IN THE IOWA DISTRICT COURT FOR POLK COUNTY

MIKA COVINGTON, AIDEN DELATHOWER, and ONE IOWA, INC., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA and IOWA DEPARTMENT OF HUMAN SERVICES, Respondents.	Equity Case No. _____ **BRIEF IN SUPPORT OF MOTION FOR TEMPORARY INJUNCTION**

COME NOW Petitioners, Mika Covington, Aiden DeLathower ("Aiden Vasquez"), and One Iowa, Inc., and in support of their Motion for Temporary Injunctive Relief pursuant to Iowa R. Civ. P. 1.1502, state as follows:

TABLE OF CONTENTS

I. INTRODUCTION

This action challenges the validity of Division XX of House File 766 ("the Division"), to be codified at Iowa Code § 216.7(3) (2019), under the Iowa Constitution. The Division, entitled "Provision of Certain Surgeries or Procedures--Exemption from Required Accommodations or Services," was passed by the Iowa Legislature on April 27, 2019, "deemed of immediate importance," and thus given an immediate effective date upon the Governor's signature. It was enacted with the sole purpose of overturning a recent Iowa Supreme Court precedent affirming a decision of this Court. Governor Reynolds signed the Division into law on May 3, 2019, https://www.legis.iowa.gov/legislation/BillBook?ga=88&ba=hf766, at p. 87.

The Division facially discriminates against transgender Iowans by creating an exception to the Iowa Civil Rights Act's ("ICRA") protections against discrimination in public accommodations, specifically allowing discrimination against transgender people in the provision of publicly funded, medically necessary healthcare. Petitioners Covington and Vasquez[1] are people who are transgender, which means that their gender identity differs from their birth-assigned sex. On March 8, 2019 the Iowa Supreme Court struck down Section 441-78.1(4) of the Iowa Administrative Code (the "Regulation"), a provision barring transgender individuals from obtaining Medicaid coverage for medically necessary surgery to treat gender dysphoria, a

[1] Mr. Vasquez and his wife, Tammi, have not been able to save up enough money yet to legally change both of their last names from DeLathower to Vasquez, a family name on Mr. Vasquez's side. Mr. Vasquez associates the name DeLathower with his former name before he began living full time as himself, a man, and experiences discomfort when he is referred to using that name. He and his wife intend to change their last names together as soon as possible, and they identify with the name Vasquez. Mr. Vasquez would prefer to be referred to either by his first name, "Aiden", or "Mr. Vasquez" when possible.

condition that only affects transgender people. *Good v. Iowa Dep't of Human Servs.*, 924 N.W.2d 853, 862-863 (Iowa 2019).

In a unanimous decision, the Iowa Supreme Court found that the Regulation violated the ICRA protections against discrimination on the basis of gender identity in public accommodations, because the Regulation excluded transgender Iowans from coverage under Iowa Medicaid for medically necessary gender affirming surgery to treat gender dysphoria--a serious medical condition which only arises in transgender people--while otherwise providing coverage for medically necessary surgery. *Id*.

The Iowa Supreme Court also recognized that the history of the Regulation revealed its discriminatory intent to "expressly exclude[] Iowa Medicaid coverage for gender-affirming surgery specifically because this surgery treats gender dysphoria of transgender individuals." *Id.* at 862. While the Iowa Supreme Court decided that it did not need to reach the constitutional equal protection challenge that Petitioners *Beal* and *Good* had also raised to the Regulation, in the district court challenge below, Chief Judge Gamble found that the Regulation also violated the Iowa Constitutional guarantee to equal protection. *EerieAnna Good and Carol Beal*, Case No. CVCV054956 and CVCV055470 (consolidated), Ruling on Pets. for Judicial Review, at *33 (Iowa Dist. Ct. June 6, 2018), *available at* https://www.aclu-ia.org/sites/default/files/6-7-18_transgender_medicaid_decision.pdf.

Thus, while the Iowa Supreme Court affirmed this District Court's invalidation of the Regulation based on the ICRA, this District Court's invalidation of the Regulation based on the equal protection guarantee of the Iowa Constitution also stands, and is controlling in this challenge to the Division on the same constitutional grounds.

If the Division is allowed to stand, Iowa Medicaid will continue its policy of denying transgender Iowans on Medicaid coverage for life-saving, medically necessary surgery to treat their gender dysphoria, reverting to the enforcement of the exact same Regulation this Court declared unconstitutional in the *Good* case. In the case of Mr. Vasquez, the Division has *already* interfered and will with their ability to access their medically necessary care, and absent a temporary injunction, will continue to suffer that harm; likewise, Ms. Covington's care will soon be disrupted absent an injunction by this Court. (Ex. 1: Vasquez Aff. ¶¶ 19-22; Ex. 6: Covington Aff. ¶¶ 29-30; *See* Ex. 2: Nisley/Vasquez Aff.; Ex. 3: Daniels Letter; Ex. 4: Eadeh/Vasquez Letter; Ex. 5: Waters-Vasquez Letter; Ex. 7 Nisley/Covington Aff.; Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter.) Both Petitioners planned to have gender affirming surgery in September 2019. (Ex. 1: Vasquez Aff. ¶ 19; Ex. 6: Covington Aff. ¶ 26.) Mr. Vasquez and Ms. Covington began the process of obtaining preapproval for Medicaid coverage of their gender affirming surgeries after the recent Iowa Supreme court decision. (Ex. 6: Covington Aff. ¶ 20 ; Ex. 1: Vasquez Aff. ¶ 18.) But they have been and will soon be, respectively, unable to complete the process and receive the requisite preapproval as a result of the Division. (Ex. 1: Vasquez Aff. ¶¶ 19-22; Ex. 6: Covington Aff. ¶¶ 29-30.) By singling out transgender Iowans for discriminatory treatment in this way, the Division intentionally and facially violates the rights of Petitioners Ms. Covington and Mr. Vasquez, and members of Petitioner One Iowa to equal protection under the Iowa Constitution.

The Division also violates the Iowa Constitution's "single-subject rule," which requires legislation to embrace a single subject expressed in the legislation's title. Here, the title of the legislation in which the Division is contained pertains only to appropriations for health and human services. The title provides no notice that the Division creates an exception to the substantive

nondiscrimination protections under ICRA for transgender Iowans who rely on Medicaid to obtain their medically necessary healthcare. The Division is a quintessential example of unconstitutional logrolling.

Additionally, the Division violates the Iowa Constitution's inalienable-rights clause, which prohibits legislative action that impacts an inalienable right. The Division arbitrarily and unreasonably bars transgender Iowans who receive Medicaid coverage from obtaining medically necessary surgical care. The inalienable right to receive such care for Iowans who receive Medicaid arises from its medical necessity and its connection to the expression of transgender Iowans' gender identity. The Division interferes with this right.

For these reasons, and as discussed in further detail below, Petitioners seek judicial relief declaring the Division unconstitutional and enjoining its enforcement.

II. FACTUAL BACKGROUND

A. Standards of Care for Gender Dysphoria

Gender dysphoria is a serious medical condition codified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-V"), and the International Statistical Classification of Diseases and Related Health Problems, Tenth Edition. (Ex.10: Ettner Aff. ¶ 12.) The criteria for diagnosing gender dysphoria are set forth in Section 302.85 of DSM-V. (Ex.10: Ettner Aff. ¶13; Ex. 2: Nisley/Vasquez Aff., at 1; Ex. 7 Nisley/Covington Aff. at 1.)

Gender dysphoria, if left untreated, can lead to serious medical problems, including clinically significant psychological distress and dysfunction, debilitating depression, and, for some people without access to appropriate medical care and treatment, suicidality and death. (Ex. 10: Ettner Aff. ¶ 15.) The standards of care for treating gender dysphoria ("Standards of Care" or "Standards") are set forth in the World Professional Association of Transgender Health

("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Nonconforming People. *See* The World Professional Association of Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Nonconforming People*, https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf. (*Id*. ¶ 16.)

The Standards of Care are widely accepted evidence-based medical protocols that articulate professional consensus to guide health-care providers in medically managing gender dysphoria. (Ex. 10: Ettner Aff. ¶ 17.) They are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association, among others. (*Id*. ¶ 16.) They are, in fact, so well established that federal courts have declared that a prison's failure to provide health care in accordance with the Standards may constitute cruel and unusual punishment under the Eighth Amendment of the US Constitution. *Rosati v. Igbinoso*, 791 F.3d 1037, 1039–40 (9th Cir. 2015); *De'lonta v. Johnson*, 708 F.3d 520, 522–26 (4th Cir. 2013); *Fields v. Smith*, 653 F.3d 550, 553–59 (7th Cir. 2011); *Keohane v. Jones*, No. 4:16CV511a–MW/CAS, 2018 WL 4006798, at *3 (N.D. Fla. Aug. 22, 2018).

For many transgender people, necessary treatment for gender dysphoria may require medical interventions to affirm their gender identity and help them transition from living as one gender to another. (Ex. 10: Ettner Aff. ¶ 18-19.) This transition-related care may include hormone therapy, surgery—sometimes called "gender affirming surgery," "gender-confirmation surgery" or "sex-reassignment surgery"—and other medical services to align a transgender person's body with the person's gender identity. (*Id.* at ¶ 18.)

The treatment for each transgender person is individualized to fulfill that person's particular needs. (Ex. 10: Ettner Aff. ¶ 18-19.) The WPATH Standards of Care for treating gender dysphoria address all these forms of medical treatment, including surgery. (*Id.* at ¶ 19.)

By the mid-1990s, there was consensus within the medical community that surgery was the only effective treatment for many individuals with severe gender dysphoria. (Ex. 10: Ettner Aff. ¶ 36). More than three decades of research confirms that surgery to modify primary and secondary sex characteristics and anatomy to align with a person's gender identity is therapeutic, and therefore effective treatment for gender dysphoria. (*Id.* at ¶ 28, 39.) For severely gender-dysphoric patients, surgery is, in fact, the only effective treatment. (*Id.* at ¶ 42.)

Health experts have rejected the myth that these treatments are "cosmetic" or "experimental." (Ex. 10: Ettner Aff. ¶ 37-41.) Indeed, all major medical associations—including the American Medical Association, the American Psychological Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and WPATH—agree that gender dysphoria is a serious medical condition and that treatment for gender dysphoria is medically necessary for many transgender people. (Ex. 10: Ettner Aff. ¶ 43.)

