regulation's ban on coverage for gender-affirming surgical care to treat gender dypshoria violates ICRA, the Iowa Constitution's equal-protection guarantee, and the APA and (2) an order invalidating the Regulation and enjoining any further application of it to deny Medicaid coverage for gender-affirming surgical care.

ARGUMENT

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

A. The Regulation violates the plain meaning of ICRA.

DHS does not dispute that ICRA prohibits discrimination against transgender individuals. (*See* Resp. at 9, 18–24.) Nor does it dispute that the Regulation categorically prohibits surgical treatment for gender dysphoria. (*See id*. at 9.) Instead, DHS takes the position that the Regulation is not discriminatory because its "broad 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 surgery. (Resp. at 9, 17.)

This argument is problematic for several reasons. First, it ignores the Regulation's categorical ban on gender-affirming surgery, the burden of which falls squarely—*and solely*—on the shoulders of transgender individuals. As set forth in Petitioners' initial brief (Br. at 29–30), 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, since transgender people are the only individuals who seek surgery related to "transsexualism" or "gender identity disorders" as set forth in the Regulation. Discrimination against transgender persons is, by its very nature, discrimination on the basis of gender identity given that a person is defined as transgender by the fact that their gender identity fails to match their birth-assigned gender. (Beal AR 77 ¶¶ 9–10.)

Gender dysphoria is a serious medical condition that, if left untreated, can lead to clinically significant distress and dysfunction, debilitating depression, and, for some people without access to appropriate medical care and treatment, suicidality and death. (*Id*. 78–79, ¶¶

11, 14.) Since the mid-1990s, there has been consensus within the medical community that surgery is the only effective treatment for many individuals with severe gender dysphoria. (*Id*. 82, ¶ 28; 83, ¶ 36; 86, ¶ 53; 87, ¶ 54.) But despite this consensus, and despite health experts' rejection of the myth that gender-affirming surgery is "cosmetic" or "experimental" (*id*. 86, ¶¶ 48–52; Good Ans. ¶ 67), the Regulation categorically prohibits transgender individuals from receiving Medicaid coverage for surgical care that is available to nongtransgender individuals for conditions other than gender dysphoria, such as testicular cancer, pain, and torsion; postoncologic reconstruction; posttraumatic reconstruction; postinfection reconstruction; and reconstruction of congenital defects or anomalies. (Good AR 150–53; Beal AR 70, ¶ 5.) This discriminatory treatment of transgender individuals is a per se violation of ICRA's prohibition against gender-identity discrimination and should be enjoined by the Court.

Second, DHS's argument ignores the medical science showing that gender dysphoria has a fundamental biological component placing it outside the realm of purely "psychological" conditions. As Dr. Ettner noted in her affidavit, gender dysphoria "is not to be confused with Body Dysmorphic Disorder," which "is characterized by a distorted perception that a particular aspect of one's physical appearance, e.g. one's nose, is flawed, causing [an] individual to feel 'deformed.'" (Beal AR 70, ¶ 12.) Gender dysphoria "is based on a realistic perception that one's body habitus does not align with one's gender identity." (*Id*.) And gender identity, according to current scientific research, "is innate or fixed at an early age," "has a strong biological basis," and, because it is "biologically based, . . . cannot be altered." (*Id*., ¶¶ 33–34.)

Consistent with these characteristics of gender dysphoria and gender identity, "[t]he idea that gender dysphoric patients [are simply] 'demonstrating psychotic mechanisms'" has been "discredited by the weight of research." (*Id*., ¶ 26.) Clinical psychologists have "debunked" the

theory that a transgender patient can be "cured" through "psychoanalysis." (*Id*., ¶ 27.) Instead, the prevailing theory, based in part on findings that "the brains of transsexual persons differ[] from [those of] non-transsexual persons," has become "that gender identity evolves as a result of the interaction of the developing brain and sex hormones." (*See id*., ¶ 28.) Thus, WPATH "no longer require[s] psychotherapy as a necessary prerequisite to medical and/or surgical treatment" for gender dysphoria. (*Id*., ¶ 29.)

Third, and most importantly, the undisputed medical evidence in the record shows that gender-affirming surgical treatment for gender dysphoria is not "primarily for psychological purposes," but rather to prevent social dysfunction, physical pain, and even death. Unlike elective cosmetic surgery that a person undergoes for aesthetic reasons, medically necessary gender-confirmation surgery is intended to address the life-altering—and, at times, life-threatening—consequences of gender dysphoria.

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. (Beal AR 78–79, ¶¶ 14, 53.) Suicidality and death are all too common among persons who are unable to access gender-dypshoria treatment, with a 41 to 43% attempted-suicide rate for those individuals, as compared to a baseline rate of 4.6% in North America. (*Id*.) Surgical treatment of gender dysphoria is therefore intended not only to address the psychological distress associated with the condition, but also the dysfunction and death that can occur without such treatment.

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. (Good AR 31–33.) And it would reduce the risks she faces from her hormone treatment by allowing her to reduce her hormone dosage to a safer level. (*Id*. 138–39.)

For these reasons, DHS's reliance on the Regulation's "psychological purposes" exclusion is unpersuasive and does not, in any way, alter the conclusion that the Regulation, and the denials of Petitioners' request for Medicaid coverage, violate ICRA's prohibition against gender-identity discrimination.

B. DHS qualifies as a "public accommodation" under ICRA.

As set forth in Petitioners' initial brief, DHS qualifies as a "public accommodation" under both Section 216.2(13)(a) and 216.2(13)(b) of ICRA. *See* Iowa Code §§ 216.2(13)(a), (b) (2017). DHS is a "state . . . government unit" within the meaning of Section 216.2(13)(b). (Br. at 30.) And even under a restrictive reading of the Act that limits "state . . . government unit[s]" to physical facilities, DHS falls within the purview of Sections 216.2(13)(a) and 216.2(13)(b). (*Id*. at 30–32.) Each of these interpretations is consistent with, and dictated by, ICRA's plain language. *See Univ. of Iowa v. Dunbar*, 590 N.W.2d 510, 511 (Iowa 1999). Therefore, ICRA governs DHS's conduct.

The Court previously agreed with this conclusion, rejecting "DHS's contention that, as a matter of law, neither DHS nor Iowa Medicaid is a public accommodation within the meaning of [ICRA]." (11/27/17 Order at 3.) The Court determined that, "[a]ccording to the well-pleaded facts of the petition, DHS is alleged to be a unit of a state government that offers the services and benefits of Iowa Medicaid to the public. Iowa Medicaid is the alleged service and benefit. DHS is the alleged public accommodation under ICRA." (*Id*.) Based on this, the Court found that "the issue should be decided on the merits of the petition." (*Id*.)

Despite the Court's prior decision, DHS continues to argue, as it did in its motion to dismiss Ms. Good's petition for judicial review, that ICRA does not apply because DHS's denials of Medicaid coverage do not prohibit access to a physical facility. (*See* Resp. at 19–25.) This argument, as stated before and as set forth again below, has no merit.

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); *U.S. Jaycees v. Iowa Civil Rights Comm'n*, 427 N.W.2d 450, 454 (Iowa 1988).

