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IN THE

Supreme Court of Iowa

No. 18-1158

EERIEANNA GOOD and CAROL BEAL,

Petitioners-Appellees,

vs.

IOWA DEPARTMENT OF HUMAN SERVICES,

Respondent-Appellant.

On Appeal from the Iowa District Court
Case Nos. CVCV054956, CVCV055470 (consolidated)

BRIEF OF *AMICI CURIAE* NATIONAL HEALTH LAW PROGRAM, NATIONAL WOMEN'S HEALTH NETWORK, AND CHICAGO LAWYERS' COMMITTEE FOR CIVIL RIGHTS IN SUPPORT OF PETIONER-APPELLEES GOOD AND BEAL

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IDENTITY AND INTEREST OF *AMICI CURIAE*

Amicus **National Health Law Program ("NHeLP")** works to ensure that people of color, people with disabilities, those with limited English proficiency, women, and LGBTQ individuals can achieve their fullest health potential and to remove barriers to the essential right of health care for all people. Amicus protects and advances the health rights of low-income and underserved individuals and families, guided by the belief that each generation should be healthier than the last.

Amicus **National Women's Health Network ("NWHN")** improves the health of all women by influencing public policy and providing health information to support decision-making by individual consumers. Founded in 1975 to give women a greater voice within the health care system, NWHN aspires to create systems guided by social justice that reflect the needs of women in all their diversities. NWHN is committed to ensuring that women have self-determination in all aspects of their reproductive and sexual health and establishing universal access to health care. NWHN is a membership-based organization supported by thousands of individuals and organizations nationwide.

Amicus **Chicago Lawyers' Committee for Civil Rights** is a public interest law organization founded in 1969 and works to secure racial equity

and economic opportunity for all. Chicago Lawyers' Committee on Civil Rights provides legal representation through partnerships with the private bar and collaborates with grass roots organizations and other advocacy groups to implement community-based solutions that advance civil rights. Through coalition work, litigation, and policy advocacy, Chicago Lawyers' Committee for Civil Rights advocates in partnership with communities of color and other organizations in the City of Chicago and surrounding municipalities to implement systems of transparency, accountability, and oversight to end racial disparity in policing and restore trust between police and the communities they serve.

Amici submit this brief to provide the Court with historical context of the evolution and realization of the promise of equality in the critical area of health care. *Amici* believe that the fight against discrimination in access to health care across the lines of race, gender, and sexual orientation provides important guidance to the Court as it addresses how best to apply the promise of equal protection provided by the Iowa Constitution and the Iowa Civil Rights Act to the provision of medically necessary surgery to treat gender dysphoria, a condition that only affects transgender people.

ARGUMENT

I. Introduction

Ms. Good and Ms. Beal seek access to medically necessary health care. That care has been denied to them because of the State's failure to properly acknowledge them for who they are—women who are transgender with a serious medical need for gender affirming treatment.

The Iowa Constitution and its requirement for equal protection is the "foundation principle" of Iowa's government. *Varnum v. Brien*, 763 N.W.2d 862, 877 (Iowa 2009). Equal protection provides a guarantee to every Iowa citizen that "laws treat all those who are similarly situated with respect to the purposes of the law alike." *Id.* at 883 (citing *Racing Ass'n of Cent. Iowa v. Fitzgerald*, 675 N.W.2d 1, 7 (Iowa 2004)). That commitment is likewise embodied in the Iowa Civil Rights Act. According to the main draftsman of the 1965 and 1967 Iowa Civil Rights Act, the ICRA "enshrines in the law . . . a fundamental moral principle" that because of their humanity, "every person deserves to be treated on the basis of his or her own individual capacities and attributes rather than on the basis of harmful prejudices and stereotypes." Arthur Earl Bonfield, Allan Vestal Distinguished Chair, Univ. of Iowa Law Sch., The Origin and Rationale of the Iowa Civil Rights Act: A Speech on the Occasion of the Iowa Civil Rights Commission Celebration of

the Fiftieth Anniversary of the Iowa Civil Rights Act (May 20, 2015), *available at* https://law.uiowa.edu/sites/law.uiowa.edu/files/OriginCivilRightsAct%252050th%2520anniversary%2520speech2015.pdf.

This Court has recognized that "times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress." *Varnum*, 763 N.W.2d at 876 (quoting *Lawrence v. Texas*, 539 U.S. 558, 578-79 (2003). As such, the Court has a proud and robust tradition—going back to its first recorded opinion— of applying the "foundational principles" of equality in a variety of contexts, often before a national consensus has been achieved. *See, e.g., Varnum*, 763 N.W.2d 862 (2009) (approving same-sex marriage); *In re Marriage of Kramer*, 297 N.W.2d 359 (Iowa 1980) (rejecting racial discrimination in connection with child custody decisions); *State v. Pilcher*, 242 N.W.2d 348 (Iowa 1976) (overturning sodomy laws); *Coger v. N.W. Union Packet Co.*, 37 Iowa 145 (1873) (rejecting racial discrimination in public accommodations); *Clark v. Bd. of Dirs.*, 24 Iowa 266 (1868) (rejecting school segregation); *In re Ralph*, 1 Morris 1 (Iowa 1839) (rejecting treatment of African American as fugitive slave).