B. Medicaid Coverage for Gender-Affirming Surgery in Iowa Prior to the Enactment of the Division

As the Iowa Supreme Court recognized in the *Good* case, the history of the Regulation that banned coverage for gender affirming surgery demonstrated that the bar discriminated against transgender Iowans who receive Medicaid. *Good*, 924 N.W.2d at 862. Forty years ago, in *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980), the Eighth Circuit found that "Iowa[] Medicaid['s] . . . specific[] exclu[sion] [of] coverage for sex reassignment surgery" violated the federal Medicaid Act. *Id.* at 547–48. The exclusion was improper because, "[w]ithout any formal rulemaking proceedings or hearings," DHS created "an irrebuttable presumption that the procedure of sex reassignment surgery [could] never be medically necessary when the surgery [was] a treatment for transsexualism." *Id.* at 549. This ban "reflect[ed] inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated

knowledge of the medical community." *Id*. It also violated one of Congress's core objectives in passing the Medicaid Act—that "medical judgments" would "play a primary role in the determination of medical necessity." *Id*.

Following the *Pinneke* decision, DHS initiated its normal rulemaking process. In 1995, after a public meeting of DHS's rulemaking body and review by the Iowa General Assembly's administrative-rules committee, DHS adopted the Regulation struck down in *Good*. *Good*, 924 N.W.2d at 862; *see also Smith v. Rasmussen*, 249 F.3d 755, 760 (8th Cir. 2001) (upholding the Regulation based on inaccurate and outdated research in a challenge asserting only federal claims; no challenge under the ICRA or Iowa Constitution was asserted or considered.)

In March 2019, the Iowa Supreme Court, like the District Court below, found that the Medicaid Regulation was discriminatory as a violation of the ICRA protections against discrimination in public accommodations on the basis of gender identity. *Good,* 924 N.W.2d at 853, 862-863; *Good*, No. CVCV054956, at *12, 29. It recognized that a medical consensus had emerged that gender dysphoria is a serious medical condition and that treatment for gender dysphoria is medically necessary for many transgender people. *Good,* 924 N.W.2d at 862; *Good*, No. CVCV054956, at *28, 33; (Ex. 10: Ettner Aff. ¶ 43)

However, despite the Court's decision in *Good,* the discriminatory Regulation remains in place, and Respondents have not removed it from the Iowa Administrative Code, or taken any steps to do so. *See* Iowa Admin. R. 441-78, *available at* https://www.legis.iowa.gov/docs/iac/chapter/05-22-2019.441.78.pdf (current as of May 22, 2019).

C. The Division

On April 27, 2019, the last day of the Iowa legislative session, in a highly divided vote, the Iowa legislature amended the annual Health and Human Services Appropriations bill (the "Act"), House File 766, with the Division. Division XX, in full, provides:

> DIVISION XX
> PROVISION OF CERTAIN SURGERIES OR PROCEDURES ——
> EXEMPTION FROM REQUIRED ACCOMMODATIONS OR SERVICES
>
> Sec. 93. Section 216.7, Code 2019, is amended by adding the following new subsection:
> NEW SUBSECTION. 3. This section shall not require any state or local government unit or tax-supported district to provide for sex reassignment surgery or any other cosmetic, reconstructive, or plastic surgery procedure related to transsexualism, hermaphroditism, gender identity disorder, or body dysmorphic disorder.
> Sec. 94. EFFECTIVE DATE. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

2019 Iowa Acts, House File 766, Division XX, https://www.legis.iowa.gov/legislation/BillBook?ga=88&ba=hf766, at p. 87. The Division thus adds a new subsection to section 216.7, which is the section in the ICRA that provides protection against discrimination in public accommodations on the basis of race, creed, color, sex, sexual orientation, gender identity, national origin, religion, or disability. Iowa Code § 216.7. The Governor signed the Division into law on May 3, 2019.

Thus, the relevant section of the ICRA, now including new subsection 3 pursuant to the Division, provides as follows:

> 216.7 Unfair practices — accommodations or services.
>
> 1. 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:

> a. To 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 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.
>
> b. To directly or indirectly advertise or in any other manner indicate or publicize that the patronage of persons of any particular race, creed, color, sex, sexual orientation, gender identity, national origin, religion, or disability is unwelcome, objectionable, not acceptable, or not solicited.
>
> 2. This section shall not apply to:
>
> a. Any bona fide religious institution with respect to any qualifications the institution may impose based on religion, sexual orientation, or gender identity when such qualifications are related to a bona fide religious purpose.
>
> b. The rental or leasing to transient individuals of less than six rooms within a single housing accommodation by the occupant or owner of such housing accommodation if the occupant or owner or members of that person's family reside therein.
>
> *3. This section shall not require any state or local government unit or tax-supported district to provide for sex reassignment surgery or any other cosmetic, reconstructive, or plastic surgery procedure related to transsexualism, hermaphroditism, gender identity disorder, or body dysmorphic disorder.*

Iowa Code § 216.7 (as amended by the Division, 2019 Iowa Acts, House File 766) (emphasis added to show the new section challenged in this case).

The Division specifically creates an exception to the ICRA protections afforded to transgender Iowans from discrimination in access to public accommodations. The Iowa Supreme Court in *Good* found that the Regulation's denial of Medicaid coverage to transgender Iowans for their medically necessary gender affirming surgery violated these provisions of the ICRA, and the Division has now taken that civil rights protection away from transgender Iowans.

Legislators' contemporaneous comments also demonstrate its intent to undo the *Good* case by specifically authorizing this form of discrimination against transgender Iowans on Medicaid under the ICRA as contained in the discriminatory Regulation. *See, e.g.,* Tony Leys and Barbara Rodriguez, *Iowa Republican lawmakers ban use of Medicaid dollars on transgender surgery*, Des Moines Register (Apr. 27, 2019), https://www.desmoinesregister.com/story/news/politics/2019/04/26/iowa-legislature-senate-republicans-propose-ban-medicaid-money-transgender-surgery-lawsuit-courts/3578920002/ (Sen. Mark Costello said the intent of the bill was "to change the administrative code back to the way it was for years before the lawsuit. He said he didn't feel such procedures are 'always medically necessary.'")

The Governor's comments demonstrate the same animus toward the *Good* decision, and toward transgender Iowans, as the comments of Iowa's legislators. The Governor publicly stated her intent to enforce what she described as the state's long-standing policy of denying Medicaid recipients coverage for medically necessary gender affirming care that had been in place prior to the *Good* decision: "This [the legislation] takes it back to the way it's always been. This has been the state's position for decades." *See* Caroline Cummings, *Gov. Reynolds stands by signing bill with Medicaid coverage ban for transgender surgery*, CBS 2/Fox 28 (May 7, 2019), *available at* https://cbs2iowa.com/news/local/gov-kim-reynolds-stands-by-decision-to-sign-budget-bill-with-transgender-surgery-ban. In signing the legislation, the Governor "acknowledged the *Good* decision but declined to weigh in on future lawsuits." *Id*. She made her intent to revert to the state's pre-*Good* policy of denying coverage under Iowa Medicaid plain: "The Supreme Court in their decision pointed out the statute. That gives the legislature . . . to go back and address it. They did that." *Id. See also* Stephen Gruber-Miller, *Kim Reynolds signs bill*, Des Moines

Register (May 3, 2019), *available at* https://www.desmoinesregister.com/story/news/politics/2019/05/03/kim-reynolds-health-care-budget-transgender-surgeries-planned-parenthood-sex-education-iowa/1095376001/ ("'This narrow provision simply clarifies that Iowa's Civil Rights Act does not require taxpayer dollars to pay for sex reassignment and other similar surgeries. This returns us to what had been the state's position for years,' Reynolds spokesman Pat Garrett said in a statement.").

D. Mr. Vasquez

Aiden Vasquez is a fifty-one-year-old man who is transgender and has known that he is male since the age of two. (Ex. 1: Vasquez Aff. ¶¶ 1, 3-4.) He was diagnosed with gender dysphoria in 2016. (Ex. 1: Vasquez Aff. ¶ 7.) As part of his treatment for gender dysphoria, Mr. Vasquez has lived full time as a man in every aspect of his life for several years. (Ex. 1: Vasquez Aff. ¶ 8.); *See* Standards of Care at 9–10, https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.

In early 2016, Mr. Vasquez began hormone therapy. (Ex. 1: Vasquez Aff., ¶ 7.) In May 2016, he legally changed his first name. (Ex. 1: Vasquez Aff. at ¶ 10.) In September 2016 he underwent a medically necessary double mastectomy as part of his treatment for gender dysphoria. (Ex. 1: Vasquez Aff. ¶ 11.) In October 2016 Mr. Vasquez amended the gender marker on his birth certificate, driver's license, and social-security card to reflect his male identity. (Ex. 1: Vasquez Aff. ¶ 12.) Mr. Vasquez's gender dysphoria exacerbates his depression and anxiety. He is distressed and very uncomfortable with his genitalia, which does not align with his male gender identity. (Ex. 1: Vasquez Aff. ¶ 13; 26.)

Mr. Vasquez's health-care providers have also uniformly concluded that surgery is necessary to treat his gender dysphoria. (*See* Ex. 2 Nisley/Vasquez Aff.; Ex. 3: Daniels/Vasquez

Letter; Ex. 4: Eadeh/Vasquez Letter; Ex. 5: Waters/Vasquez Letter.) Mr. Vasquez's primary care physician, Dr. Nicole Nisly, concluded that "[g]ender affirming bottom surgery is medically necessary to treat Aiden's gender dysphoria…" (Ex. 2: Nisley/Vasquez Aff., at 1.)

Following the Iowa Supreme Court's decision Mr. Vasquez began the process of obtaining preapproval for his gender affirming surgery. (Ex. 1: Vasquez Aff. ¶ 18.) He had scheduled a pre-operative consultation with his surgeon, Dr. Gast, for May 30, 2019, in preparation for his gender affirming surgery to take place approximately September 2019. (Ex. 1: Vasquez Aff. ¶ 20.) However, as a result of the new law, Dr. Gast's office was unable to confirm coverage under Medicaid for the preoperative appointment and informed him that they also could not assure preapproval for his surgery. (Ex. 1: Vasquez Aff. ¶¶ 22-23.) As a result, he was forced to cancel the consultation. (Ex. 1: Vasquez Aff. ¶ 25.) Because of the Division, Mr. Vasquez has been forced to indefinitely postpone his medically necessary procedure. (Ex. 1: Vasquez Aff. ¶ 25-27). If the Division is not enjoined, Mr. Vasquez will continue to be deprived of the gender affirming surgery for which he has a serious medical need. (Ex. 1: Vasquez Aff. ¶¶ 22-25.)