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*, *available at*: http://www.merriam-webster.com/dictionary/unit (last visited Oct. 25, 2017). 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. *See 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. *See 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. *See 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. *See 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) ("[W]hen the language of a statute is plain, we do not read words or restrictions into a statute that are not readily apparent from the express terms.").

2. The doctrine of *noscitur a sociis* supports Ms. Good's interpretation of "unit."

The doctrine of *noscitur a sociis* 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); *see also Des Moines Flying Serv., Inc. v. Aerial Servs., Inc.*, 880 N.W.2d 212, 221 (Iowa 2016) ("[*N*]*oscitur a sociis* . . . "summarizes [a] rule of both language and law . . . .") (internal quotation marks omitted).

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) (2017) (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*, *available at*: http:/www.merriam-webster.com/dictionary/district (last visited Oct. 25, 2017). 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.

Contrary to DHS's contention, Petitioners do not assert that DHS itself is a "tax-supported district" (Resp. at 22), but rather that the association between the terms "unit" and "district," supports Petitioners' interpretation of "unit." DHS fails to address this argument. (*See id*.)

3. Even under a restrictive definition of "unit," 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, as previously set forth in Petitioners' initial brief. (*See* Br. at 30–32.)

First, DHS has multiple offices across the State of Iowa. *See, e.g.,* Iowa Dep't of Human Servs., DHS Offices Map, *available at*: http://dhs.iowa.gov/dhs_office_locator. At least one of those offices was involved in denying Medicaid benefits to Petitioners. (*See* Good Ans. ¶ 14; Good AR 1–3; Beal AR 1–5.) Petitioners were therefore subject to a discriminatory practice by an agent or employee of DHS operating out of a DHS facility when DHS denied them Medicaid coverage on the basis of their gender identity. These circumstances satisfy even DHS's proposed restrictive definition of "public accommodation" under Section 216.2(13)(b) of ICRA. *See* Iowa Code § 216.2(13)(b) (2017).

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." *See* Iowa Code § 216.2(13)(a) (2017).

DHS operates "facilities" throughout the State of Iowa that "offer services" to members of the public "gratuitously," such as Medicaid. (*See* Good Ans. ¶ 14.) And those facilities

"receive[] governmental support or subsidy" in that they are funded by the State of Iowa. (*See* Good Ans. ¶ 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 on the basis of gender identity in administering the Iowa Medicaid program from an office of the Iowa state government. *Cf.* Ltr. from Richard C. Turner, Attorney General, to Dennis L. Freeman, State Representative, and Rolland A. Gallagher, Director, Iowa, Beer & Liquor Control Dep't, 1972 WL 262259 (Feb. 2, 1972) (noting that even a private club may become a 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. *See Torres v. N. Fayette Comty. Sch. Dist.,* 600 F. Supp. 2d 1026, 1031 (N.D. Iowa 2008) ("[A] person subject to discrimination in accommodation is denied 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) ("[A] properly adapted prima facie case . . . requires [the plaintiff] to prove . . . [that the 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, without citing any authority, that its "mere[] own[ership] or operat[ion] [of] physical facilities is insufficient to implicate . . . ICRA's protections." (Resp. at 19.) 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 there is no "relationship

between the alleged discrimination and 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. (*See* Good Ans. ¶ 14; Good AR 1–3; Beal AR 1–5.) So, too, for that matter, were the administrative-law judges ("ALJs") who recommended the denials to DHS from their state offices in Des Moines. (Good AR 70–76; Beal AR at 93–101.) These decisions did not simply materialize from thin air; they were made and implemented at discrete, tangible locations. (*See, e.g.,* Good AR 1 (decision issued from "1305 E. Walnut Street, Des Moines, IA"); Good AR 70 (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.

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

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

a. DHS's interpretation of "public accommodation" renders key statutory language superfluous.

DHS's emphasis on Section 216.2(13)(a) to interpret "public accommodation" renders Section 216.2(13)(b) of ICRA superfluous. (Resp. at 23–24.) As the Iowa Supreme Court has repeatedly emphasized, courts must "not construe a statute to make any part of it superfluous." *Petition of 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 856

(quoting *Rojas v. Pine Ridge Farms, LLC*, 779 N.W.2d 223, 231 (Iowa 2010)); *see Ramirez-Trujillo v. Quality Egg, LLC*, 878 N.W.2d 759, 770 (Iowa 2016) (same).

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) (2017). Emphasizing this component of the public-accommodation definition to the exclusion of the component including "state . . . government unit[s]" renders the latter superfluous. Iowa Code § 216.2(13)(b) (2017). 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. This is improper. *See Chapman*, 890 N.W.2d at 856; *see also id*. at 857 ("When the legislature chooses to act as its own lexicographer by defining statutory terms, we are ordinarily bound by its definitions.") (internal quotation marks omitted).

b. DHS's interpretation of "public accommodation" produces absurd results.

DHS's interpretation of "public accommodation" also produces absurd results. Under Iowa law, courts "will not construe the language of a statute to produce an absurd or impractical result." *State v. Adams*, 810 N.W.2d 365, 369 (Iowa 2012); *see In re Detention of Bosworth*, 711 N.W.2d 280, 283 (Iowa 2006) (same). Instead, courts "presume the legislature intends a reasonable result when it enacts a statute." *Adams*, 810 N.W.2d at 369 (internal quotation marks omitted); *see Bosworth*, 711 N.W.2d at 283 (same).

DHS's interpretation of Section 216.2(13)(b) of ICRA attempts to exclude "state . . . government unit[s]," such as DHS, from ICRA's prohibition against gender-identity and sex discrimination by distinguishing between the programs provided by those government units and the government units themselves. (*See* Resp. at 18 ("Petitioners' ICRA claims hinge on whether

Iowa Medicaid qualifies as a 'public accommodation.'").) If this were the proper interpretation of the Act, then any state agency could avoid ICRA's prohibition against discrimination by "public accommodation[s]" by arguing that its services and benefits are not "government unit[s]." This is an absurd and impractical interpretation of Section 216.2(13)(b) that artificially circumscribes ICRA's coverage.

c. DHS fails to broadly construe ICRA.

Additionally, DHS's interpretation of "public accommodation" runs afoul of the principle that ICRA must be broadly construed. The Iowa legislature has declared that ICRA "shall be broadly construed to effectuate its purpose." Iowa Code § 216.18(1) (2017). And the Iowa Supreme Court has reaffirmed this principle, noting 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 should be construed liberally consistent with its statutory purpose.").

Here, Petitioners maintain that the only plausible interpretation of "public accommodation" includes DHS, a "state . . . government unit." (*See supra* Arg., § I(B)(1).) 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." *See* Iowa Code § 216.18(1) (2017); *Pippen*, 854 N.W.2d at 28.

5. Federal law is irrelevant to interpreting ICRA's public-accommodation provisions.

Finally, DHS impermissibly relies on federal law to interpret ICRA's public-accommodation provisions. (*See* Resp. at 24–25.)

Although "it is generally true that Iowa courts have traditionally looked to federal law for guidance in interpreting . . . [ICRA]," they are "not bound by federal law . . . ." *Pippen v. State*, 854 N.W.2d 1, 18 (Iowa 2014) (internal quotation marks omitted). Federal law is inapplicable here because ICRA's public-accommodation provisions differ substantially from those of the Civil Rights Act of 1964.