Health care has been a critical battleground in the area of equality. For the past seventy-five years, minority groups—based on race, gender, and lesbian, gay, bi-sexual and transgender ("LGBT") identity—sought access to health care and were denied equal access and fair treatment. Progress has occurred only by recognition that immutable characteristics such as race, gender or LGBT identity should not be used to thwart access to medically necessary care. This brief seeks to provide the Court with some of this history, to inform the Court's analysis as it fulfills its constitutional role of applying the foundational principles of equality to the health care issues presented by this case.

As described below, in the middle of the last century, African Americans sought access to equal health care facilities. They wanted the best care; the same as other Americans were receiving. They were told that an alternative arrangement was good enough. Courts applying the foundational principle of equality decided otherwise, and they desegregated the health care system for patients. Legislation furthered the desegregation of health care, enforced by the courts.

Women, too, have long faced discrimination in the access to health care. They were charged higher rates for health coverage, their fundamental health problems were not covered by their health plans, and they have faced

sexism in receiving treatment. Discriminated against in this century and the last, women pushed back on their lack of fair access to health care. Laws were passed that made discrimination illegal. Our health care norms for women were corrected by omnibus health care reform. And women turned to the courts when needed to seek the protection of the nation's laws, and the courts, again applying foundational principles of equality, provided those protections.

Members of the LGBT community have faced invidious discrimination as they have sought equal access to health care and providers as well. They have been denied treatment by providers and denied coverage by insurers. The members of the LGBT community have not been silent, nor have their allies. As a result, laws have been written that specifically champion LGBT health rights. And United States and Iowa Supreme Court decisions have provided guideposts for further equality for the LGBT community.

This case is the latest example of ongoing historical evolution. Ms. Good and Ms. Beal—like the disfavored groups before them—ask to be treated as equals, and not be excluded from access to medically necessary health care simply because they are transgender. Consistent with the historical march towards equality in health care described herein, the Court

should affirm the decision of the District Court and affirm Ms. Good's and Ms. Beal's right to be treated as equals under Iowa law.

II. Historical Racial Discrimination in Access to and Provision of Health Care.

Racial discrimination occupied a nefarious place in America's health care system, and people of color found that they did not have the same access to health care as the majority. From Reconstruction through the Jim Crow era, health care laws and systems denied treatment to non-white Americans and created a system of "separate but equal" for medical care access. African Americans were systemically denied the same type of medical treatment that was available to white Americans.[1] It took a combination of judicial intervention and legislative change to address the problems.

The inequity of health care access that African Americans faced was a "function of explicitly racist black codes and Jim Crow laws." Vann R. Newkirk II, *America's Health Segregation Problem*, The Atlantic (May 18, 2016), *available at https://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219/*. Racist attitudes, embodied

[1] Of course, African Americans were not the only disfavored group to seek and be denied access to health care. Other races and ethnicities have and continue to have faced hardship as well.

in the black codes and Jim Crow laws of the South "prevented African Americans from having equal health facilities and equality under the law." Kerri L. Hunkele, *Segregation in United States Healthcare: From Reconstruction to Deluxe Jim Crow* (2014), Honors Theses and Capstones 188, 2, *available at* https://scholars.unh.edu/cgi/viewcontent.cgi?article=1189&context=honors ("the worst of these [segregation laws] affected the ability of African Americans to gain access to medical care that was equal to whites"). For example, Southern states' laws through the early 20th Century kept white female nurses out of hospital units with African Americans in them, installed separate entrances for the races, and created separate rooms at hospitals. *Jim Crow Laws*, National Park Service, ("Nurses / Alabama – No person or corporation shall require any white female nurse to nurse in wards or rooms in hospitals, either public or private, in which negro men are placed."); 1916 Miss. Laws page 145, Ch. 108 § 8, *available at* https://play.google.com/store/books/details?id=7gZGAQAAIAAJ&rdid=book-7gZGAQAAIAAJ&rdot=1 ("The white and colored races shall be kept separate in said hospital, and suitable provisions made for their care and comfort by the board of trustees."); *The Rise and Fall of Jim Crow: Interactive Maps—Jim Crow Laws*, Thirteen: Media With Impact, *available at* https://www.thirteen.org/wnet/jimcrow/themap/index.html ("Mississippi:

There shall be maintained by the governing authorities of every hospital maintained by the state for treatment of white and colored patients separate entrances for white and colored patients and visitors, and such entrances shall be used by the race only for which they are prepared. [1930]"). In 1959, a nationwide survey determined that 83 percent of Northern hospitals had fully integrated patient admissions, but only 6 percent of Southern hospitals did. Emily Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*, Hospital & Health Networks (June 3, 2014), *available at* https://www.hhnmag.com/articles/4179-u-s-hospitals-and-the-civil-rights-act-of-1964. Of the remaining 94 percent of Southern hospitals that did not have fully integrated admissions systems, 33 percent refused to treat African Americans. *Id.* These types of segregation resulted in diminished quality of treatment for African American patients. Hunkele, *Segregation in United States Healthcare: From Reconstruction to Deluxe Jim Crow* at 18 (citing The Jim Crow Encyclopedia (Nikki L. M. Brown & Barry M. Stentiford eds., Greenwood Press 2008); *The African American Experience*, Greenwood Publishing Group, *available at* http://testaae.greenwood.com/doc/aspx?fileID=GR4181&chapterID=GR41813616&path=encyclopedias/greenwood).

In 1963, as change was sweeping over the nation and the theory of "separate but equal" was falling, African American patients, doctors, and dentists (joined by the intervening United States Department of Justice) sued two hospitals in North Carolina, seeking to stop the hospitals from denying patients admission based on race and to stop the hospitals from denying African American doctors and dentists from using the hospital. *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959, 961 (4th Cir. 1963) (en banc). The two defendant hospitals had received federal funds from the Hill-Burton Act, 42 U.S.C. § 291 *et seq.* *Simkins*, 323 F.2d at 963.