E. Ms. Covington

Mika Covington is a twenty-eight-year-old woman who is transgender and has known that she is female since she was six years old. (Ex. 6: Covington Aff. ¶¶ 1, 3-4.) She has expressed her female identity in various ways since high school, and in 2009 began the social transition to living as female full time. (Ex. 6: Covington Aff. ¶¶ 4-5, 7.) In 2015, Ms. Covington was diagnosed with gender dysphoria and began hormone therapy. (Ex. 6: Covington Aff. ¶ 11.) In 2014, Ms. Covington legally changed her name. (Ex. 6: Covington Aff. ¶ 8.) In 2019, she amended the gender makers on her passport and social-security card to reflect her female identity. (Ex. 6: Covington Aff. ¶ 16.)

As part of her treatment for gender dysphoria, Ms. Covington has lived full time as a woman in every aspect of her life for several years. (Ex. 6: Covington Aff. ¶ 15; Ettner Aff at ¶ 15; *See* Standards of Care at 9–10, https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf.) Ms. Covington's gender dysphoria causes her to experience severe depression and anxiety. She is distressed and very uncomfortable with her genitalia, which does not align with her gender identity and intensifies her depression and anxiety.

Ms. Covington's health-care providers have uniformly concluded that surgery is necessary to treat her gender dysphoria. (Ex. 7 Nisley/Covington Aff.; Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter.) For example, Ms. Covington's primary care physician, Dr. Nicole Nisly, has determined that "[g]ender affirming surgery is medically necessary to treat Mika's gender dysphoria" in accord with the standards and guideline set forth by the World Professional Association for Transgender Health ("WPATH"). (Ex. 7: Nisley/Covington Aff., at 1.) Two psychologists have also determined that gender affirming surgery is appropriate to treat her gender dysphoria under the WPATH standards. (Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter; Ex. 6: Covington Aff. ¶ 28.)

22. Following the Iowa Supreme Court's decision in *Good*, Ms. Covington began the process to obtain preapproval for her gender affirming surgery. (Ex. 6: Covington Aff. ¶ 24.) For example, Ms. Covington's primary care physician, Dr. Nicole Nisly, has referred her for surgery, and determined that "[g]ender affirming surgery is medically necessary to treat Mika's gender dysphoria" in accord with the standards and guideline set forth by the World Professional Association for Transgender Health ("WPATH"). (Ex. 7: Nisley/Covington Aff., at 1.) Ms. Covington has also been evaluated by Elizabeth Watters and Hana-May Eadeh, two psychologists

at the University of Iowa Hospitals and Clinics, who approved her for gender affirming surgery to treat her gender dysphoria under the WPATH standards. (Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter.) According to her care plan with Dr. Nisley, she intended to schedule her surgery to occur at the University of Iowa Hospitals and Clinics in September 2019. (Ex. 6: Covington Aff. ¶ 26.) However, because of the Division, her request for preapproval of coverage for surgery to treat her gender dysphoria will be denied by Iowa Medicaid, and her treatment plan will be seriously disrupted. (Ex. 6: Covington Aff. ¶¶ 30-31.) If the Division is not enjoined, Ms. Covington will be deprived of the gender affirming surgery for which she has a serious medical need. (Ex. 6: Covington Aff. ¶¶ 30-33.)

F. One Iowa

Petitioner One Iowa is a nonpartisan, nonprofit organization. (Pet. ¶ 52.) It advances, empowers, and improves the lives of LGBTQ Iowans statewide. (*Id.*) Its work includes educating Iowans about the LGBTQ community, training healthcare providers, law enforcement, business leaders, and others to ensure LGBTQ Iowans are respected in every facet and stage of their lives, promoting policies within state and local government that protect the civil rights, health, and safety of LGBTQ Iowans, empowering tomorrow's LGBTQ leaders through training and mentorship, and connecting LGBTQ Iowans with vital resources. (*Id.* at ¶ 53.)

One Iowa has a major focus on increasing healthcare access for transgender Iowans. ((*Id.* at ¶ 55.) Working with healthcare providers who specialize in issues related to transgender individuals, they help to inform other healthcare professionals and agencies about how to address transgender people who might be transitioning, and what kind of resources exist to help them through this process. (*Id.*)

In addition to serving the needs of the transgender community, many of One Iowa's supporters, donors, board members, and staff are transgender. (Pet. ¶ 56.) The organization has also recently developed a Transgender Advisory Council to guide their work for transgender Iowans. (*Id.* ¶ 57.) Petitioners Covington and Vasquez are members of One Iowa's Transgender Advisory Council. (Ex. 1: Vasquez Aff. ¶ 9; Ex. 6: Covington Aff. ¶ 9.) In addition, One Iowa maintains a program called the LGBTQ Leadership Institute, which actively recruits transgender Iowans to develop skills and enter community leadership roles. (Pet. ¶ 59.) Some of One Iowa's Transgender Advisory Council and LGBTQ Leadership Institute transgender members are on Iowa Medicaid, and gender affirming surgery is medically necessary to treat their gender dysphoria. (Pet. ¶ 60.)

II. ARGUMENT

A. Standard for Temporary Injunctive Relief

The Iowa Rules of Civil Procedure establish that the Court may grant a temporary injunction "when the petition, supported by affidavit, shows the plaintiff is entitled to relief which includes restraining the commission or continuance of some act which would greatly or irreparably injure the plaintiff." Iowa R. Civ. P. 1.1502(1). "A temporary injunction is a preventive remedy to maintain the status quo of the parties prior to final judgment and to protect the subject of the litigation," *Kleman v. Charles City Police Dep't,* 373 N.W.2d 90, 95 (Iowa 1985), specifically in situations where a plaintiff is likely to succeed on the merits of her claim and is at risk of irreparable harm absent immediate judicial intervention, *Max 100 L.C. v. Iowa Realty Co.*, 621 N.W.2d 178, 181 (Iowa 2001).

Petitioners easily meet the standard for this relief.

B. Petitioners have established a likelihood of succeeding on their claims that the Division violates protected constitutional rights.

A temporary injunction is warranted in this case because Petitioners are likely to succeed on their claims that (1) the Division violates Petitioners' and their members rights to equal protection under the Iowa Constitution, (2) the Division violates the Iowa Constitution's single-subject rule; and (3) the Division violates the Iowa Constitution's inalienable-rights clause. Petitioners need only show a likelihood of success on one of these claims to justify temporary injunctive relief.

1. The Division violates Equal Protection because it facially discriminates on the basis of being transgender.

The district court in the *Good* case has already correctly concluded that it facially violates the Iowa Constitution's equal-protection guarantee for the state to deny transgender Iowans Medicaid coverage for medically necessary gender affirming surgery, while as a general matter providing coverage to all Medicaid beneficiaries for their medically necessary care. *Good*, No. CVCV054956, at *20-34. In so finding, it carefully reviewed the challenged Regulation in light of the appropriate analysis to decide questions brought under Iowa's equal protection guarantee, as set forth in *Varnum*. *Good*, No. CVCV054956, at *20-33 (determining heightened scrutiny applies under state equal protection); *Varnum v. Brien*, 763 N.W.2d 862, 882 (Iowa 2009). Under this analysis, the same discrimination in Division XX also fails, and this District Court's prior invalidation of the Regulation based on the equal protection guarantee of the Iowa Constitution is controlling in this challenge to the Division on the same constitutional grounds.

i. Transgender and non-transgender Iowans eligible for Medicaid are similarly situated for equal-protection purposes.

The Iowa Constitution contains a two-part equal-protection guarantee. Iowa Const. art. I, §§ 1, 6. Although this Court looks to federal courts' interpretation of the US Constitution in

construing parallel provisions of the Iowa Constitution, it "jealously reserve[s] the right to develop an independent framework under the Iowa Constitution." *NextEra Energy Res., LLC v. Iowa Utilities Bd.*, 815 N.W.2d 30, 45 (Iowa 2012). This is because, as this Court recently reaffirmed, the rights guaranteed to individuals under the Iowa Constitution have critical, independent importance, and the courts play a crucial role in protecting those rights. *Godfrey v. State*, 898 N.W.2d 844, 864–65, 869 (Iowa 2017).

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

Here, the Division facially discriminates against transgender Medicaid recipients by specifically authorizing the discriminatory denial of medically necessary gender affirming surgery which the Iowa Supreme Court, and this District court, rejected in the *Good* case. As the district court correctly concluded in the *Good* case *Good*, No. CVCV054956, at *21-22, transgender and non-transgender Iowans eligible for Medicaid—the public accommodation that administers publicly-financed healthcare insurance most directly impacted by the Division—are similarly situated for equal-protection purposes. They are the same in all legally relevant ways because Medicaid recipients—transgender or not—share a financial need for medically necessary treatment. *In re Estate of Melby*, 841 N.W.2d 867, 875 (Iowa 2014) ("The Medicaid program was designed to serve individuals and families lacking adequate funds for basic health services . . . .").

Despite medical necessity, the Division expressly authorizes the state to discriminate against transgender Medicaid recipients by denying Petitioners and other transgender individuals coverage for medically necessary health care based on nothing more than the fact that they are transgender.

ii. The Division is discriminatory under the Iowa Constitution's equal-protection guarantee.

As discussed above, and as the district court recognized already in *Good*, No. CVCV054956, at *17-20, 29-30, the Division facially discriminates against transgender Medicaid recipients.

The Division is facially discriminatory against transgender Medicaid recipients because it singles out transgender recipients, such as Petitioners, by authorizing the denial of coverage for medically necessary care expressly because they are transgender—and then further deprives them of a remedy to challenge that discriminatory treatment under ICRA. Specifically, it authorizes the Department's denial of coverage for gender-affirming surgery to treat gender dysphoria, a condition only affecting transgender persons, and withholds necessary medical treatment that is inextricably tied to the fact of a person's status as transgender. *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") (invalidated by the Iowa Supreme Court in the *Good* case as discrimination in public accommodations under ICRA) *Good*, No. CVCV054956.

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

closely correlated with being [transgender] as to make it apparent" that the discrimination specifically authorized by the Division, allowing for the denial of such treatment, "is targeted at [transgender] people as a class." *See id.* (quotation marks omitted). The Division's disparate treatment of transgender Medicaid recipients is a sufficient basis to support Petitioners' equal-protection claim.

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

This District Court should hold, as it did in the *Good* case, that heightened scrutiny applies to classifications that discriminate against transgender individuals. First, the factors the Court relies on to decide whether a heightened level of review should apply to an identifiable group strongly support applying intermediate or strict scrutiny to transgender Iowans. Second, discrimination against transgender Iowans is a form of gender-based discrimination, which this Court reviews under intermediate scrutiny.

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

The highest and most probing level of scrutiny under the Iowa Constitution—strict scrutiny—applies to classifications based on race, alienage, or national origin and those affecting fundamental rights. *Varnum v. Brien*, 763 N.W.2d 862, 880 (Iowa 2009); *Sherman v. Pella Corp.*, 576 N.W.2d 312, 317 (Iowa 1998). Under this approach, classifications are presumptively invalid and must be "narrowly tailored to serve a compelling state interest." *In re S.A.J.B.*, 679 N.W.2d 645, 649 (Iowa 2004).