ICRA defines a "public accommodation" as "each and every place, establishment, or facility of whatever kind, nature, or class that caters or offers services, facilities, or goods" to the public and "each state and local government or tax-supported district of whatever kind, nature, or class that offers services, facilities, benefits, grants or goods to the public, gratuitously or otherwise." Iowa Code § 216.2(13) (2017).

The federal Civil Rights Act of 1964, by contrast, defines a "public accommodation" as:

> (1) any inn, hotel, motel, or other establishment which provides lodging to transient guests . . .;
>
> (2) any restaurant, cafeteria, lunchroom, lunch counter, soda fountain, or other facility principally engaged in selling food for consumption on the premises . . . or any gasoline station;
>
> (3) any motion picture house, theater, concert hall, sports arena, stadium or other place of exhibition or entertainment; and
>
> (4) any establishment (A)(i) which is physically located within the premises of any establishment otherwise covered by the subsection, or (ii) within the premises of which is physically located any such covered establishment, and (B) which holds itself out as serving patrons of such covered establishment.

42 U.S.C. § 2000a(b). This 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, than the definition in ICRA. It bears very little relation to ICRA's definition and is of no value in interpreting that statute.

Indeed, when ICRA was enacted in 1965, it replaced a previous Iowa civil-rights statute with language similar to the federal Civil Rights Act of 1964. Under ICRA's predecessor, 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).

The old language was similar to the federal statute in that it listed facilities constituting public accommodations instead of defining "public accommodation" in general terms. It was abandoned by the Iowa legislature because of a concern that it would be interpreted to exclude all establishments not explicitly listed in the statute, such as banks, gas stations, and doctor's offices. *See U.S. Jaycees v. Iowa Civil Rights Comm'n*, 427 N.W.2d 450, 454–55 (Iowa 1988). DHS's reference to the portion of Professor Bonfield's article cited in the *U.S. Jaycees* case (Resp. at 24–25) is not a persuasive basis for concluding that DHS is not a public accommodation since that case addressed an entirely different question—namely, whether a private-membership organization qualifies as a "public accommodation" for purposes of ICRA. *See id*. at 453.

Because the public-accommodation language of ICRA differs substantially from that of the federal Civil Rights Act of 1964 and, in fact, replaced similar language over a concern that it

was too narrow, the Civil Rights Act of 1964 is irrelevant to interpreting ICRA's public-accommodation provisions.

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

For the reasons set forth in Petitioners' initial brief, the Regulation also violates ICRA's prohibition against sex discrimination. (Br. at 32–35.) 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. (*Id*. at 33–34.) And the Iowa Supreme Court's decision in *Sommers v. Iowa Civil Rights Commission*, 337 N.W.2d 470 (Iowa 1983), which predates this case law, is easily distinguishable. (*Id*. at 34–35.)

DHS does not discuss any of the federal case law cited by Petitioners. (Resp. at 25–26.) Nor does it dispute that *Sommers* is premised on case law that was "eviscerated" by the intervening federal case law. *See Smith v. City of Salem*, 378 F.3d 566, 573 (6th Cir. 2004). Its sole contention is 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. (*Id*. at 26.)

DHS's argument contravenes the principle, reflected in ICRA itself, that remedial statutes must be construed liberally to effectuate their purpose. Iowa Code § 216.18(1) (2017); *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). Here, a liberal construction of ICRA requires interpreting its prohibition against sex discrimination to encompass gender-identity discrimination.

The Iowa Supreme 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. *See id*. at 6 (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, e.g., Fabian v. Hosp. of Cent. Conn.*, No. 3:12–CV–1154 (SRU), 2016 WL 1989178, at *14 n.12 (D. Conn. Mar. 18, 2016) ("The fact that the Connecticut legislature added [language explicitly protecting gender identity to the statute in question] does not require the conclusion that gender identity was not already protected by the plain language of the statute [prohibiting sex discrimination], because legislatures may add such language to clarify or to settle a dispute about the statute's scope rather than solely to expand it."). Such is the case here.

III. *Smith v. Rasmussen* is inapposite.

DHS argues, as it did in moving to dismiss Ms. Good's petition, that the Eighth Circuit's outdated decision in *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001), "should inform this Court's analysis of" the Regulation. (Resp. at 26.) But the Court has already rejected this argument and should do so again.

In denying DHS's motion to dismiss, the Court noted that *Smith* was "not dispositive." (11/27/17 Order at 3.) 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." (*Id*.) Nor did *Smith* "consider or decide challenges to the Regulation or application of the Regulation to the facts under the []APA." (*Id*.) "The medical facts alleged in [Ms.] Good's petition," observed the Court, "are not the same as the facts considered by *Smith*." (*Id*.) For these reasons, the Court

concluded that "[t]he issues presented by [Ms.] Good's petition should be decided on the merits by Iowa courts applying Iowa law and the Iowa Constitution." (*Id*.)

The same rationale continues to apply. The *Smith* decision does not justify adhering to the Regulation. In *Smith*, the court never considered or ruled on the claims Petitioners make here, and the case provides no precedent to this Court on those claims.

Smith, as the Court has noted, 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 U.S. Constitution. *Id*. at 758. The ICRA and Iowa constitutional claims at issue in this case were not asserted or adjudicated in *Smith*. In fact, at the time *Smith* was decided in 2001, the 2007 ICRA amendment prohibiting gender-identity discrimination had not even been enacted. *See* Acts 2007 (82 G.A.) ch. 191, S.F. 427, §§ 5, 6 (inserting references to "gender identity").

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 such surgery was also excluded from coverage under Medicare. *Smith*, 249 F.3d at 761. 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. (*See* Beal AR 78–79, ¶¶ 11, 14; 82, ¶ 28; 83, ¶ 36; 86, ¶ 53; 87, ¶ 54.) This shift is reflected in the federal Medicare regulations, which no longer prohibit Medicare coverage for gender-affirming surgery. *See, e.g.*, Dep't of Health & Human Servs. Dept'l Appeals Bd. Dec. No. 2576 (May 30, 2014), *available at*: https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

DHS's latest reliance on *Smith* focuses solely on *Smith*'s alleged applicability to Petitioners' arbitrary-and-capricious claims, not its ICRA or equal-protection claims. (Resp. 26–28.) But DHS fails to acknowledge the Court's prior rejection of this argument. (11/27/17 Order at 3.) And it also fails to acknowledge that the arbitrary-and-capricious claims themselves are based, in part, on Petitioners' ICRA and equal-protection challenges to the Regulation, which were not at issue in *Smith*.

DHS also argues that, because it was "obligated" to enforce the Regulation, its decision to do so cannot be considered arbitrary and capricious. (Resp. 28–29.) 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. *See Soo Line R.R. Co. v. Iowa Dep't of Transp.*, 521 N.W.2d 685, 688–89 (Iowa 1994) (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); *Hough v. Iowa Dep't of Personnel*, 666 N.W.2d 168, 170 (Iowa 2003) (same). Here, DHS blindly applied the Regulation without any regard for ICRA (*see supra* Arg. §§ I–II), the Iowa Constitution's equal-protection guarantee (*see infra* Arg., § IV), or the unrefuted evidence that the surgical procedures requested by Petitioners are medically necessary and consistent with modern standards of care (*see infra* Arg., § V). Its decision to do so was improper.