The Hill-Burton Act, passed in 1946, gave grants and loans to hospitals for construction and modernization so that the hospitals could increase their service volume and make their services available to more patients, including by providing free or reduced-cost care. *Hill-Burton Free and Reduced-Cost Health Care*, Health Resources & Services Administration, *available at* https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html. A program of "cooperative federalism," the States designated state agencies to administer the program, oversee health facilities, and develop state plans for health care under the Act. W. David Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, 16 J. Gender Race & Just. 139, 144

(2013). The Hill-Burton Act required hospitals receiving Hill-Burton funds not to discriminate on the account of race. 42 U.S.C. § 291f(a)(4)) (1944). But the Hill-Burton Act allowed the hospitals to meet the nondiscrimination requirement by providing separate but equal hospitals for separate racial populations. 42 U.S.C. § 291e(f) (1944). The implementing regulation of the 1944 statute also allowed "separate hospital . . . facilities and services of like quality for each such population group." 42 C.F.R. § 53.112. Thus, hospitals receiving Hill-Burton funds also received government-approval to exclude some Americans from fair access to health care.

The plaintiff patients sought access to a Hill-Burton Act hospital despite the Hill-Burton Act's and its regulation's allowance of discrimination. The plaintiff patients sought to declare unconstitutional the portions of the Hill-Burton Act (Hospital Survey and Construction Act), 42 U.S.C. § 291e(f), and its promulgated regulation, 42 C.F.R. § 53.112, that allowed the hospitals to be built with Hill-Burton funds and yet still distribute health care services under the doctrine of "separate but equal."

An *en banc* panel of the Fourth Circuit agreed. It was obvious to the majority that the government-authorized segregation in the hospitals was unconstitutional. *Simkins*, 323 F.2d at 969. "Separate but equal" was an unconstitutional device. *Brown v. Bd. of Educ. of Topeka, Shawnee Cty.*,

Kan., 347 U.S. 483, 495 (1954).[2] Hospitals built or running with Hill-Burton Act funding were constructed to provide adequate health services to all people. *Simkins*, 323 F.2d at 970. Splitting "all their people" into different groups who could or could not share the same services violated the law. *See id.* at 969. Such a system brought severe discrimination. *Id.* at 970. The Fourth Circuit found the Hill-Burton Act's and its regulation's "separate but equal" allowance unconstitutional and struck the provisions from the statute and regulation. *Id.* at 969–70. The United States Supreme Court denied the hospitals' petition for writ of certiorari, *Moses H. Cone Mem'l Hosp. v. Simkins*, 376 U.S. 938 (1964), and, effectively, *Simkins* became important precedent. *See Eaton v. Grubbs*, 329 F.2d 710, 715 (4th Cir. 1964) (holding hospitals could not discriminate on the basis of race against physicians and patients). Many hospitals receiving Hill-Burton funding desegregated. Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*.

The same year that the United States Supreme Court denied certiorari review of *Simkins*, the legislative and executive branches of the United States Government put forward another tool against discrimination, the Civil

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[2] Iowa, of course, had already rejected the doctrine of "separate but equal" in the prior century, in *Clark v. Board of Directors*, 24 Iowa 266 (1868).

Rights Act of 1964 ("Civil Rights Act"). Title VI of the Civil Rights Act was partly enacted to end racial segregation in health care facilities. Kimani Paul-Emile, *Patient Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. Rev. 462, 489 (2012), *available at* http://ir.lawnet.fordham.edu/faculty_scholarship/503; Civil Rights Act of 1964, Legislative History and scope of H.R. 7152: Title VI, 1–2, n.2, *available at* https://www.jfklibrary.org/Asset-Viewer/Archives/BMPP-029-009.aspx (noting elimination of any racially discriminatory effect in the Hill-Burton Act and recognizing that *Simkins* "enjoined non-profit hospitals which received Hill-Burton funds from excluding Negro patients and doctors"). To the framers of Title VI, discrimination at hospitals was "contrary to national policy, and to the moral sense of the nation." *Id.* at 34. In the words of one Senator, Title VI "would eliminate that kind of confusion [posed by discriminatory laws] and override all such separate-but-equal provisions for the future." 4 Legislative History of the Civil Rights Act of 1964, at 6842 (1964).

With Title VI prohibiting discrimination in federally funded programs on the basis of race, "color," or national origin, the President's administration attacked "the greatest of all discriminatory evils, differential treatment towards [African Americans] with respect to hospital facilities."

Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*. Civil rights proponents pushed for the enforcement of Title VI in Southern hospitals, a push supported by the executive branch. W. David Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, at 145. The Surgeon General encouraged hospitals to comply with Title VI of the Civil Rights Act because the hospitals were programs receiving some form of federal financial assistance. Friedman, *U.S. Hospitals and the Civil Rights Act of 1964* at 5. Hospitals took heed, and, as federal inspectors checked hospital compliance with Title VI, the inspectors noted moderate improvements. *Id.* at 5–6. When the Medicare and Medicaid programs were put into law in 1965 with the amendment of Social Security, federal authorities mounted new pressure on hospitals to accept African Americans and treat them fairly—or lose out on the funding of Medicare. *Id.* at 6. By the time that Medicare became effective, States had largely agreed to accept Medicare, and by doing so, those States had agreed to accept African American patients without discrimination. *Id.* (noting that "the day before Medicare became effective" in "all but five Southern states, 80 percent of hospital beds would be available for Medicare patients"). Those who refused to accept the terms of Title VI became the subjects of enforcement actions that further desegregated hospitals. *See, e.g.*, *Rackley v. Bd. of Trs.*

of Orangeburg Reg'l Hosp., 238 F. Supp. 512, 520 (E.D.S.C. 1965) (enjoining hospital from segregated rooms because the hospital received federal funding and the segregation practice violated Title VI of the Civil Rights Act).