A middle level of scrutiny called "intermediate scrutiny" exists between rational-basis review—discussed below—and strict scrutiny. *Varnum*, 763 N.W.2d at 880. Intermediate scrutiny requires the party seeking to uphold a classification to demonstrate that it is "substantially related"

to achieving an "important governmental objective[]." *Sherman*, 576 N.W.2d at 317 (quotation marks omitted). The justification for the classification must also be "genuine" and must not depend on "overbroad generalizations." *United States v. Virginia*, 518 U.S. 515, 533 (1996). This Court's decisions confirm that intermediate scrutiny applies to classifications based on gender, illegitimacy, and sexual orientation. *Varnum*, 763 N.W.2d at 895–96; *NextEra Energy Res., LLC v. Iowa Utilities Bd.*, 815 N.W.2d 30, 46 (Iowa 2012).

Iowa courts apply a four-factor test to determine the appropriate level of scrutiny under the Iowa Constitution's equal-protection guarantee. *Varnum*, 763 N.W.2d at 886–87. The factors include "(1) the history of invidious discrimination against the class burdened by [a particular classification]; (2) whether the characteristics that distinguish the class indicate a typical class member's ability to contribute to society; (3) whether the distinguishing characteristic is immutable or beyond the class members' control; and (4) the political power of the subject class." *Id.* at 887–88.

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

The four-factor *Varnum* test mandates applying at least intermediate scrutiny to classifications that discriminate against transgender Iowans. This District Court has already found that intermediate scrutiny applies to classifications based on transgender status under the Iowa

Constitution. *See Good*, No. CVCV054956, at *26 ("the Court concludes that all four factors clearly point towards finding gender identity to be a quasi-suspect class. Therefore, it is appropriate to apply heightened scrutiny . . .").

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

In *Varnum*, the court relied on national statistics, case law from other jurisdictions, and other sources to find that lesbian and gay individuals have experienced a history of invidious discrimination and prejudice. *Varnum v. Brien*, 763 N.W.2d 862, 889–90 (Iowa 2009). The Iowa General Assembly's enactment of several laws to protect individuals based on sexual orientation was critical to the Court's reasoning in *Varnum*, particularly the General Assembly's decision to add sexual orientation to ICRA as a protected class in 2007. *Id*. at 889–91. These enactments, which included laws to counter bullying and harassment in schools and prohibit discrimination in credit, education, employment, housing, and public accommodations, demonstrated legislative recognition of the need to remedy historical sexual-orientation-based discrimination. *Id*. at 890.

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

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

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

Transgender people nationally and in Iowa continue to face discrimination. And to the extent they have seen progress in protecting their rights, there is considerable backlash against that progress—including, unfortunately, through discriminatory legislation introduced in the most recent Iowa General Assembly. *See Trump's Record of Action Against Transgender People*, National Center for Transgender Equality, https://transequality.org/the-discrimination-administration; Sarah Tisinger, *Branstad Calls Obama's Transgender Policy 'Blackmail,'* WQAD (May 18, 2016), https://wqad.com/2016/05/18/branstad-calls-obamas-transgender-bathroom-policy-blackmail; Jeremy W. Peters et al., *Trump Rescinds Rules on Bathrooms for Transgender Students*, N.Y. Times (Feb. 22, 2017), https://www.nytimes.com/2017/02/22/us/politics/devos-sessions-transgender-students-rights.html; Brianne Pfannenstiel & Courtney Crowder, *Transgender 'Bathroom Bill' Introduced in Iowa House, Though Support Lags*, Des Moines Register (Jan 31., 2018), https://www.desmoinesregister.com/story/news/politics/2018/01/31/transgender-bathroom-bill-iowa-lgbtq/1077963001/; Iowa H.B. 2164, 87 Gen. Assem. (Jan. 31, 2018) (if passed, law would

deprive transgender K through 12 students in Iowa of access to boys' and girls' restrooms consistent with their gender identity); Lee Rood, *Nursing Facility Doors Slam Shut for Transgender Iowan*, Des Moines Register (May 18, 2016), https://www.desmoinesregister.com/story/news/investigations/readers-watchdog/2016/05/18/nursing-facility-doors-slam-shut-transgender-iowan/84490426.

Of course, the worst and most recent example of animus against transgender people in Iowa is the Division itself, which intentionally and facially discriminates against transgender Iowans by stripping them of the right to nondiscrimination in Medicaid under ICRA following the Iowa Supreme Court's *Good* decision. Legislators' comments in debating the Division, discussed in Section II.B.2, below, further illustrate the profound animus faced by transgender Iowans.

These examples show the long, troubling history of invidious discrimination against transgender individuals in Iowa and elsewhere. *Varnum*, 763 N.W.2d at 889–90.

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

The second *Varnum* factor examines whether the class members' characteristics are related in any way to their ability to contribute to society. *Varnum v. Brien*, 763 N.W.2d 862, 890 (Iowa 2009). In *Varnum*, the test was satisfied by (1) the lack of any holding by any court that lesbian, gay, or bisexual people are unable to contribute to daily life and (2) the existence of ICRA's protections against sexual-orientation discrimination. *Id*. at 890–91.

A person's gender identity or transgender status is irrelevant to the person's ability to contribute to society. The fact the Iowa General Assembly has outlawed discrimination based on gender identity shows that it recognizes transgender Iowans' ability to contribute to society. *Id*. at 891 (finding that the Iowa legislature's prohibition against sexual-orientation discrimination sets forth "the public policy . . . that sexual orientation is not relevant to a person's ability to contribute

to a number of societal institutions"). The same is true of various letters that Iowa corporations submitted to the Iowa Civil Rights Commission in support of the 2007 ICRA amendments. Rainbow Health Clinic Report at 10. Those letters, which attest to the need for a state law protecting lesbian, gay, bisexual, and transgender ("LGBT") Iowans against discrimination, illustrate the high premium Iowa employers place on their LGBT employees. (*Id*.) Additionally, the evidence in the record includes unrebutted expert testimony that "[m]edical science recognizes that transgender individuals represent a normal variation of the diverse human population" and that "transgender people are fully capable of leading healthy, happy and productive lives." (Ex. 10: Ettner Aff. ¶ 32.) "Being transgender does not affect a person's ability to be a good employee, parent, or citizen." (*Id*.)

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

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

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

Gender identity, like sexual orientation, is a trait central to a person's identity. (Ex. 10: Ettner Aff. at ¶ 9, 32-34.) The WPATH Standards of Care and other medical literature in the record demonstrate that gender identity is not subject to change through outside influence. (*Id.* ¶. 32-34.) *See also* Standards of Care at 16, https://www.wpath.org/media.cms/Documents/SOC%20v7/SOC%20V7_English.pdf ("Treatment aimed at trying to change a person's gender identity and expression to become more

congruent with sex assigned at birth has been attempted in the past without success . . . . Such treatment is no longer considered ethical."); (Ex. 10: Ettner Aff. ¶ 23-25) (gender identity is biologically based, innate or fixed at a very early age, and cannot be altered).

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

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

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

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

Applying these principles here strongly supports a finding that transgender Iowans are politically weak, if not powerless. Although the transgender community does not suffer from "absolute political powerlessness," transgender individuals cannot overturn discriminatory laws

and policies, such as the Division, through the legislative process. Transgender Iowans lack the political power to bring a "prompt end to the prejudice" that they experience because of the community's small population size and the enduring societal prejudices against transgender people. *Id*. (quotation marks omitted).

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

A growing number of courts have found that intermediate or strict scrutiny is appropriate to examine classifications based on transgender status. For example, in *Adkins v. City of New York*, 143 F. Supp. 3d 134 (S.D.N.Y. 2015), the court found that discrimination against transgender individuals is subject to heightened scrutiny since transgender people have suffered a history of discrimination and prejudice, a person's identity as transgender has nothing to do with the person's ability to contribute to society, and transgender people represent a discrete minority class that is politically powerless to bring about change on its own. *Id*. at 139–40.

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

2018 WL 1784464, at *1 (W.D. Wash. Apr. 13, 2018) (finding that "any attempt to exclude [transgender people] from military service will be looked at with . . . 'strict scrutiny'").

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

Because the Division classifies Medicaid beneficiaries based on transgender status, heightened scrutiny is applicable.

v. The Division cannot survive intermediate or strict scrutiny.

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

Respondents cannot meet these standards, as the district court acknowledged in striking down the discriminatory Regulation in the *Good* case. *Good*, No. CVCV054956, at *26-30. There is no "compelling governmental interest" or "important governmental objective" advanced by excluding transgender individuals from Medicaid reimbursement for medically necessary procedures. *Id.* Gender dysphoria is a serious medical condition. *Id.* (Ettner Aff; Nisly Affs; Vasquez Aff.; Covington Aff.) And surgical treatment for gender dysphoria is medically necessary

and effective for Petitioners. (Ex. 6: Covington Aff. ¶¶ 30-33; Ex. 7: Nisley/Covington Aff., at 1; Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter; Ettner Aff at ¶ 10; Ex. 1: Vasquez Aff. ¶¶ 22-25; Ex. 2: Nisley/Vasquez Aff., at 1. Ex. 3: Daniels/Vasquez Letter; Ex. 4: Eadeh/Vasquez Letter; Ex. 5: Waters/Vasquez Letter.)

The statement of one legislator that he personally does not believe the surgery is medically necessary, (*see* Section II.B.2, below), is insufficient to overcome the determination of medical necessity made by this District Court and the Iowa Supreme Court in *Good* that was based on the actual medical evidence in the case, as well as the uniform acceptance in the medical community of this treatment's medical necessary. Therefore, denying coverage cannot be justified on medical grounds. Nor, under intermediate or strict scrutiny, can it be justified as a cost-savings measure. *Varnum*, 763 N.W.2d at 902–04 (cost savings could not justify exclusion of same-sex couples from marriage).

vi. The Division cannot survive rational-basis review.

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

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

Dep't of Agric. v. Moreno, 413 U.S. 528, 534 (1973). At the very least, a "more searching form of rational basis review [is applied] to strike down such laws under the Equal Protection Clause." *Lawrence v. Texas,* 539 U.S. 558, 580 (2003) (O'Connor, J., concurring).

In the *Good* case, the district court concluded that the same classification at issue here did not withstand rational-basis review. *Good*, No. CVCV054956, at *30-34. For the reasons discussed above, there simply is no plausible policy reason advanced by, or rationally related to, excluding transgender individuals from Medicaid reimbursement for medically necessary procedures. Surgical treatment for gender dysphoria, a serious medical condition, is necessary and effective. (Ex.10: Ettner Aff. ¶ 50-54.) And Medicaid coverage is crucial to ensuring the availability of that necessary treatment.