IV. The Regulation and its application to deny coverage to Petitioners violate equal protection.

A. DHS's Regulation facially discriminates against similarly situated Medicaid recipients.

As shown in Petitioners' initial brief, Ms. Beal, Ms. Good, and other persons who are denied surgical treatment for gender dysphoria are substantially similar to other persons who

receive Medicaid coverage for treatment of other medical conditions. (Br. at 35–38.) They are the same in all legally relevant ways because Medicaid recipients—transgender or not—share a financial need for medically necessary treatment for a medical condition. *See 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.").

DHS concedes that "transgender and non-transgender Medicaid recipients may be similarly situated" but claims the Regulation does not intentionally discriminate against transgender recipients. (Resp. at 34.) This is incorrect.

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-confirmation surgery to treat gender dysphoria, a condition only affecting transgender persons. *See* 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").

In the same way that the "benefit denied by the marriage statute—the status of civil marriage for same-sex couples—is so 'closely correlated with being homosexual' as to make it apparent the law [was] targeted at gay and lesbian people as a class," *see Varnum v. Brien*, 763 N.W.2d 862, 885 (Iowa 2009), the Regulation's ban on surgical treatment for gender dysphoria "is so 'closely correlated with being' [transgender] as to make it apparent" that the Regulation "is targeted at [transgender] people as a class," *see id.* The Regulation's disparate treatment of transgender Medicaid recipients is a sufficient basis to support Petitioners' equal-protection claim. *McQuistion v. City of Clinton*, 872 N.W.2d 817, 830 (Iowa 2015).

DHS argues for the first time in this proceeding that the Regulation is facially neutral because it excludes coverage for "surgeries for psychological purposes." (Resp. at 35.) The Regulation, however, more broadly excludes coverage for "cosmetic, reconstructive, or plastic surgery," which it defines as surgery that "can be expected primarily *to improve physical appearance* or which is performed primarily *for psychological purposes* or *which restores form but which does not correct or materially improve the bodily functions*." Iowa Admin. Code r. 441.78.1(4) (emphasis added). Surgery that "primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance," is not excluded from coverage. *Id*. "Surgeries for the purpose of sex reassignment" are expressly defined as not "restoring bodily function and are excluded from coverage." *Id.*

The Regulation provides coverage for "cosmetic, reconstructive, or plastic 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." Iowa Admin. Code r. 441.78.1(4); *see also* Iowa Benefit Plan Coverage List, Iowa Dep't of Human Servs., *available at* https://dhs.iowa.gov/sites/default/files/Iowa%20Wellness%20Plan%20Benefits%20Coverage%20List_0.pdf (stating that "non-cosmetic reconstructive surgery" and "breast reconstruction" are covered, even if the surgery is "primarily for psychological purposes" or "which restores form but which does not correct or materially improve the bodily functions").

A review of the medical literature illustrates how covered procedures involve both psychological trauma and cosmetics. "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 (emphasis added),

available at https://www.plasticsurgery.org/reconstructive-procedures. "Breast reconstruction is achieved through several plastic surgery techniques that attempt to restore a breast to near normal shape, appearance and size following mastectomy," American Society of Plastic Surgeons, Reconstructive Procedures, Breast Reconstruction, *available at* https://www.plasticsurgery.org/reconstructive-procedures/breast-reconstruction. And "[s]car revision surgery will attempt to minimize a scar so that it is less conspicuous and blends in with the surrounding skin tone and texture." American Society of Plastic Surgeons, Reconstructive Procedures, Scar Revision, *available at* https://www.plasticsurgery.org/reconstructive-procedures/scar-revision.

Moreover, the history behind the language of the Regulation explicitly barring coverage for surgical treatment for "transsexualism" and "gender identity disorder" clearly illustrates that its 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 a rulemaking to "exclude[ ] Medicaid coverage for sex reassignment surgery." (Good AR 212.) It did so following the 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*. 213.) 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 paid 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 this 1994 rulemaking to "reevaluat[e] . . . its policy on sex reassignment treatment." (*Id.*)

Finally, the undisputed medical evidence in the record shows that the denial of medically necessary surgical treatment for gender dysphoria should not be trivialized as DHS attempts to

do. The denial of assistance can result in dysfunction and even death. 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. (Beal AR 78–79, ¶¶ 14, 53.) Suicidality and death are all too common among persons who are unable to access gender-dypshoria treatment, with a 41 to 43% attempted-suicide attempt rate for those individuals, as compared to a baseline rate of 4.6% in North America. (*Id*.)

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. (Good AR 31–33.) And it would reduce the risks she faces from her hormone treatment by allowing her to reduce her hormone dosage to a safer level. (*Id*. 138–39.)

DHS's assertion that the Regulation's exclusion of surgical treatment for gender dypshoria is the result of a generally applicable test for whether the surgery is for "psychological purposes" is thus belied by the Regulation's language, the Regulation's history, and the record evidence showing that surgical treatment addresses not only psychological distress, but also the dysfunction, pain, and even death that can result from untreated gender dypshoria. All of this is included in the record; none of it has been challenged by DHS with evidence.

B. DHS's discrimination against Medicaid recipients who are transgender should be reviewed under heightened security.

The Iowa Supreme Court has not decided what level of constitutional review should apply to review classifications that discriminate against transgender Iowans. But this Court should find that heightened scrutiny applies for two reasons: (1) the factors the Iowa Supreme Court relies on to decide whether a heightened level of review should apply to an identifiable

group strongly support applying heightened scrutiny to transgender Iowans, and (2) discrimination against transgender Iowans is a form of gender-based discrimination, which the Iowa Supreme Court reviews under heightened scrutiny.

The absence of an Iowa case addressing this open question is not a sufficient basis for refusing to review the Regulation and its application under a heightened level of review. (*See* Resp. at 29.) There is likewise no Iowa case supporting DHS's assertion that rational-basis review should be applied. As a result, this Court should consider Petitioners' arguments for why heightened scrutiny is the proper standard for reviewing a classification that discriminates against transgender individuals.

In their initial brief, Petitioners demonstrated that Iowa's four-factor test for ascertaining the appropriate level of equal-protection scrutiny mandates applying heightened scrutiny to laws that discriminate against persons because they are transgender. (Br. at 38–45.) Petitioners also showed that discrimination against transgender persons is a form of sex discrimination. (*Id.* at 32–35.) That fact provides a second reason for applying heightened review to analyze the Regulation and its application to Ms. Good and Ms. Beal. (*Id.* at 45.)

DHS notes that not all courts have concluded that discrimination against transgender persons should be reviewed under heightened scrutiny. (Resp. at 29.) But, in fact, the overwhelming bulk of recent authority has reached the conclusion that heightened scrutiny should be applied in reviewing such discrimination because transgender persons have faced a history of discrimination, a person's transgender identity has nothing to do with a person's ability to contribute to society and is core to their identity, and transgender people represent a discrete minority who are politically powerless to bring a prompt end to the discrimination they experience through traditional political means. (Br. at 44–45.) In addition, heightened scrutiny

should be applied because discrimination against transgender individuals is a form of gender discrimination. (*Id*. at 45.)