All of this has had a direct and meaningful impact on public health. There is measurable evidence that civil rights progress has had "beneficial effects on the health or on other social determinants of health of racial and ethnic minority populations." R.A. Hahn, Bi.I Truman, and D.R. Williams, *Civil rights as determinants of public health and racial and ethnic health equity: Health care, education, employment, and housing in the United States*, SSM – Population Health 4, 17 (2018), *available at* https://www.ncbi.nlm.nih.gov/pubmed/29250579. Between 1965 and 1971, the infant mortality rate among non-white Americans fell by 40% while the infant mortality rate for white Americans changed little. *Id.* at 20. The timing and specifics of the non-white infant mortality rate suggests that Civil Rights Act was the cause of the rate drop. *Id.* Researchers believe that the Civil Rights Act prevented 38,600 African American infant deaths between 1965 and 2002. *Id.* This was confirmed by another study of African American children born in any state with segregationist policies that were reversed by the Civil Rights Movement. Studies showed that African

American children were being born healthier after the imposition of the Civil Rights Act: African American women born in the late 1960s and later had higher birthweights and lesser indications of a need for immediate medical care than African American women born earlier did. *Id.* A commitment to equality and fairness—legislatively mandated, judicially enforced—literally improved lives by ensuring full access to health care.

To this day, Title VI of the Civil Rights Act continues to make its mark in the prevention of discrimination in the provision of or access to health care. The Affordable Care Act, 42 U.S.C. § 18001 *et seq.*, builds on Title VI (and other civil rights laws) and prohibits the exclusion from participation in, the denial of benefits of, or the subjecting to of discrimination under a health program receiving federal financial assistance on the basis of race, "color," or national origin. 42 U.S.C. § 18116(a); *see also Section 1557 of the Patient Protection and Affordable Care Act*, U.S. Department of Health & Human Services, *available at* https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html (explaining Section 1557 incorporates Title VI's exclusion of discrimination on the basis of race).

Medicare continues to play an anti-discrimination role as well. The U.S. Centers for Medicare and Medicaid Services continue to uphold

nondiscrimination on the account of race, affirmatively stating that they do not "exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, [or] national origin . . . in admission to, participation in, or receipt of the services and benefits under any of its programs and activities[.]" *Accessibility & Nondiscrimination Notice*, Medicare.gov: The Official U.S. Government Site for Medicare, *available at* https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice.

Of course, as with all battles for civil rights, there is still much work to be done. According to studies, race still affects the quantity and quality of health care provided to people of color. Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 San Diego L. Rev. 135, 136 (1998). That includes African Americans, Hispanics and the Latinx community, African immigrants, and Asian and Pacific Islander groups. *Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage*, Centers for Medicare & Medicaid Services (Apr. 2018), *available at* https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2018-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf. Stakeholders and allies continue to work towards leveling the field of care for racial and ethnic minorities. *E.g., Racial and Ethnic Disparities in Health Care*, American College of Physicians (2010), *available at*

https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf.

Ultimately, faced with a "fork in the road" of whether to fulfill the constitutional ideals of equality, *Varnum*, 763 N.W.2d at 877, the *Simkins* court chose to protect African American patients who wanted access to the best health care that other Americans were already receiving. The makers and enforcers of laws took heed as well—they had watched the courts lead the way and responded with affirmative legislation that championed equality. Courts and lawmakers should continue to ensure that our health care laws are just and fair and give access to all.

III. Historical Gender Discrimination in Access to and Provision of Health Care.

The story of women's civil rights in the provision of medical care is similar to that of the fight for racial equality in health care. While a full discussion of the issues of gender discrimination in the provision of health care is beyond the scope of this brief, we provide a brief overview of the various areas in which that discrimination has been addressed by the Courts and legislatures.

Women have historically faced discrimination in access to medical care. Women have faced discrimination in the cost and coverage for medical care. They have been charged more for health coverage based only

on gender (a practice known as "gender rating"), and individual marketplace health plans often exclude coverage for services that only women need, such as maternity coverage. Moreover, women have faced – and continue to face – sexism in receiving treatment, with medical providers ignoring or discounting female complaints based on unsupported views of women as the emotional sex. Even so, while discrimination continues to exist, significant progress has been made in preventing and prohibiting discrimination based on gender in the provision of medical care.

As with race, federal legislation provided the first significant step forward in the civil rights movement with the passage of the Civil Rights Act. 42 U.S.C. § 2000e-2(a)(1) (2008). Title VII of the Civil Rights Act prohibits employers covered by the statute from charging female employees higher premiums than male employees. *Id.* Similarly, the Pregnancy Discrimination Act of 1978 amended Title VII to specify that discrimination on the basis of pregnancy, childbirth, or related medical conditions constitutes unlawful sex discrimination under Title VII. The Family Medical Leave Act ("FMLA") passed in 1993 mandated that covered employers provide employees with job-protected leave for qualified medical and family reasons, including pregnancy and childbirth. And courts have upheld the broad protections granted by the FMLA, including specifically

permitting states to be sued in federal court for violations of the FMLA. *See Nev. Dep't of Human Res. v. Hibbs*, 538 U.S. 721 (2003).