Moreover, under rational-basis review, the Division cannot be justified as a measure to save money since there is no reasonable distinction between transgender and nontransgender individuals with regard to their need for Medicaid coverage for medically necessary surgical care. Both groups need financial assistance for critically necessary medical treatments. Costs savings are insufficient to justify the arbitrary distinction the Regulation creates between transgender persons and nontransgender persons in need of necessary medical care. *RACI*, 675 N.W.2d at 12–15 (even under rational-basis review, there must be some reasonable distinction between the group burdened with higher taxes, as compared to the favored group, to justify the higher costs); *see also Diaz v. Brewer*, 656 F.3d 1008, 1014 (9th Cir. 2011); *Bassett v. Snyder*, 59 F. Supp. 3d 837, 854–55 (E.D. Mich. 2014).

Varnum further supports this conclusion. While *Varnum* held that intermediate scrutiny applied to Iowa's marriage statute, the Court's explanation for rejecting cost savings as a rationale for the discriminatory treatment of same-sex couples applies equally well to rational-basis review:

> Excluding any group from civil marriage—African–Americans, illegitimates, aliens, even red-haired individuals—would conserve state resources in an equally 'rational' way. Yet, such classifications so obviously offend our society's collective sense of equality that courts have not hesitated to provide added protections against such inequalities.

Varnum, 763 N.W.2d at 903.

Additionally, any assertion by individual legislators, (*see* Section II.B.2 below), that surgical treatments for gender dysphoria have an "excessive cost" has no factual basis at all, and there was no fiscal analysis of the Division in the House File 766 legislative history to support that contention. *See* Iowa Legislative Services Agency, Fiscal Services Division, Notes on Bills and Amendments (NOBA), *Health and Human Services Appropriations Bill, House File 766,* https://www.legis.iowa.gov/docs/publications/NOBA/1045129.pdf. Publicly available data shows otherwise. *See* Herman, Jody L., *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans* (Williams Institute, Sept. 2013) ("Herman Study"). In fact, there are medical costs associated with denying transgender people access to medically necessary transition-related care since, with the availability of care, their overall health and well-being improve, resulting in significant reductions in suicide attempts, depression, anxiety, substance abuse, and self-administration of hormone injections. Cal. Dep't of Ins., *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (Apr. 13, 2012), https://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf. Providing insurance coverage for transgender patients has been shown to be "affordable and cost-effective, and has a low budget impact." William V. Padula, PhD et. al, *Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, Johns Hopkins Bloomberg Sch. of Public Health, Dep't of Health Policy and Management (Oct.

19, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4803686/ (finding the budget impact of this coverage is $0.016 per member per month, and provided "good value for reducing the risk of negative endpoints--HIV, depression, suicidality, and drug use").

2.The Division violates Equal Protection because it was motivated by animus toward transgender people.

The Division's sole purpose was to take away publicly funded Medicaid coverage for transgender Iowans. It does so by creating an exception to the ICRA's protections against discrimination in public accommodations that is directed specifically at transgender people to take away the protections that only transgender people were afforded under the Iowa Supreme Court's decision in *Good.* A law is irrational and violates equal protection if its purpose is to target a disadvantaged group, as was the Division's purpose. *Windsor,* 133 S.Ct. at 2693 ("[t]he Constitution's guarantee of equality 'must at the very least mean that a bare [legislative] desire to harm a politically unpopular group cannot' justify disparate treatment of that group.") (quoting *Moreno,* 413 U.S. at 534–35; *Romer,* 517 U.S. at 632)("[T]he amendment seems inexplicable by anything but animus toward the class it affects; it lacks a rational relationship to legitimate state interests."); *Cleburne,* 473 U.S. at 448 ("[M]ere negative attitudes, or fear, ... are not permissible bases for [a statutory classification]."); *Moreno,* 413 U.S. at 534 ("[The] amendment was intended to prevent so called 'hippies' and 'hippie communes' from participating in the food stamp program," and such "a bare congressional desire to harm a politically unpopular group cannot constitute a legitimate governmental interest.").

Here, the Division suffers from the same, rare constitutional deficiency of being a law plainly motivated by animus towards a disfavored group. It literally was passed in order to take away publicly funded healthcare for transgender individuals, who were, prior to the Division, entitled to such medical care. As the Iowa Supreme Court recognized in the *Good* decision in

Good, all Iowans qualified to receive Medicaid are entitled to coverage for medically necessary surgery. *Good,* 924 N.W.2d at 858. But the Division literally denies transgender Iowans this medical care, by taking away their protections under the ICRA from discrimination in access to such health care.

The plain text, factual history, and legislative debate make clear the purpose of the law was specifically to deprive transgender Iowans on Medicaid of the protections against discrimination in public accommodations that served as the basis for the Iowa Supreme Court decision in *Good*. Notably, in *Good*, the Court also found that the history of the adoption of the challenged Regulation prohibiting coverage for medically necessary gender affirming surgery also "support[ed] its holding that the rule's express bar on Medicaid coverage for gender-affirming surgical procedures discriminates against transgender Medicaid recipients in Iowa under the ICRA." *Good*, 924 N.W.2d at 862.

The legislature unfortunately doubled-down on that discriminatory history in passing the Division to authorize the discrimination the Court just invalidated in *Good*. In beseeching his colleagues to vote against the bill, Sen. Bolkcom stated:

> The language in this bill targets coverage for their [transgender Iowans'] essential and necessary medical treatments. It's ignorant. It's discrimination of the worst kind. It's a clear violation of the equal protection under the Iowa Constitution. And I hope somebody on your side has the guts to explain to us this afternoon why this language is in this bill.
>
> . . .
>
> The American Medical Association, the American Psychological Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists all support the view that medically necessary care is needed, and they believe these medical procedures should be covered under public insurance programs.
>
> . . .

> The undisputed medical evidence shows that gender affirming surgical treatment may prevent social dysfunction, physical pain, and even death. If left untreated gender dysphoria often causes acute distress and isolation, impedes healthy personal development and interpersonal relationships, and destroys a person's ability to function effectively in daily life. Why we would want to prevent somebody from getting the medical care they need to function effectively in daily life I have no understanding of. Suicide and death are common among persons who are unable to access gender dysphoria treatment, with an attempted suicide rate of 41 to 43 percent for those individuals . . . compared to a baseline rate of about five percent for everybody in this room . . . the language in this bill is cruel. I think it's ignorant, it doesn't understand the science, and it discriminates against Iowans already marginalized.

Iowa General Assembly, Session, *House File 766* video recording of debate on 2019-04-027, https://www.legis.iowa.gov/dashboard?view=video&chamber=S&clip=s20190426012941549&dt=2019-04-26&offset=2721&bill=HF%20766&status=r, at 2:27:55 (Rep. Bolkcom).

Senator Costello, when asked by Sen. Bolkcom why the language was in the bill, plainly stated:

> As you probably know this language was in the administrative code for, has been for years and it was always practiced that way. A recent court case was decided that changed that and said that doesn't count, you have to, you are forced to provide those surgeries, so we are changing that policy back . . . It is a pretty expensive surgery, and I don't know that I agree with you that it is always medically necessary, which is what Medicaid is about. So we are taking the Code and saying it the way it was prior to this court decision, and I think a lot might people might have trouble paying for this surgery think it's not a proper use of federal or of our state monies. So we are trying to react to the lawsuit that came up.

Id. at 2:31:44.

Sen. Mark Costello said the intent of the bill was "to change the administrative code back to the way it was for years before the lawsuit. He said he didn't feel such procedures are 'always medically necessary.'" Tony Leys and Barbara Rodriguez, *Iowa Republican lawmakers ban use of Medicaid dollars on transgender surgery*, Des Moines Register (Apr. 27, 2019), https://www.desmoinesregister.com/story/news/politics/2019/04/26/iowa-legislature-senate-republicans-propose-ban-medicaid-money-transgender-surgery-lawsuit-courts/3578920002/

In the Iowa House, the only comments in support of the Division came from the bill manager, Rep. Fry, who described the function of the Division in plainly discriminatory terms, as "amending the Iowa Civil Rights Act to clarify that we are not requiring any government unit in the state to provide for gender reassignment surgeries." Iowa General Assembly, Session, *House File 766* video recording of debate on 2019-04-27, https://www.legis.iowa.gov/dashboard?view=video&chamber=H&clip=h20190427092516225&dt=2019-04-27&offset=6564&bill=HF%20766&status=r, at 11:24:30 (Rep. Fry). The rest of the comments in debate came from opponents. Rep. Wessel-Kroeschell criticized the Division, saying "[t]his amendment takes away the civil rights of Iowa's transgender population." *Id.* at 11:36:50 (comments by Rep. Wessel-Kroeschell). She added that "This proposal deserved to be thoroughly examined, and it was not. This amendment was mean-spirited and cruel." *Id.* at 11:37:10.

Legislators debating the bill understood its discriminatory purpose. For example, Representative Running-Marquardt stated "I question the integrity of a body that passes language that denies Iowans critical healthcare because they're transgender. That's what this bill does. . . We are codifying discrimination against people and their healthcare needs because they're transgender. . . . It is the doctor's decision what is critical healthcare. It is not the people in this chamber. It is not your decision." *Id.* at 12:30:20.

For these reasons, Petitioners are likely to succeed on the merits of their equal protection claim.

3.The Division violates the Iowa Constitution's single-subject rule.

Petitioners are also likely to succeed on the merits of their claim that the Division violates the Iowa Constitution's single-subject rule.

Article III, section 29 of the Iowa Constitution states that "Every act shall embrace but one subject, and matters properly connected therewith; which subject shall be expressed in the title. But if any subject shall be embraced in an act which shall not be expressed in the titled, such act shall be void only as to so much thereof as shall not be expressed in the title." Iowa Const. art. III, § 29.

In *State v. Mabry,* the Iowa Supreme Court stated that the purpose of the single-subject rule is threefold: to prevent logrolling, "which occurs when unfavorable legislation rides in with more favorable legislation," to prevent surprise when legislators are not informed of the insertion of an unrelated rider, and to keep citizens of the state fairly informed of the subjects of legislative debate. *State v. Mabry*, 460 N.W. 472, 473 (Iowa 1990) (citing Note, *Before a Bill Becomes a Law—Constitutional Form*, 8 Drake L.Rev. 66, 67 (1958)); *see also Rants v. Vilsack*, 684 N.W.2d 193, 201 (Iowa 2004) ("[L]ogrolling" is "legislators' practice of combining in a single bill provisions supported by various minorities in order to create a legislative majority."); *Utilicorp United Inc. v. Iowa Utils. Bd.,* 570 N.W.2d 451, 454–55 (Iowa 1997) (describing general principles related to Iowa's single-subject provision).