C. The Regulation fails review under both heightened scrutiny and rational-basis review.

The Regulation, and its application to Petitioners, fails heightened scrutiny (*see* Br. at 45–46), which DHS does not contest. And it also fails rational-basis review.

DHS argues that the disparate treatment of transgender persons is justified because denying Medicaid reimbursement saves the state money. (Resp. at 30–32.) But cost savings are insufficient to justify the arbitrary distinction the Regulation creates between transgender persons and nontransgender persons in need of necessary medical care. *Racing Ass'n of Cent. Iowa v. Fitzgerald*, 675 N.W.2d 1, 12–15 (Iowa 2004); *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).

In *Varnum v. Brien*, 763 N.W.2d 862 (Iowa 2009), the Iowa Supreme Court applied heightened scrutiny to its review of Iowa's marriage statute. Its explanation for rejecting cost savings as a rationale for the marriage ban at issue in *Varnum* 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." *Id*. at 903.

In contrast, the decision in *Kantrowitz. v. Weinberger*, 388 F. Supp. 1127 (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"). *Id.* at 1131. Unlike the arbitrary distinction between transgender Medicaid recipients in need of surgical treatment for gender dypshoria and nontransgender recipients in need of treatment for other medical conditions, the distinction in *Kantrowitz* was not one made on "purely arbitrary grounds." *Id.*

DHS further asserts that the "nature and diagnosis of gender identity disorder" is "evolving" and that there is "disagreement regarding the efficacy of sex reassignment surgery." (Resp. at 32–33 (quoting *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001).) But the facts in the record plainly show otherwise. Dr. 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. (Beal AR 87, ¶ 54.) That is why leading medical groups all endorse the standards of care that include surgical treatment as one of the medically necessary treatments for gender dysphoria. (*Id*., 79–80, ¶¶ 15–18; 87, ¶ 54.)

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. (*See* Resp. at 33.) Additional studies have confirmed that the surgery is medically necessary, and the medical consensus regarding its efficacy has strengthened since 1995. (Beal AR 81–82, ¶¶ 25–31.) Medicare and several states have ended exclusions on coverage for this treatment since that time. *See, e.g.,* Department of Health and Human Services Departmental Appeals Board Decision No. 2576 (May 30, 2014), *available* at http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf.

But more to the point is that even if the consensus were the same, the *Smith* decision rejecting a federal Medicaid challenge to the Regulation has no relevance to the question whether the Regulation violates Iowa's equal-protection guarantee. The fact that not everyone with

gender dysphoria needs surgery (*see* Resp. at 33) cannot possibly justify a blanket prohibition on its coverage for persons, such as Petitioners, for whom it is medically necessary treatment. DHS's assertion that these surgeries "do not restore function" (*id.* at 32) is addressed above (*see supra* Arg., § IV(A)). These surgeries can make it possible for persons with gender dysphoria to function in daily life and are life-saving. And other surgeries covered for Medicaid recipients are not more, and are possibly even less, restorative of function than surgical treatments for gender dypshoria. The relationship between the ban on surgical treatment for gender dypshoria 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) (internal citations and quotation omitted).

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. (*See* Resp. at 31.) In fact, publicly available data shows otherwise. *See, e.g.,* Herman, Jody L., PhD, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* (Williams Institute, Sept. 2013).[2]

As DHS concedes, justification for a classification must be "credible as opposed to specious." (Resp. at 33 (quoting *Tyler v. Iowa Dep't of Revenue*, 904 N.W.2d 162, 166 (Iowa

[2] 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. *See* State of California, Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (Apr. 13, 2012), *available at* http://translaw.wpengine.com/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf. The fiscal and medical advantages of providing this medical treatment have motivated a number of states, including New York and Massachusetts, to lift their Medicaid bans on transition-related care. *See* NYS Register, Rulemaking Activities (Dec. 17, 2014), *available at* https://docs.dos.ny.gov/info/register/2014/dec17/pdf/rulemaking.pdf; Jeremy C. Fox, *Mass. to cover range of transgender medical care*, Boston Globe (June 20, 2014, *available at*: https://www.bostonglobe.Com/metro/2014/06/20/state-cover-gender-reassignment-surgery-and-hormone-treatment-for-transgender-patients/a9OPrvqdUPmRoiAQugVwEO/story.html.

2017).) A rational basis must be "realistically conceivable" and have some "basis in fact." *See Racing Ass'n of Cent. Iowa v. Fitzgerald*, 675 N.W.2d 1, 7–8 (Iowa 2004); *see also Residential & Agric. Advisory Comm.*, 888 N.W.2d 24, 50 (Iowa 2016). DHS baldly asserts that "the credibility of the justification is self-evident." (Resp Br. at 33.) But a review of the Regulation itself, as well as the facts, shows otherwise.

V. DHS's efforts to limit the relief provided by this Court should be rejected.

A. This Court should grant Petitioners the specific relief they seek.

DHS has denied Petitioners coverage under Medicaid for care that is medically necessary. This denial is based solely on their transgender identity, in violation of ICRA and the Iowa Constitution. To remedy DHS's unlawful conduct, Petitioners seek declaratory and injunctive relief specifically reversing DHS's denials of their claims and promptly providing them with the needed medical care. (Beal Pet. at 23–24; Good Pet. at 24.)

DHS argues that even if the Court grants the declaratory and injunctive relief Petitioners seek, it should nonetheless deny them the specific relief that would allow them to promptly receive the medically necessary care at the heart of this case. (Resp. at 37.) Such a further denial of relief, after determining Petitioners' rights have been so grossly violated based on their transgender identity, is not only procedurally inappropriate, but would also perpetuate the harm they have suffered as a result of DHS's discriminatory denial of their claims.

1. As a matter of law, the relief Petitioners seek is appropriate, and the agency is limited to the record below.

First, this Court is not limited to reversal and remand in granting relief to Petitioners. The APA provides that the "court shall reverse, modify, or grant other appropriate relief from agency action, equitable or legal and including declaratory relief, if it determines that substantial rights of the person seeking judicial relief have been prejudiced because the agency action meets one of

the enumerated criteria contained in section 17A.19(10)(a) through (n)." Iowa Code § 17A.19(10) (2017); *Renda v. Iowa Civil Rights Comm'n*, 784 N.W.2d 8, 10 (Iowa 2010). Declaratory and injunctive relief is the preferred remedy for cases such as this. DHS, however, seeks a remand to consider medical necessity. This is improper.

Second, this was a contested case of actual medical claims belonging to Petitioners, not an abstract rulemaking challenge.[3] As detailed below (*see infra* Arg., § V(A)(2)), the medical necessity of Petitioners' claims was squarely before the agency at all stages. In a judicial-review action of a contested case, the court sits in an appellate capacity, and the parties are bound by the agency record absent circumstances not present here. *See Iowa Med. Soc'y v. Iowa Bd. of Nursing,* 831 N.W.2d 826, 838 (Iowa 2013); *Fisher v. Iowa Bd. of Optometry Exam'rs*, 478 N.W.2d 609, 611 (Iowa 1991) ("The court, in judicial review of a contested case, sits in an appellate capacity. Because the court has no authority to hear additional evidence, it normally will have no authority to order discovery."); *Mary v. Iowa Dep't of Transp.*, 382 N.W.2d 128, 131 (Iowa 1986) (citing *Black v. University of Iowa,* 362 N.W.2d 459, 463 (Iowa 1985) ("In judicial review of a contested case proceeding the district court is limited to the record made before the agency.")).