Iowa law has similarly progressed to provide greater protections for women's civil rights. The Iowa Civil Rights Act did not originally prohibit discrimination on the basis of sex. *See* Iowa Code § 105A.7 (1966). However, six years after the original bill passed, Iowa amended its law to explicitly prohibit discrimination on the basis of sex. 1970 Iowa Acts ch. 1058 (codified at Iowa Code ch. 105A (1971)). In 1975, this Court held that pregnancy constituted a temporary disability and that an employment policy that treated pregnant employees differently from disabled employees regarding the imposition and use of leave constituted discrimination under the Iowa Civil Rights Act. *Cedar Rapids Cmty. Sch. Dist. v. Parr*, 227 N.W.2d 486, 493, 495–96 (Iowa 1975). In 1987, the legislature codified that ruling and others by amending the Iowa Civil Rights Act to prohibit discrimination in the employment context based upon pregnancy. Iowa Code § 601A.6(2) (1989).

Other states' legislation has likewise progressed in protecting women from discrimination in the provision of medical care. Thirteen states have implemented state legislation to ban gender rating for premiums in the individual health market. This includes California, Colorado, Maine,

Maryland, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New York, Oregon, Vermont, and Washington.[3] Nine states, including California, Colorado, Massachusetts, Montana, New Jersey, New York, Oregon, Vermont, and Washington, implemented state legislation to require all insurers to cover maternity care.[4]

The Affordable Care Act, signed into law just eight years ago in 2010, provided even greater protection for women's civil rights in the provision of medical care. Under the ACA, Congress required that all medical plans sold inside the health insurance exchanges and all new plans sold outside of the exchanges to require maternity care.

Congress also explicitly addressed discrimination in the provision of medical services. Section 1557 of the ACA states:

> an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C.

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[3] *See* Cal Ins. Code § 10140.2; C.R.S. § 10-16-107; 24-A M.R.S. § 2808-B; Md. Code Ann., INSURANCE § 11-201; M.G.L.A. ch. 176J § 3; MCLS § 500.838; MN Stat. § 72A.20; MCA 49-2-309; N.R.S. § 420-G:4; N.Y. Ins. Law § 3231(a); O.R.S. § 743B.013(8); 8 V.S.A. § 4724; RCW § 48.21.045(3)(a).

[4] *See* Cal Ins Code § 10123.865; C.R.S. 10-16-104; M.G.L.A. ch. 176A § 8H; MCLS § 33-22-133; N.J. Stat. § 17B:26B-2; N.Y. Ins. Law § 3216; O.R.S. § 442.600; 8 V.S.A. § 4099d; RCW § 48.43.115.

> 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title.

42 U.S.C. § 18116. The Department of Health and Human Services issued a final rule implementing Section 1557 in July 2016 stating, in relevant part:

> an individual shall not, on the basis of race, color, national origin, sex, age, or disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any health program or activity to which this part applies.

45 CFR § 92.101. The regulation includes examples that make clear that discrimination on the basis of gender is broadly prohibited:

> A covered entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration that have the effect of subjecting individuals to discrimination on the basis of sex, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals on the basis of sex.

Id. § 92.101(b)(3)(ii). The regulation explicitly requires equal program access on the basis of sex. *Id.* § 92.206 ("A covered entity shall provide individuals equal access to its health programs or activities without

discrimination on the basis of sex"). The regulation further prohibits insurance companies from discriminating on the basis of sex or using gender to determine premiums. *See e.g.*, *id.* § 92.207 ("A covered entity shall not, in providing or administering health-related insurance or other health-related coverage, discriminate on the basis of race, color, national origin, sex, age, or disability").

While gender discrimination continues to exist in the provision of medical care, federal and state laws and regulations have made significant progress in protecting the civil rights of women in the provision of medical care over the past 50 years. This history is particularly relevant as this Court weighs the application of the principles of equality as they pertain to the provision of health care to transgender individuals.

IV. Historical LGBT Discrimination in Access to and Provision of Health Care.

The final area we address is discrimination against members of the LGBT community. In many respects, the civil rights movement for the LGBT community in the provision of health care faces many of the same challenges faced in the fights for race and gender civil rights. Again, a full discussion of the discrimination faced by those in the LGBT community—particularly during the AIDS crisis of the 1980s and 1990s—is beyond the

scope of this brief. Nevertheless, we wish to highlight a few salient points as they bear upon the issues that this Court is being asked to consider.

LGBT people experience discrimination in the form of delays and denials to medically necessary care. In many areas of the country outside major cities, alternative services are not available to LGBT people. Discrimination based on LGBT identity remains prevalent.