As set forth in *Mabry*, the four requirements of the single-subject rule are as follows:

> (1) "the act may have only one subject together with matters germane to it."
> (2) "the title of the act must contain the subject matter of the act"
> (3) "any subject not mentioned in the title is invalid";
> (4) "an invalid subject in the act does not invalidate the remaining portions that are expressed in the title"

Mabry, 460 N.W.2d at 474. In applying the single-subject rule:

> [a court] must find that the act encompasses two or more dissimilar or discordant subjects that have no reasonable connection or relation to each other. Even if the matters grouped as a single subject might more reasonably be classified as separate subjects, no violation occurs if these matters are nonetheless relevant to some single more broadly stated subject.

> So to pass constitutional muster the matters contained in the act must be germane. To be germane, all matters treated within the act should fall under some one general idea and be so connected with or related to each other, either logically or in popular understanding, as to be part of … one general subject.

Id. (internal quotations and citations omitted).

The Division violates the requirements of Article III, section 29, as set forth in *Mabry*. *First*, the subject matter of the Act of which the Division is part—appropriations and conditions thereof—has nothing to do with the subject matter of the Division—ICRA's substantive protections against discrimination in public accommodations. *Second*, the Act's title, "An Act relating to appropriations for health and human services and veterans and including other related provisions and appropriations, providing penalties, and including effective date and retroactive and other applicability date provisions," does not reference the ICRA at all, much less make clear that the Division created an exception to the ICRA's prohibition against gender-identify discrimination in public accommodations.[2]

Indeed, this case is analogous to *Western International v. Kirkpatrick,* 396 N.W.2d 359 (1986). In *Kirkpatrick*, a change to the workers' compensation appeal process was buried in a technical "Code Corrections" bill. *Id*. at 365. The Court reasoned that the "title must . . . give fair notice of the act's subject and it must not deceive its reader." *Id.* (internal citations omitted). It found the title in that case:

> states it is a code corrections bill altering current practices, but does not enlighten the reader as to what practices are being changed. There is no indication in the title . . . that the enactment effected a change in workers' compensation law or in appellate procedure involving workers' compensation cases . . . These provisions are buried in the middle of a sixty-one section enactment which could fairly be said to make otherwise lexicographical changes. The reader of the title is not informed that a drastic change in the workers' compensation law will result from this bill's enactment.

[2] Invalidating the ICRA exception under the single-subject rule would not invalidate the remaining provisions of the Act. *Mabry*, 460 N.W.2d at 474

Id.

Burying a substantive, highly controversial piece of legislation that creates an exception to the ICRA in an Act entitled "Appropriations" is even more dramatic than the workers' compensation amendment at issue in *Kirkpatrick*. Neither legislators nor the public could fairly anticipate a major change to the ICRA based on the title of the Act. Under *Kirkpatrick*, the Division violates the single-subject rule.

4.The Division violates the Iowa Constitution's inalienable-rights clause.

Petitioners are also likely to succeed on the merits of their claim that the Division violates the Iowa Constitution's inalienable-rights clause.

Article I section 1 of Iowa's Constitution guarantees:

> All men are, by nature, free and equal, and have certain inalienable rights—among which are those of enjoying and defending life and liberty, acquiring, possessing and protecting property, and pursuing and obtaining safety and happiness.

Iowa Const. art I, § 1.

The Iowa Supreme Court has stated that the clause requires rational-basis review coextensive with the federal and state due-process clauses, *City of Sioux City v. Jacobsma*, 862 N.W.2d 335, 352 (Iowa 2015), and prevents "arbitrary, unreasonable legislative action that impacts an inalienable right," *Atwood v. Vilsack*, 725 N.W.2d 641, 651 (Iowa 2006). This "rational basis" test in practice, however, is not toothless under the Iowa Constitution. *See City of Sioux City*, 862 N.W.2d at 351.

The constitutionality of a law that impacts an inalienable right depends on whether "the interests of the public generally, as distinguished from those of a particular class, require [state] interference; and, second, [whether] the means are reasonably necessary for the accomplishment

of the purpose, and not unduly oppressive upon individuals." *Gacke v. Pork Xtra, L.L.C.*, 684 N.W.2d 168, 177 (Iowa 2004). As to the first prong, the interests of the public, "[i]n each case, it is a question whether or not the collective benefit outweighs the specific restraint." *Benschoter v. Hakes*, 8 N.W.2d 481, 485 (Iowa 1943). As to the second prong, "restrictions that are prohibitive, oppressive or highly injurious . . . are invalid." *Gacke*, 684 N.W.2d at 177 (quoting *Steinberg-Baum & Co.*, 77 N.W.2d 15, 19 (Iowa 1956)); *see also State v. Osborne*, 154 N.W. 294, 300 (Iowa 1915) (inalienable-rights clause protects "the right to pursue a useful and harmless business without the imposition of oppressive burdens by the lawmaking power.").

The Court has also suggested that the inalienable-rights clause should provide greater protections than both the federal and state due-process clauses. In *City of Sioux City*, the Court acknowledged that it has never engaged in "any substantial analysis of the historical or philosophical origins of the clause, its function and purpose as the first section of the Bill of Rights in the Iowa Constitution, or the meaning of its generous text in contrast to the rights language in the Federal Constitution." 862 N.W.2d at 351. The Court quoted with approval a 1993 law-review article by Bruce Kempkes. *Id.* at 352 (quoting Bruce Kempkes, *The Natural Rights Clause of the Iowa Constitution: When the Law Sits Too Tight*, 42 Drake L. Rev. 593 (1993), hereinafter "Kempkes"). In particular, the Court emphasized Kempkes's explanation of why the inalienable-rights clause should have meaning separate and independent from federal and state due-process principles:

> [T]he inalienable rights clause predated the passage of the Fourteenth Amendment by eleven years; the Iowa drafters placed a due process clause five clauses away in article I, section 6, which cannot be considered redundant; and the text of article I, section 1 is fundamentally different than either the Due Process or Equal Protection Clauses of the Federal Constitution.

Id. at 353 (citing Kempkes at 634). According to Kempkes, the debates at the Iowa Constitutional Convention suggest that the clause should be read to "invalidate legislation adversely affecting personal liberty and happiness unless their exercise in some way harms or presents an actual and substantial risk of harm to another person." Kempkes at 637.

Under either approach, rational-basis review or the heightened scrutiny contemplated by *City of Sioux City*, the Division violates the inalienable-rights clause. The Division arbitrarily and unreasonably bars transgender Iowans on Medicaid from obtaining medically necessary surgical care. The inalienable right to receive such care arises from its medical necessity, the fact that impacted transgender Iowans rely on Medicaid to receive that medically necessary care, and its connection to the expression of transgender Iowans' gender identity. There is no public interest in interfering with this right that all Iowans on Medicaid have. *See Gacke*, 684 N.W.2d at 177. As demonstrated extensively above, gender dysphoria is a serious medical condition, and surgical treatment for gender dysphoria is medically necessary and effective. And there is no evidence that providing this treatment will impose excessive costs on the state, but rather that denying access to it will *increase* the costs of addressing transgender individuals' disproportionately high susceptibility to suicide attempts, depression, anxiety, and substance abuse and their self-administration of hormone injections. (*See* Argument § B(1)(vi), above.) Given these considerations, the Division's categorical ban on public funding for gender-affirming surgery is "unduly oppressive upon" transgender Iowans who rely on Medicaid for healthcare coverage for medically necessary care. *See id*.

The Iowa Supreme Court has upheld rights against state interference under the inalienable-rights clause in a wide variety of cases, particularly those involving rights to property and bodily safety. *See, e.g., In re N.N.E.*, 752 N.W.2d 1 (Iowa 2000) (upholding the right of parents to make

child-rearing decisions without state interference); *Gacke*, 684 N.W.2d at 185 (upholding the right of property owners to bring a nuisance suit notwithstanding the statutory immunity of putative defendants); *Gibb v. Hansen*, 286 N.W.2d 180 (Iowa 1979) (upholding the right of a witness to refuse to testify if doing so would threaten the witness's safety); *State v. Reese*, 272 N.W.2d 863 (Iowa 1978) (upholding an incarcerated person's right to a necessity defense in situations where the person escapes prison out of fear for his or her safety); *Hoover v. Iowa State Highway Comm'n*, 222 N.W. 438 (Iowa 1928) (upholding the right of a property owner to an injunction preventing a highway from being built on the property); *State v. Osborne*, 154 N.W. 294 (1915) (upholding the right of transient merchants to do business without first posting bond); *State v. Ward*, 152 N.W. 501 (Iowa 1915) (upholding the right of a property owner to shoot deer that threaten to damage property notwithstanding a statutory prohibition on unauthorized hunting). This Court should follow suit and acknowledge that the Division violates the Iowa Constitution's inalienable-rights clause.

C. Petitioners will continue to be substantially injured if this Court does not enjoin Respondents from enforcing the Division, and the balance of hardships warrants injunctive relief.

In addition to being likely to succeed on the merits of their petition, Petitioners will continue to be substantially injured if the Division is allowed to be enforced to deny them coverage for their medically necessary care under Iowa Medicaid. *See Ney v. Ney*, 891 N.W.2d 446, 451 (Iowa Mar. 10, 2017) (district court may issue an injunction when "substantial injury will result from the invasion of the right or if substantial injury is to be reasonably apprehended to result from a threatened invasion of the right").

As an initial matter, the Division will continue to irreparably harm Petitioners by violating their constitutional rights: "It is well established that the deprivation of constitutional rights

'unquestionably constitutes irreparable injury.'" *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *Ezell v. City of Chicago*, 651 F.3d 684, 699 (7th Cir. 2011) (infringement of constitutional rights by facially invalid law causes irreparable harm) (citing 11A Charles Wright et al., Practice & Procedure § 2948.1 (2d ed. 1995) ("When an alleged deprivation of a constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary."). As outlined in detail above, the Division will also continue to irreparably harm Petitioners by further preventing them from accessing medically necessary care that is critical to their health, safety and welfare. (*See* Factual Background Part A.)