[3] For purposes of illustration, it is helpful to map out how a rulemaking challenge to the discriminatory ban brought by transgender individuals who are on Medicaid, or organizations that represent them, would be different. In that case, unlike this one, it would arguably make sense for this Court to rule only on the legality of the ban and require the petitioners to submit claims for preauthorization to the agency prior to requiring the agency to provide them care in their specific cases. In that type of rulemaking-challenge scenario, there would not be an administrative record of a contested case involving specific evidence of medical necessity; the issue before the Court would be limited to the constitutionality and legality of the ban. But here, by contrast, Petitioners are transgender Iowans who submitted actual claims for medical care to DHS for prior authorization, which *is* the agency's mechanism to determine medical necessity, and the agency had the opportunity to cross-examine Petitioners' witnesses, develop whatever record it desired regarding Petitioners' specific medical claims, or otherwise base its denial on medical necessity.

In a contested case, the record includes "all evidence received or considered and all other submissions [made before the agency below]." Iowa Code § 17A.12(6)(b) (2017). The APA is explicit that, absent a showing of good cause for why the record was not developed by a party below, it will not allow further development of the record on appeal. Iowa Code § 17A.19(7) (2017) (in judicial review of agency action of contested cases, a court "shall not itself hear any further evidence with respect to those issues of fact whose determination was entrusted by the Constitution or a statute to the agency in that contested case proceeding" absent demonstration of inability to develop record below).

Third, the relief that Petitioners seek, reversing DHS's denials of care and thereby authorizing their claims, follows the normal course for Medicaid appeals in contested cases. Medicaid appeal processes recognize the urgent nature of claims for medical care. Upon a successful appeal, Medicaid patients should be provided with the care they need.

For example, under Medicaid regulations, an agency appeal resulting in the reversal of a managed-care organization's ("MCO") decision denying care triggers authorization of the claim within three days. *See* 42 C.F.R. § 438.424 ("If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination."); *see also* Iowa Admin. Bulletin ARC 3652C at 1 (most recent administrative bulletin, implementing 42 C.F.R. § 438.424).

Fourth, DHS's late-in-the-game change of strategy to get a do-over is belied by its own letters to Petitioners laying out the procedures for appeal. The denial letters to Ms. Beal and Ms. Good, respectively, stated:

> If a decision is made in your favor as a result of the appeal process, we will:
>
> - Start to cover services as quickly as you have need for care and no later than seven calendar days from the date we get written notice of the decision.
>
> - Approve and pay for the services we denied coverage of before.

(Beal AR 185; Good AR 185.)

Taylor v. Iowa Department of Job Service, 362 N.W.2d 534 (Iowa 1985), cited by DHS (Resp. at 37), offers no support for remand here. There, the court concluded that remand for further specific findings was appropriate where "the agency's ruling d[id] not clearly disclose a sound factual and legal basis for its decision," which is not the case here. *See id.* at 537. *Loeb v. Employment Appeal Board*, 530 N.W.2d 450 (Iowa 1995), also cited by DHS (Resp. at 37), supports Petitioners since that case involved remand for entry of judgment rather than for further fact-finding. *See id*. at 452.

2. The medical necessity of Petitioners' claims is uncontested, and any untimely challenges have been forfeited.

DHS's argument is premised on its assertion that the agency "deferred its determination of medical necessity as moot given the existence of the Rule," further stating it "would be inappropriate at this juncture for Petitioners to be provided their surgeries without undergoing the appropriate review typically applied to requests for prior approval of procedures." (Resp. at 37–38.) This is an invention by DHS on appeal.

This is a case in which there is not, and never has been, any factual dispute; the dispute is entirely legal. The record shows that Petitioners' treating medical providers determined a

specific course of treatment was medically necessary for each, submitted ample evidence of their determinations to the MCOs and DHS in their requests for preauthorization, and received denials of their claims. DHS could have denied the claims based both on the law and medical necessity, but it declined to do so (indeed, Petitioners' evidence of medical necessity is overwhelming).

This was not an interlocutory or partial agency action; Petitioners dutifully followed the rules and exhausted agency appeals, obtaining final agency action now before this Court. There were two separate internal agency appeals in each matter—one before the MCO, the other before DHS—at which DHS had the opportunity to present evidence contesting the medical-necessity determinations made by Petitioners' treating medical providers or even request discovery or cross-examination regarding the medical providers' affidavit testimony. Ms. Good presented extensive evidence regarding medical necessity. (*See* Br. at 18–20, 21–26.)

The matter of medical necessity was squarely at issue in both Petitioners' cases at both stages of their internal agency appeals. Presented with Petitioners' evidence of medical necessity, the MCOs and agency declined to call Petitioners' witnesses for cross-examination or present contravening evidence to rebut medical necessity. DHS had the opportunity to provide contrary evidence and, indeed, submitted exhibits and made arguments in Ms. Beal's proceeding. But it declined to challenge the medical-necessity determination made by Ms. Beal's treating medical providers. (*See* Beal AR 29– 30, 95.) There was no element of surprise or other good cause not to develop an argument contesting medical necessity, and the agency and MCOs had ample opportunity to challenge Petitioners' claims for treatment based on medical necessity. DHS has forfeited any argument regarding medical necessity in this case.

The record reflects that the ALJ in each Petitioner's case carefully considered the evidence presented by both sides, including as to medical necessity. In Ms. Good's case, the ALJ

recounted that the issue before her on appeal was "[w]hether the managed care contractor correctly denied payment for cosmetic, reconstructive, or plastic surgery." (Good AR 70.) The ALJ engaged with all Ms. Good's evidence regarding medical necessity. (*Id*. 71 (describing the various sworn affidavits Ms. Good submitted from treating medical providers regarding medical necessity).) The ALJ's findings of fact recited the request for prior approval of Ms. Good's orchiectomy submitted by Dr. Imborek, her treating physician. (*Id*. ("The request was initially examined by the MCO and given to the medical director *for a medical necessity determination*.") (emphasis added).)

As the ALJ documented, the MCO denied the claim after engaging in the medical-necessity review. (*Id*. 76 ("The MCO initially denied the prior authorization request at issue here because '[S]urgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.' In an appeal review, the MCO determined that the further documentation did not establish medical necessity, stating, 'procedures related to transsexualism . . . [and] gender identity disorders[] . . . are excluded for payment under the Iowa Medicaid Plan. Therefore, the request for Orchiectomy for gender dysphoria remains denied.'").)

As the ALJ's findings of fact recount, in the first-level appeal of Ms. Good's claim, medical necessity remained part of the inquiry but was simply not the basis of the denial. (*Id.* 71.) The MCO's letter denying her appeal laid out its rationale:

> Based on review of all the information provided, per the Iowa Administrative Code (IAC 441.78) procedures related to transsexualism [and] gender identity disorders[] . . . are excluded for payment under the Iowa Medicaid Plan. Therefore, the request for Orchiectomy for gender dysphoria remains denied.