For example, a national study found that 8 percent of lesbian, gay, bisexual, and queer ("LGBQ") respondents stated that a health care provider had refused to see them because of their sexual orientation. Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Center for American Progress (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care. Six percent of LGBQ respondents reported that a health care provider refused to give them health care related to their sexual orientation. *Id.* Discrimination and the lack of alternatives discourages some LGBQ from seeking necessary medical treatment. Eight percent of LGBQ respondents avoided or delayed medical care as a result of health care discrimination. *Id.* This

discrimination has had serious consequences for the well-being of LGBQ Americans.[5]

Some progress has been made. Iowa has been a leading advocate in the equal treatment for lesbian and gay persons. In 2007, Iowa become one of twenty-two states to enact laws that prohibit discrimination in public accommodations based on a person's sexual orientation. Iowa Code § 216.7(1)(a). In addition to Iowa, the list includes California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin.[6]

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[5] A national study found that 68.5 percent of LGBT people who experienced discrimination in health care said it negatively affected their psychological well-being. Sejal Singh & Laura E. Durso, *Widespread Discrimination Continues to Shape LGBT People's Lives in Both Subtle and Significant Ways*, Center for American Progress (May 2, 2017), *available at* https://www.americanprogress.org/issues/lgbt/news/2017/05/02/429529/widespread-discrimination-continues-shape-lgbt-peoples-lives-subtle-significant-ways. Forty-four percent of respondents in the same study said discrimination negatively affected their physical well-being. *Id.*

[6] *See* Cal. Civ. Code § 51; Colo. Rev. Stat. §24-34-601; Conn. Gen. Stat. §§ 46a-64, 81d; Del. Code tit. 6, § 4504; Hawaii Rev. Stat. §489-3; Ill. Comp. Stat. Ch. 775, § 5/1-102; Me. Rev. Stat. tit. 5, §§4552, 4591; Md. Code State Gov't § 20-304; Mass. Gen. Laws CH. 272, § 98; Minn. Stat. §363A.11; Nev. Rev. Stat. § 651.070; N.H. Rev. Stat. § 354-A:17; N.J. Stat. § 10:5-12; N.M. Stat. § 28-1-7(F); N.Y. Civil Rights Law § 40-c(2); Or. Rev. Stat. §

In 2009, this Court issued its historic decision in *Varnum* holding that denying same-sex couples the right to marry violated Iowa's Equal Protection clause. 763 N.W.2d at 906-07. Four years later, the Supreme Court of the United States followed suit and ruled that the federal Defense of Marriage Act was unconstitutional. *United States v. Windsor*, 570 U.S. 744 (2013). Two years after that decision, the Supreme Court of the United States legalized same-sex marriage nationwide in *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015). As a result of these decisions, civil rights protections for same-sex spouses have progressed in the area of health care. For example, HHS issued guidance clarifying that Medicare Advantage beneficiaries of a same-sex spouse have equal access to coverage for care in a skilled nursing facility in which the spouse is located. Similarly, the Center for Medicare and Medicaid Services ("CMS") issued guidance that same-sex spouses were entitled to equal treatment by health insurance companies offering spousal benefits. HHS released a policy that hospitals receiving Medicare and Medicaid payments should allow patients to designate visitors, regardless of sexual orientation, gender identity, or any other non-clinical factor. And CMS issued guidance that clarifies that same-sex couples have

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659A.403; R.I. Gen. Laws § 11-24-2.2; Vt. Stat. tit. 9, § 4502; Wash Rev. Code § 49.60.215; Wis. Stat. § 106.52; D.C. Code § 2-1402.31.

the same rights as other couples to name a representative who can make medical decision on a patient's behalf.

The significant progress made with respect to prohibiting discrimination on the basis of sexual orientation has provided a foundation for progress in protecting transgender individuals. But the issues involving discrimination suffered by transgender people in the provision of health care are particularly acute. Suicide is a serious issue for the transgender population. A comprehensive survey of 27,000 transgender individuals found that an astonishing *40 percent* had reported a suicide attempt. S.E. James et al., Nat'l Center for Transgender Equality, *Report of the 2015 U.S. Transgender Survey*, (Dec. 2016) at 114 *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf. And transgender individuals report higher incidents of discrimination in the health care context than lesbian, gay and bisexual individuals. Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Center for American Progress (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care. Twenty-nine percent of transgender respondents in a nationwide study reported that a

health care provider had refused to see them because of their gender identity. *Id.* And twelve percent of transgender respondents reported that a health care provider refused to give them health care related to gender transition. *Id.* As a result of this discrimination, twenty-three percent of transgender respondents avoided or delayed medical care as a result of health care discrimination. *Id.*

In light of the serious and potentially life threatening consequences of this discrimination, the medical profession has recognized the importance of preventing discrimination based on sexual orientation and gender identity. The American Medical Association ("AMA") Code of Ethics is the leading ethical guide for medical practitioners. The AMA policy on LGBTQ issues states plainly:

> The American Medical Association (AMA) supports the equal rights, privileges and freedom of all individuals and opposes discrimination based on sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age. Sexual orientation and gender identity are integral aspects of the AMA communities and AMA policies on LGBTQ issues that work to inform individuals about LGBTQ discrimination and abuse. AMA's policies for lesbian, gay, bisexual and transgender people's rights represent a multiplicity of identities and issues.

AMA Policies on Lesbian, Gay, Bisexual, Transgender & Queer (LGBTQ) Issues, *available at* https://www.ama-assn.org/delivering-care/policies-lesbian-gay-bisexual-transgender-queer-lgbtq-issues.

In 2009, the AMA further modified its ethical opinions to explicitly support equal treatment for LGBT community, including nondiscrimination based on gender identity. AMA Opinion 9.12 Patient-Physician Relationship: Respect for Law and Human Rights[7] states:

> [P]hysicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity or any other basis that would constitute invidious discrimination.

Moreover, the AMA has adopted more than 25 rules and opinions calling for equal treatment of gay, lesbian, bisexual, and transgender patients, doctors, and medical students. *See e.g.*, Policy H-65.983 Nondiscrimination Policy[8] ("The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity."); Policy H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria ("The AMA opposes the denial of health insurance

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[7] *Available at* https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinion-respect-patient-beliefs/2009-10.