Courts repeatedly have held that emotional distress, anxiety, depression and physical pain resulting from inadequate medical treatment for gender dysphoria amount to irreparable harm. *See Hicklin v. Precynthe*, 2018 WL806764, at *10, *14 (E.D. Missouri Feb. 9, 2018) (enjoining prison system's denial of medically necessary transition-related treatments to transgender plaintiff in Eighth Amendment case, finding plaintiff showed irreparable harm based on evidence of worsening emotional distress and a substantial risk of self-harm, including "intrusive thoughts of self-castration" and suicidal ideation); *Edmo v. Idaho Dep't of Corrections*, 358 F.Supp.3d 1103, at 1128 (D. Idaho Dec. 13, 2018) (finding transgender inmate plaintiff satisfied the irreparable harm prong "by showing that she will suffer serious psychological harm and will be at high risk of self-castration and suicide in the absence of gender confirmation surgery"); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931 (W.D. Wis. 2018) (granting preliminary injunction to transgender Medicaid recipients under Affordable Care Act and equal protection in their challenge to regulation excluding coverage for surgery to treat gender dysphoria).

The balance of harms between the parties in this case further supports a grant of temporary injunctive relief. While Petitioners will be severely harmed by the Division's requirements,

Respondents will not suffer any harm from Petitioners receiving the medical care they require. *See Am. Civil Liberties Union v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999) ("[T]hreatened injury to [constitutional rights] outweighs whatever damage the preliminary injunction may cause Defendants' inability to enforce what appears to be an unconstitutional statute.") (citation omitted); *Saint v. Neb. Sch. Activities Ass'n*, 684 F.Supp. 626, 628 (D. Neb. 1988) (no harm to defendant in losing the ability to enforce unconstitutional regulations).

Finally, the status quo that this Court should protect with a temporary injunction is that Petitioners were already in the process of medical transition, including obtaining gender affirming surgery, prior to the Division's signing and effective date. Gender affirming surgery had already been determined to be medically necessary to treat both Ms. Covington's and Mr. Vasquez's gender dysphoria. They had already initiated the process to receive preapproval for coverage under Iowa Medicaid for the medically necessary gender affirming surgeries, and already have care plans in place with their physicians to receive those procedures in September 2019. (*See* Ex. 2: Nisley/ Vasquez Aff.; Ex. 3: Daniels/Vasquez Letter; Ex. 4: Eadeh/Vasquez Letter; Ex. 5: Waters/Vasquez Letter; Ex. 7 Nisley/ Covington Aff.; Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter.) Absent the challenged Division and the discriminatory Regulation, there is no other basis, factual or legal, to deny them care. (Ex. 1: Vasquez Aff. ¶¶ 19-22, 27-28; Ex. 6: Covington Aff. ¶¶ 29-30.) They were both in process of seeking preapproval when the Division was signed into law. (Ex. 6: Covington Aff. ¶ 20 ; Ex. 1: Vasquez Aff. ¶ 18.) Mr. Vasquez had to cancel his pre-surgical consultation with Dr. Gast in Madison because of the Division, and Ms. Covington's preapproval request following her upcoming July 2019 appointment will be denied despite medical necessity. (Ex. 1: Vasquez Aff. ¶¶ 19-22; Ex. 6: Covington Aff. ¶¶ 29-30.) Because temporary injunctions serve to protect the status quo of the parties during litigation, and because the status

quo in this case is that Petitioners are already entitled to receive the care for which they have demonstrated medical necessity under Iowa Medicaid and the *Good* decision, this factor also strongly favors a grant of a temporary injunction.

Because the injuries to the Petitioners in denying them medically necessary care is significant, and because there is no harm to the state in allowing them to receive the care to which they are entitled, this Court grant the Petitioners' motion for a temporary injunction to protect their ability to get care during the pendency of this case.

D. There is no adequate legal remedy available.

Finally, Petitioners are entitled to an injunction because they have no adequate legal remedy for the Division's gross violation of their constitutional rights and their rights to necessary medical care, causing significant distress, pain and discomfort, risks of self-harm, and suicidality. (*See* Ex. 6: Covington Aff. ¶ 32; Ex. 1: Vasquez Aff. ¶ 26; Ex. 2: Nisley/ Vasquez Aff.; Ex. 3: Daniels/Vasquez Letter; Ex. 4: Eadeh/Vasquez Letter; Ex. 5: Waters/Vasquez Letter; Ex. 7 Nisley/ Covington Aff.; Ex. 8: Eadeh/Covington Letter; Ex. 9: Waters/Covington Letter; Ex. 10: Ettner Aff. ¶ 15.); Monetary damages are insufficient remedies to protect against these serious medical risks and harm. *See Ney*, 891 N.W.2d at 452 (there is no adequate legal remedy "if the character of the injury is such that it cannot be adequately compensated by damages at law") (internal quotation marks omitted). The Division will cause transgender Iowans who rely on Medicaid for their medical coverage, and Petitioners Covington and Vasquez in particular—grievous injuries that cannot later be compensated by damages.

III. CONCLUSION

WHEREFORE, Petitioners pray this Court grant their Motion for Temporary Injunctive Relief and enjoin Respondents from enforcing the Division during the pendency of this case.

Respectfully submitted,

/s/ Rita Bettis Austen
Rita Bettis Austen (AT0011558)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: 515.243.3988
Fax: 515.243.8506
rita.bettis@aclu-ia.org

/s/ Shefali Aurora
Shefali Aurora (AT00012874)
American Civil Liberties Union of Iowa Foundation
505 Fifth Ave., Ste. 808
Des Moines, IA 50309–2317
Phone: 515.243.3988
Fax: 515.243.8506
shefali.aurora@aclu-ia.org

/s/ John Knight
John Knight*
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

/s/ F. Thomas Hecht
F. Thomas Hecht*
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*
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*
Nixon Peabody LLP
70 West Madison Street, Ste. 3500
Chicago, IL 60601
Telephone: 312-977-4443
Facsimile: 312-977-4405
sahorvath@nixonpeabody.com

ATTORNEYS FOR PETITIONERS

*Application for admission *pro hac vice* forthcoming

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

MIKA COVINGTON, AIDEN DELATHOWER, and ONE IOWA, INC., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA and IOWA DEPARTMENT OF HUMAN SERVICES, Respondents.	Equity Case No. _____ **AFFIDAVIT OF AIDEN DELATHOWER**

AFFIDAVIT OF AIDEN DELATHOWER ("AIDEN VAZQUEZ")

STATE OF IOWA)
)
COUNTY OF [redacted])

I, Aiden DeLathower being duly sworn, depose and state the following to the best of my recollection and under oath and penalty of perjury:

1. I am a United States citizen and I am fifty-one years old.
2. I currently reside in southeast Iowa.
3. I am a man. I am also transgender, having been assigned the female sex at birth.
4. Since I was approximately two years old, I have known that I am male. I even began dressing in male clothes when I was eight years old.
5. I met my wife, Tammi DeLathower, in 1995. We got married on July 30, 2011. In 2015 she was diagnosed with multiple sclerosis and I am her caregiver.
6. The primary care physician overseeing my transition has been Dr. Nicole Nisly with the University of Iowa Hospital and Clinics.

7. I was diagnosed with gender dysphoria in January 2016 and my healthcare provider prescribed hormone therapy as the first step in my treatment. The hormone therapy, which involves receiving dosages of testosterone, is intended to induce physiological changes that promote the matching of my gender identity and my body.
8. Shortly after beginning hormone therapy I began the process of social transition by using the pronouns "he," "him," and "his". Around May 2016, I began using men's restrooms in public places and have used them consistently ever since.
9. I am a member of One Iowa's Transgender Advisory Council.
10. In May 2016, I legally changed my name and amended my driver's license and Social Security card to reflect my legal name.
11. As part of my medically necessary treatment for gender dysphoria, I underwent a double mastectomy in September 2016. This was a crucial step to better align my body with my gender identity. I paid for this procedure using a CareCredit card I obtained for that purpose.
12. In October 2016, I amended my birth certificate and changed the gender markers on my identification documents to reflect my male gender identity.
13. While the physical changes to my body resulting from the hormone therapy and mastectomy has helped to reduce the distress that my gender dysphoria causes me, I remain severely distressed with my female genitalia, which does not align with my gender identity.
14. I have been preparing to undergo a phalloplasty as the next step in my transition in order to better conform my body to my male gender identity.

15. My physician, Dr. Nisly, has determined that a phalloplasty is medically necessary to treat my gender dysphoria.
16. Dr. Nisly referred me to Dr. Katherine Gast, a surgeon who performs phalloplasty procedures at the University of Wisconsin-Madison.
17. I currently am enrolled in Iowa Medicaid. I have received coverage through Iowa Medicaid since 2014. My managed care organization is currently United Healthcare, although this will change to Amerigroup on July 1, 2019.
18. After the Iowa Supreme Court's decision in the *Good* case, I had an appointment with Dr. Nisly on April 17, 2019. At that time, she made a referral to Dr. Gast for my gender affirming bottom surgery.
19. The next day, April 18, 2019, I called Dr. Gast's office. Emily at Dr. Gast's office told me I would need to have a pre-operative consultation with Dr. Gast before I could schedule my gender affirming surgery. Then, at the time of the pre-operative consultation appointment, Dr. Gast's office would submit the request for pre-authorization to Medicaid for my gender affirming surgery. She told me that if I had my pre-operative consultation in May, I could expect to be able to schedule my surgery with Dr. Gast to take place in September 2019.
20. Approximately one week later, on April 25, 2019, Dr. Gast's office called me to schedule the consultation. We scheduled the consultation for May 30, 2019.
21. However, on May 3, 2019, I learned that the Iowa Governor had signed a new law that would allow Medicaid to deny coverage for gender affirming surgery again.

22. On approximately May 13, 2019, I called Dr. Gast's office to confirm that I would still be able to have my pre-operative consultation and schedule surgery, given the new law. Dr. Gast's staff told me that in light of the new law, they couldn't confirm that Medicaid would cover the pre-operative consultation, and that if it denied payment, I would have to pay for the cost of the pre-operative consultation myself.
23. Further, even if the pre-operative consultation was paid for, they could not confirm that Medicaid would provide me coverage for the surgery itself.
24. The food, travel, and lodging cost for me to travel with my wife and our dogs to Dr. Gast's office in Wisconsin, stay overnight at a campground we found nearby, and return would be approximately $400. Our monthly food budget is $160. I have no ability to pay for the consult out-of-pocket. We could not afford to spend $400 to travel to the pre-operative consultation without confirmation that it would be covered, knowing that I wouldn't be able to schedule the surgery because the new law would allow Medicaid to deny coverage.
25. Because Dr. Gast's office could not confirm Medicaid coverage, I had to cancel my consultation with Dr. Gast.
26. I have a long history of self-harm and suicidality stemming from the depression caused by my gender dysphoria. To this day I feel incomplete and struggle with many of these feelings. My depression, as well as my thoughts of self-harm, have been even more heightened after the new law passed and I was forced to postpone the phalloplasty I need.