(*Id*.)

In Ms. Beal's case, too, the ALJ's findings of fact referenced the materials Ms. Beal submitted and detailed the unrebutted recommendations of her treating medical team. (Beal AR

96–97.) As the ALJ found, the agency "denied the appeal based upon Iowa Admin. Code r. 441-78.1(4)(b)(4)(249A)," not evidence of medical necessity. (*Id*. 97.) The certified issue on appeal, as considered by the ALJ, was "whether or not the managed care contractor in this case, Amerigroup, correctly denied payment for cosmetic or plastic surgery." (*Id*. 119:2–4.) The ALJ reviewed evidence of medical necessity at the hearing. (*Id*. 119:6–23, 120:1–6, 131:12–15 (Petitioners' counsel stating that "the evidence we've submitted as part of the record establishes that the procedures Ms. Beal has requested are, in fact, medically necessary in the judgment of her medical providers").) The ALJ asked attorneys for the MCO and DHS whether they objected to the administrative record in any way, and they did not. (*See id*. 124:5 ("No, we have no objection.").) The MCO, through its counsel, further stated: "Amerigroup is required to follow Iowa Regulation 441.78.1 subsection 4, which excludes surgeries for the purpose of sex reassignment from coverage. That is the sole grounds [on which] Amerigroup denied coverage as demonstrated in the August 14, 2017 letter which cites to the regulation." (*Id*. 129:1–8.)

The record demonstrates that medical necessity was asserted by Petitioners to seek authorization for coverage but never constituted an additional or alternative basis for DHS's denials. The MCOs' and agency's decisions not to engage in a challenge to medical necessity do not grant DHS the ability to do so now at the cost of continued harm to Petitioners' health. Medical necessity is an uncontested fact: the only basis asserted for denying Petitioners' requests for Medicaid coverage was the discriminatory ban. DHS was presented squarely with Petitioners' overwhelming evidence of medical necessity, which it considered and referenced in its communications and arguments, but which it never contested and which ultimately was not the basis of its denials. It cannot now be permitted to go back and look for additional or other reasons that it did not assert in denying Petitioners' claims. Invalidating the Regulation will

mean that the agency's sole asserted rationale for denying care has been reversed. Therefore, care should be provided within the normal procedures established under Medicaid—i.e., authorization for treatment within seventy-two hours of notice to DHS that its decisions have been reversed.

3. Granting DHS a do-over in this scenario leads to absurd and unjust results.

DHS attempts to characterize its request to this Court to deny Petitioners the specific care they seek, despite normal practice when denials are reversed on appeal, as some sort of procedural inevitability. To the contrary, it would be absurd to require Medicaid patients to resubmit their claims for a new determination when a denial is reversed on appeal. There is no limiting principle to that logic. An individual could be required to restart a request for treatment ad infinitum, allowing DHS to continue to assert one new legal or factual reason to deny care each time as long as it failed to assert that reason the first time around.

The rules of civil procedure are applicable to proceedings for judicial review to the extent they do not conflict with a more specific provision of the APA. *See Medco Behavioral Care Corp. v. Iowa Dep't of Human Servs.*, 553 N.W.2d 556, 563 (Iowa 1996); Iowa R. Civ. P. 1.1601. The district court sits in an appellate capacity in judicial review of contested cases before state administrative agencies, where the parties have the opportunity to develop a factual record of all claims and defenses before the agency. *See Iowa Med. Soc'y v. Iowa Bd. of Nursing,* 831 N.W.2d 826, 838 (Iowa 2013); *Fisher v. Iowa Bd. of Optometry Exam'rs*, 478 N.W.2d 609, 611 (Iowa 1991).

Courts do not allow litigants endless bites of the apple. *See, e.g., Arnevik v. Univ. of Minn. Bd. of Regents*, 642 N.W.2d 315, 319 (Iowa 2002) (discussing claim preclusion) ("The rule applies not only as to every matter which was offered and received to sustain or defeat a

claim or demand, but also to any other admissible matter which could have been offered for that purpose . . . [and] may foreclose litigation of matters that have never been litigated.") DHS had the opportunity, and duty, to assert all the bases for denying Petitioners' claims at the time the claims were submitted so that Petitioners could appeal the denials of their requests for medical care in a comprehensive and efficient manner. Here, DHS is bound by the record on appeal. Its failure to challenge medical necessity at the first available opportunity does not mean that patients like Petitioners should be denied critical care while DHS gets to try again and again, using new arguments. Anything else would be an extraordinary departure from the way Medicaid claim denials are normally handled if reversed on appeal and a fundamentally unfair denial of due process.

B. Staying relief to allow DHS to "develop criteria the patient must meet" would also deprive Petitioners of their due-process rights.

DHS alternatively asks, as a matter of policy, that the Court stay its own grant of relief to Petitioners to allow the agency to "develop criteria the patient must meet prior to receiving approval for . . . surgery." (Resp. at 37–38.) This speculative outcome has no place in the argument before this Court. It does no more than continue denying care to transgender Iowans on Medicaid whose treating medical providers have already deemed the care medically necessary.

Such a denial of relief, based on vague assertions related to the development of criteria, would be improper. First, it is entirely speculative. Petitioners need care now. DHS has never contested that fact throughout any stage of the appeal process, which it controlled.

Rather, DHS asks this Court to supplant the medical expertise of Petitioners' qualified and renowned experts and treating physicians with DHS's own ill-informed assertions about medical necessity, of which there is no supporting evidence in the record. As extensively set forth in the record, without contest by DHS, the availability of transition-related medical care,

including surgeries, for those who need it is recommended by the American Medical Association, the American Psychological Association, the American Psychiatric Association, the American Academy of Family Physicians, the National Association of Social Workers, and many other professional associations. (Beal AR 79; 86; 87; Good AR 29.) This treatment is literally life-saving. Gender dysphoria causes severe symptoms that interfere with an individual's ability to function, including but not limited to severe anxiety, depression, self-harm, and suicidality. Indeed, DHS's offensive dismissal in its brief of the medical care sought by Petitioners to treat their gender dysphoria demonstrates precisely why medical professionals with relevant expertise, not the state based on nonmedical considerations, should determine when treatment is medically necessary.

DHS's argument is a straw man, in any case, because Petitioners are not arguing that gender-affirming surgery should be provided to any and all comers, but rather only when medically necessary. That determination is made, not by the state, but by treating medical providers. DHS already has a process by which it or its designees—the MCOs—review claims for medical necessity across the broad spectrum of all medical needs presented by all Iowa Medicaid recipients. That process is the request for prior authorization, which Petitioners have exhausted in this case.[4]

[4] The proposal that DHS should create *any* criteria that specifically carves out care that only transgender Iowans need for special scrutiny is, per se, to regulate based on transgender identity and unlikely to withstand heightened judicial scrutiny under the Iowa Constitution or a civil-rights challenge. It is no more appropriate to have a special rule allowing DHS to second-guess medical-necessity determinations by certified treating medical providers in cases of gender dysphoria than it is to have such a rule for treating any other type of serious medical need. DHS offers no compelling justification to treat medical care regarding gender dysphoria—about which there is broad consensus—differently from the way it handles considerations of medical care in all other cases. It offers absolutely no evidence for its assertion that gender dysphoria treatments are not "being appropriately prescribed" for transgender Iowans. (Resp. at 39.) DHS certainly has not called into question, at any time during this contested case, the expertise of Petitioners' well-credentialed and highly respected medical experts, who are leaders in their fields. Nor could it credibly do so.