[8] AMA policies *available at* https://policysearch.ama-assn.org/policyfinder.

on the basis of sexual orientation or gender identity."); Policy H-65.976 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population ("Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include sexual orientation, sex, or gender identity in any discrimination statement."). The AMA policy statements and Code of Ethics provide a guiding principle for medical practitioners in Iowa and around the country. The AMA's broad support for preventing discrimination against the LGBT community reflects a significant step in the right direction in protecting the civil rights of that community with respect to provision of health care.

The AMA is not the only medical organization to promote equal treatment for transgender individuals. On September 17, 2018, the American Academy of Pediatrics released a policy statement on the treatment of transgender youth. Jason Rafferty, Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents, *available at* http://pediatrics.aappublications.org/content/early/2018/09/13/peds.2018-2162. The policy statement explains:

> Despite some advances in public awareness and legal protections, youth who identify as LGBTQ

> continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender.

The AAP statement includes a number of recommendations including a gender affirming approach and support for access and care for transgender youth.

Iowa has been a leader in protecting transgender individuals from discrimination. Iowa and thirteen other states explicitly prohibit discrimination based on a person's gender identity.[9] The Iowa Civil Rights Act states:

> It shall be an unfair or discriminatory practice for any owner, lessee, sublessee, proprietor, manager, or superintendent of any public accommodation or any agent or employee thereof: [t]o refuse or deny to any person because of race, creed, color, sex, sexual orientation, gender identity, national origin, religion, or disability the accommodations, advantages, facilities, services, or privileges

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[9] Those states include California, Colorado, District of Columbia, Hawaii, Illinois, Maine, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. *See* Cal. Civ. Code § 51; Colo. Rev. Stat. §24-34-601; D.C. Code § 2-1402.31; Hawaii Rev. Stat. §489-3; Ill. Comp. Stat. Ch. 775, § 5/1-102; Me. Rev. Stat. tit. 5, §§4552, 4591; Minn. Stat. §363A.11; N.J. Stat. § 10:5-12; N.M. Stat. § 28-1-7(f); Or. Rev. Stat. §659A.403; R.I. Gen. Laws § 11-4-2; Vt. Stat. tit. 9, § 4501; Wash. Rev. Code § 49.60.215.

> thereof, or otherwise to discriminate against any person because of race, creed, color, sex, sexual orientation, gender identity, national origin, religion, or disability in the furnishing of such accommodations, advantages, facilities, services, or privileges.

Iowa Code § 216.7(1)(a). Despite these broad protections, Iowa law lags behind many of its peer states in explicitly covering medical procedures for transgender people under State Medicaid policy. Relevant here, state Medicaid policy in California, Colorado, Connecticut, the District of Columbia, Hawaii, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont and Washington covers health care related to gender transition for transgender people.[10]

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[10] Cal. Dep't of Health Care Servs., *Ensuring Access to Medi-Cal Services for Transgender Beneficiaries* (Oct. 6, 2016), *available at* http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL /APL16-013.pdf; 10 Colo. Code Regs. § 2505-10 8.735; Conn. Gen. Stat. § 46a-71(a); Del. Dep't of Ins., *The Gender Identity Nondiscrimination Act of 2013* (March 2016) Bulletin 86, *available at* https://insurance.delaware.gov/wpcontent/uploads/sites/15/2016/11domestic-foreign-insurers-bulletin-no86.pdf; Dep't of Health Care Finance, *DHCF Issues Policy Clarifying Medicaid Coverage of Gender Reassignment Surgery* (Sept. 2016), *available at* https://dhcf.dc.gov/release/dhcf-issues-policy-clarifying-medicaid-coverage-gender-reassignment-surgery.pdf; Haw. Rev. Stat. §§ 431:10A-118.3(a), 432:1-607.3, 432D-26.3 (2016); Maryland Dep't Health & Mental Hygiene, *Managed Care Organizations Transmittal No. 110* (March 2016), *available at* https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_37_16.pdf; MassHealth, *Guidelines for Medical Necessity Determination for Gender*

Advances have also been made at the federal level. As noted above, Congress addressed discrimination in the provision of medical services in the ACA. Section 1557 of the ACA prohibits discrimination on the basis of sex. The United States Department of Health and Human Service's final

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Reassignment Surgery (2015), *available at* https://www.mass.gov/files/documents/2016/ 07/ow/mg-genderreassignment.pdf; Minn. Dep't Human Servs., *Provider Manual* (2017), *available at* https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-297587; Mont. Dep't Pub. Health & Human Servs., Healthcare Programs Notice (May 2017), *available at* https://medicaidprovider.mt.gov/Portals/68/docs/providernotices/2017/provnoticenondiscriminationgendertransition05252017.pdf; Web Announcement 1532 (2018), *available at* https://www.medicaid.nv.gov/Downloads/provider/web_annoucement_1532_20180223.pdf; 2017 NJ Sess. Law Serv. Ch. 176 (ASSEMBLY 4568) (WEST); 18 N.Y.C.R.R. 505.2; Ore. Health Auth., *Oregon Health Plan Handbook* 13 (March 2017), *available at* https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he9035.pdf; Penn. Dep't Human Servs., Medical Assistance Bulletin 99-16-11 (July 2016), *available at* http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_233793.pdf; R.I. Exec. Office Health & Human Servs., *Gender Dysphoria/Gender Nonconformity Coverage Guidelines* (2015), *available at* http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/Physician/gender_dysphoria.pdf; Wash. Admin. Code § 182-531-1675; Dep't of Vt. Health Access, *Gender Reassignment Surgery* (2016), *available at* http://dvha.vermont.gov/for-providers/gender-reassignment surgeryw-icd-10-coded-111616.pdf.

rule implementing Section 1557 states that "on the basis of sex includes … gender identity." 45 C.F.R § 92.4.[11] The regulations further clarifies that:

> *Gender identity* means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth. The way an individual expresses gender identity is frequently called ''gender expression,'' and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.

Id. (emphasis added). And the regulation further states that discrimination based on gender identity is specifically prohibited. *Id.* § 92.206. The regulation further protects the LGBT community from discrimination in health-related insurance and other health related coverage. Under the regulation, covered entities may not:

> (3) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or

[11] Several months after the final rule was promulgated, a district court in Texas enjoined the rule's provisions prohibiting gender identity discrimination from taking effect nationwide on the grounds that they may violate the Administrative Procedures Act. *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016). This injunction only applies to the federal government and does not prevent courts from enforcing the ACA, as *Flack* shows. The Trump Administration has since stated that it will not defend the portion of the HHS rule protecting gender identity discrimination. The injunction remains in place and the case has been stayed pending further rulemaking by the Trump Administration.

> other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;
>
> (4) Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or
>
> (5) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

Id. § 92.207(b).

A recent decision in the United States District Court for the Western District of Wisconsin affirmed protection for transgender people under Section 1557. *See Flack v. Wis. Dept. of Health Servs.*, No. 18-cv-309-wmc, --- F. Supp. 3d. ---, 2018 WL 3574875 (W.D. Wis. July 25, 2018). Two transgender plaintiffs challenged the Wisconsin state Medicaid policy denying medically necessary procedures to treat gender dysphoria under both Section 1557 and the Equal Protection Clause of the U.S. Constitution. *Id.* at *1. The court there determined that Wisconsin's policy created irreparable harm to the plaintiffs and also concluded that the plaintiffs were

likely to succeed on their claims that the Wisconsin statute violated Section 1557. *Id.* at *11.[12]

The *Flack* decision, along with the District Court's decision below, demonstrate how the medical, political, and societal opinions on protecting transgender individuals from discrimination have evolved over the past generation. Those opinions stand in stark contrast to the Eighth Circuit's decision in *Smith v. Rasmussen* seventeen years ago. 249 F.3d 755 (8th Cir. 2001). The *Rasmussen* decision rests on the medical opinions from 1994 on which the Iowa Department of Human Services relied upon in drafting the Medicaid statute prescribing coverage for transition surgery. As the District Court found below, the scientific and medical opinions with respect to medical issues for transgender individuals has changed dramatically since 1994. Even if *Rasmussen* was correctly decided at the time, it represents an

[12] The *Flack* decision is consistent with other federal court decisions in non-health care contexts finding that sex discrimination includes discrimination based on sexual orientation and/or gender identity. *See, e.g.*, *Zarda v. Altitude Express*, *Inc.*, 883 F.3d 100 (2nd Cir. 2018); *Hively v. Ivy Tech Cmty. Coll.*, 853 F.3d 339 (7th Cir. 2017); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. Of Educ.*, 858 F.3d 1034 (7th Cir. 2017); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir. 2011); *Smith v. City of Salem, Ohio*, 378 F.3d 566 (6th Cir. 2004); *Rosa v. Park W. Bank & Tr. Co.*, 214 F.3d 213 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000).

obsolete way of thinking about the issues, and the District Court was correct to reject it below.

Despite this progress, civil rights and equal treatment for LGBT communities appear to be at a crossroads. The stay preventing HHS from enforcing the protections in the final rule implementing Section 1557 against discrimination based on gender identity remains in place. And the Trump administration is expected to roll back the rule's clarifying Section 1557 on gender identity (and the termination of pregnancy), leaving its impact in doubt. LGBT communities continue to face significant discrimination in health care, and the civil right protections gained for the LGBT community are at risk. The scientific and medical community support the equal treatment for LGBT communities. But as with progress in race and gender civil rights, progress can be slow and setbacks occur.

Consistent with this Court's long and storied history of leading the way in matters of equal justice, affirming the District Court's opinion is a step in the right direction, and historically, it parallels the civil rights gains in prohibiting discrimination based on race and gender in the provision of health care. This Court should reaffirm Iowa's commitment to providing equal rights to all of its citizens, including those who are transgender, as it has done in the past.

CONCLUSION

For the reasons stated herein, this Court should affirm the District Court's opinion and by extension reaffirm Iowa's commitment to equal treatment under the law for all of its citizens.

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CERTIFICATE OF COMPLIANCE

This brief complies with the typeface requirements and word-volume limitation of Iowa Rs. App. P. 6.06(4) and Iowa Rs. App. P. 6.903(1)(d) and 6.903(1)(g).

Specifically, this brief uses a proportionally spaced typeface in Times New Roman font of 14-point size. This brief contains 6918 words, excluding the parts of the brief exempted in Iowa R. App. P. 6.903(1)(g)(1).

Executed on September 26, 2018, at Des Moines, Iowa.

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CERTIFICATE OF SERVICE

I hereby certify that on September 26, 2018, I electronically filed this document with the Supreme Court Clerk using the EDMS System, which will serve it on the appropriate parties electronically.

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