C. The agency's arguments regarding prisoner and abortion rights are both spurious and far afield from the case before this Court.

DHS makes two spurious arguments regarding prisoner and abortion rights that do not have any bearing on this case.

First, DHS argues that developing criteria related to allow transgender Medicaid recipients to be provided with medically necessary surgical care for gender dysphoria, consistent with all other claims under Medicaid, would necessitate the State of Iowa's provision of surgical treatment to institutionalized persons when medically necessary. That issue is simply not presented in this case.[5]

Finally, DHS makes an argument regarding abortion that is both inapposite and inaccurate. (*See* Resp. at 40–41.) Like prisoner-rights cases, abortion-rights litigation involves a specific body of constitutional law that protects fundamental reproductive rights and asserted governmental interests arising after the viability of a pregnancy. *See Roe v. Wade*, 410 U.S. 113, 163 (1973) (state's interests do not become compelling prior to viability, and a state regulation prior to viability is invalid if it imposes an undue burden by having the intent or effect of placing a substantial obstacle in the path of a woman seeking an abortion); *Planned Parenthood of*

[5] The rights of institutionalized persons to medical care would need to be addressed in a separate lawsuit. It is cruel and unusual punishment under the Eighth Amendment to deny prisoners medically necessary treatment, including treatment for gender dysphoria. *See, e.g., Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011) (Wisconsin's blanket statutory ban on hormone therapy and gender-confirmation surgery constituted facial violation of Eighth Amendment). DHS's assertions that decisions about whether to provide medical care to transgender prisoners suffering from gender dysphoria should be left to the legislature, and may be dictated by fiscal or other political considerations, are wrong. (Resp. at 39–40.) *See, e.g., Harris v. Thigpen*, 941 F.2d 1495, 1509 (11th Cir. 1991) (treatments cannot be denied merely because they are expensive); *Fields*, 653 F.3d at 556 (rejecting various arguments for legislative ban on providing hormone therapy and surgery, including cost, and finding that "[r]efusing to provide effective treatment for a serious medical condition serves no valid penological purpose and amounts to torture"); *Barrett v. Coplan*, 292 F. Supp. 2d 281, 285 (D.N.H. 2003) (treatment must be "based on medical considerations"); *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 182 (D. Mass. 2002) (treatments cannot be denied merely because they are controversial).

Southeastern Penn. v. Casey, 505 U.S. 833 (1992) (reaffirming *Roe*'s determination that states cannot ban abortion prior to viability.); *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (in determining whether a pre-viability regulation imposes an undue burden, the Court will look behind the state's bald assertions to determine whether the regulation actually confers medical benefits and weigh the burdens imposed on the women actually impacted by the regulation). Put simply, that body of analysis does not apply to this set of facts, and no court has applied abortion-rights analysis to litigation regarding medically necessary surgical treatment of gender dypshoria. It would be a strange and inadvisable course of action for this Court to accept DHS's invitation to do so, and it is not clear what that would entail.[6]

This Court should decline DHS's invitation to consider cases and parties not before it. And it should weigh the "controversy" regarding transgender Iowans as evidence in support of heightened scrutiny under the Iowa Constitution, not as a rationale to deny those individuals care.

[6] As with Eighth Amendment claims, DHS's assertion about Medicaid payments for surgical abortion is simply untrue. Abortions *are* covered for Medicaid recipients when necessary to save a pregnant woman's life. Guttmacher Inst., *State Funding of Abortion Under Medicaid*, *available at*: https://www/guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid ("First implemented in 1977, the Hyde Amendment, which currently forbids the use of federal funds for abortions *except* in cases of life endangerment, rape or incest, has guided public funding for abortions under the joint federal-state Medicaid programs for low-income women. At a minimum, states must cover those abortions that meet the federal exceptions.") (emphasis added); *see also* Iowa Admin. Code r. 78.1(17) (Iowa Medicaid regulation providing payment for abortion care in the case of danger to the life of the pregnant woman, fetal abnormality, rape, or incest).

Even in the controversial realm of abortion rights, public funding is provided to save the lives of pregnant women. Given that Petitioners' case deals *only* with medically necessary care, it is hard to see what DHS is getting at, other than broadly introducing into its argument the specters of social bias and discrimination against women who seek abortion care, prisoners, and transgender people. That discrimination is precisely why Petitioners' equal-protection claims under the Iowa Constitution must be reviewed under heightened scrutiny.

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. *See* Iowa Code §§ 216.7(1)(a), 216.2(13)(b) (2017); Iowa Const. art. I, §§ 1, 6; Iowa Code § 17A.19(10)(a), (b), (c) (2017). It also has a disproportionate negative impact on private rights and is arbitrary and capricious. *See* Iowa Code §§ 17A.19(10)(k), (n) (2017).

For the reasons stated above and in their initial brief, Petitioners respectfully request the following relief:

a. A declaratory ruling that the Regulation:
    i. violates ICRA's prohibitions on sex and gender-identity discrimination;
    ii. violates the Iowa Constitution's equal-protection guarantee facially and as applied;
    iii. creates a disproportionate negative impact on private rights; and
    iv. is arbitrary and capricious;

b. An order invalidating the Regulation and enjoining any further application of it to deny Medicaid coverage for gender-affirming surgery;

c. An order:
    i. reversing and vacating DHS's affirmance of the MCOs' denials of Ms. Good's request for Medicaid coverage for an orchiectomy and Ms. Beal's request for Medicaid coverage for a vaginoplasty,

penectomy, bilateral orchiectomy, clitoroplasty, urethroplasty, labiaplasty, and perineoplasty; and

ii. requiring DHS to approve coverage for those procedures;

d. An award of attorneys' fees and costs; and

e. Any other relief the Court deems just and proper.

Dated: March 23, 2018

Respectfully submitted,

/s/ Rita Bettis
Rita Bettis, AT0011558
ACLU of Iowa Foundation Inc.
505 Fifth Avenue, Ste. 901
Des Moines, IA 50309-2316
Telephone: 515-207-0567
Facsimile: 515-243-8506
rita.bettis@aclu-ia.org

/s/ F. Thomas Hecht
F. Thomas Hecht, PHV001733
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4322
Facsimile: 312-977-4405
fthecht@nixonpeabody.com

/s/ Tina B. Solis
Tina B. Solis, PHV001311
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4482
Facsimile: 312-977-4405
tbsolis@nixonpeabody.com

/s/ Seth A. Horvath
Seth A. Horvath, PHV001734
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4443
Facsimile: 312-977-4405
sahorvath@nixonpeabody.com

/s/ John Knight
John Knight, PHV001725
ACLU Foundation
LGBT & HIV Project
150 North Michigan Avenue, Ste. 600
Chicago, IL 60601
Telephone: 312-201-9740
Facsimile: 312-288-5225
jknight@aclu-il.org