27. I desperately need to proceed with my consultation and phalloplasty procedure in order to treat my severe gender dysphoria, but am unable to do so, because of the new law.
28. My progress towards becoming the person I know myself to be has been stopped because of this new law.

I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

Executed this 30th day of May, 2019.

Aiden DeLathower, Affiant

Subscribed and sworn to me this 30th day of May, 2019.

NOTARY PUBLIC
SIGNATURE AND STAMP

TAMARAH LYNN BROOKS
Commission Number 796510
My Commission Expires
06-03-2022

UNIVERSITY OF IOWA HEALTH CARE

UIHC Iowa River Landing

LGBTQ Clinic
Internal Medicine
105 East 9th Street
Coralville, IA 52241
319-467-2000 Tel
319-467-2505 Fax

4/17/2019

RE: Referral for gender affirming surgery of AIDEN J Delathower "A J"
[redacted]
Notarized Affidavit of Nicole Nisly, MD

To Whom It May Concern,

I, Nicole Nisly, MD, am a licensed physician in the State of Iowa, and the primary care physician of AIDEN J Delathower who wishes to pursue gender affirming surgery (phalloplasty) to reflect a permanent change of sex designation from female to male, by reason of surgery and clinically appropriate treatments under my care. By way of background, I am a Doctor of Medicine and a primary care physician at the University of Iowa Hospitals and Clinics' Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Clinic.

I have treated AIDEN J Delathower since 05/23/2016 for the purpose of completing gender transition and a permanent sex designation change from female to male. These treatments and medical procedures included, but were not limited to, referral and/or coordination of mental health counseling session(s), referral for surgical procedures including mastectomy and treatment with testosterone. The treatments irreversibly altered AIDEN's body in the following manner, enlargement of clitoris, deepening of voice, growth of facial hair and increased growth and thickening of body hair.

In my professional medical opinion and judgment the sex designation of AIDEN J Delathower has been permanently changed. All of the treatments AIDEN J Delathower received under my care were medically necessary, clinically appropriate, and in accord with the standards and guidelines for treatment of Gender Dysphoria, ICD-9 Code 302.85, by the World Professional Association for Transgender Health, American Medical Association, American Psychiatric Association, American Psychological Association, and the American College of Obstetricians and Gynecologists. AIDEN has also underwent gender affirming top surgery (mastectomy).

Gender affirming bottom surgery is medically necessary to treat Aiden's gender dysphoria and I support this decision and referral.

KIM BEATTIE
Commission Number 775333
My Commission Expires
10/17/21

Kim Beattie

Nicole Nisly MD

Please contact me if you have questions or need more information.

Respectfully submitted,

KIM BEATTIE
Commission Number 775333
My Commission Expires
6/17/21

Nicole Nisly, MD
University of Iowa Hospitals and Clinics -- Iowa River Landing
105 East 9th Street Level 4
Coralville, Iowa 52241
319-384-7444

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of the information without specific written consent of the patient to whom it pertains, or as otherwise permitted by law.

MARRIAGE AND FAMILY COUNSELING SERVICE

1800 - 3RD AVENUE, SUITE 512 • ROCK ISLAND, IL 61201-8000 • TELEPHONE (309) 786-4491
FAX (309) 786-0205 • E-MAIL: MARFAMCSLG@AOL.COM • www.MFCSQC.org

A United Way Partner

April 24, 2019

Re: Patient Aiden Delathower [redacted]

Dear Dr. Katherine Gast:

Aiden Delathower was a client under my care from 2000 to about 2004, then again from about 2006-8. At that time he identified as a female, and came in as part of a same sex relationship. I recall my first and lasting impression was she was a man trapped in a woman's body. It was clear from hairstyle, demeanor, body carriage, and other factors. Many of the issues that presented then were related to the gender dysphoria that was not stated but always seemed to be the case from my perspective. At that time, the complaint was relational and not about gender identification. In my role as marriage and family therapist, we worked on those relational issues. I knew it would at some time be a presenting problem, but he moved on.

At the conclusion of therapy, he and his partner (now wife) kept in touch with me. It was clear at that time that the recognition of the gender dysphoria was recognized. He had transitioned by being on HRT for over three years, legally changing his name, gender identity on drivers' license, dress, hair, and had come out. We talked about his recognition from an early age that he knew that "she" was in fact male. He says this recognition was at about age two.

Aiden is physically healthy. He bikes, lifts weights, and observes healthy nutrition practices. I am aware of no health diagnoses that may preclude his having surgery. He and his wife are in a stable, happy relationship and home situation and are prepared for his post-operative recovery. I know of no drug use or abuse on his part. In fact, there is a very strong emphasis on good health in all aspects of his life.

I believe him to be capable of making an informed decision about undertaking surgery and that the next appropriate step for him is to undergo such surgery. In my belief, this will help him make significant progress for further treatment of his gender dysphoria. I see it as a vital quality of life and mental health issue for him, and I recommend Aiden Delathower to have gender reassignment/phalloplasty surgery.

Respectfully submitted,

Carol J. Daniels PhD LMFT

Carol J. Daniels PhD LMFT

THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
Psychological and Quantitative Foundations
361 Lindquist Center
Iowa City, Iowa 52242-1529
319-335-5577 *Fax* 319-335-6145
pandq@uiowa.edu
www.education.uiowa.edu/pandq

LGBTQ Counseling Clinic

LGBTQ Psychosocial Assessment

Legal Name:

Aiden Jayce DeLathower

Name:

Aiden

Email Address:

[redacted]

Birthdate:

[redacted]

Assessment Date:

5/27/2019

Report

Referral and Background:

Aiden was referred to the LGBTQ Counseling Clinic by Dr. Nisly for a bottom reaffirming surgery assessment. Aiden uses he/him/his pronouns and is a 51-year-old transgender man.

Gender Identity and History of Gender Dysphoria:

Aiden knew his gender identity since the age of 2 and told doctors and his mother but was not taken seriously. He was often told by others that he was "just a lesbian" and lived much of his life identifying as such. In 2016 he began to identify as a transgender man. Aiden started hormones in February of 2016 and had top surgery in September of 2016. Additionally, Aiden legally changed his name in May of 2016 and his gender marker in October of 2016.

Meaningful Closer Relationships and Support of Gender Identity/Transistion:

Aiden identified his wife, Tammy, as his main support. However, he also is part of an online support group for trans individuals which he finds very helpful. Additionally, he is passionate about and gets a sense of fulfillment from mentoring others, particularly parents of trans kids, and works closely with them.

Mental Health History (including suicidality, diagnoses, and medications):

Aiden has a history of bipolar disorder, anxiety, PTSD, depression, and ADHD. He has taken many medications in the past to help manage these symptoms. Currently he takes wellbutrin and cymbalta for his mood and for fibromyalgia, respectively. Aiden reported that together these medications help to stabilize his mood as well as his aggression. In the past, Aiden has been in counseling but does not currently attend therapy. He reported a history of suicidal ideation but has not had any plans, intent, or attempts recently. Finally, he has considered beginning counseling again.

Substance Use History:

Aiden struggled with alcohol abuse from the ages of 17 to 32, but no longer drinks alcohol and this is not a current concern for him. He reported no other substance use/abuse.

History of Trauma, Abuse, Domestic or Other forms of Violence:

[redacted]

Support in Work Environment:

N/A - Aiden is not currently working. He filed for disability in January of 2015, however his case was denied.

Coping Strategies:

When Aiden feels aggressive he takes his anger out at the gym and this has been a helpful outlet for him. Additionally, he enjoys biking and will talk to his wife, Tammy, to help process emotions and situations. Aiden is religious and has used his faith as another outlet and coping mechanism. Finally, the online support group for trans individuals in which Aiden takes part has been a great source of support.

Understanding of Risks and Benefits of Hormone Therapy or Surgery:

Aiden feels he understands the risks and benefits of bottom surgery and believes this step will make him "feel whole" again. He has spoken to several doctors about this process and is making an informed decision to have this treatment.

WPATH Standards (check box if "YES - client meets standard")

- [x] Does client have persistent, well documented gender dysphoria?
- [x] Does client have the capacity to make and informed decision?
- [x] Are other significant mental health or medical concerns well controlled?
- [x] Is the client over the age of 18?

Recommendation :

Based upon the interview completed with Aiden, it is clear he has experienced marked gender dysphoria throughout his life. Moreover, these feelings increased after top surgery due to not feeling whole. Aiden is over 18, is making an informed decision, and understands the risks and benefits of bottom surgery. It is my recommendation that Aiden has access to receive bottom surgery and that this treatment would help his mood and dysphoria.

Signatures

Therapist:

Hana-May Eadeh

Supervisor:

Armeda Wojciak, LMFT

Staff Signature: Armeda Wojciak
Armeda Wojciak, PhD, LMFT Supervisor
I approve this document
Signed: 05/28/2019 02:47 PM

THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
Psychological and Quantitative Foundations
361 Lindquist Center
Iowa City, Iowa 52242-1529
319-335-5577 Fax 319-335-6145
pandq@uiowa.edu
www.education.uiowa.edu/pandq

LGBTQ Counseling Clinic

LGBTQ Psychosocial Assessment

Legal Name:

Aiden Jayce DeLathower

Name:

Aiden

Email Address:

[redacted]

Birthdate:

[redacted]

Assessment Date:

5/27/2019

Report

Referral and Background:

Aiden was referred to the LGBTQ Counseling Clinic by Dr. Nisly for a gender reaffirming bottom surgery assessment. Aiden is a 51-year-old transgender man and uses the pronouns he, him, and his. He reports that he has been taking hormones for the last three years. He reports feeling ready to take the next step in his medical transition.

Gender Identity and History of Gender Dysphoria:

Aiden reported that he knew his gender identity since the age of 2 and told doctors and his mother but was not taken seriously. He was often told by others that he was "just a lesbian" and lived much of his life identifying as such. In 2016 he began to identify as a transgender man. He also reported that he began taking HRT in February of 2016 and had top surgery in September of 2016. Additionally, Aiden legally changed his name in May of 2016 and his gender marker in October of 2016.

Meaningful Closer Relationships and Support of Gender Identity/Transistion:

Aiden identified his wife, Tammy, as his main support. He also reported that he received support from an online group of transgender individuals. Additionally, he is passionate about and gets a sense of fulfillment from mentoring others, particularly parents of trans kids, and works closely with them.

Mental Health History (including suicidality, diagnoses, and medications):

Aiden reported that he has been diagnosed with bipolar disorder, anxiety, PTSD, depression, and ADHD. Currently, he takes Wellbutrin and Cymbalta for his mood and for fibromyalgia. Aiden reported that together these medications help to stabilize his mood as well as his aggression. In the past, Aiden has been in counseling but does not currently attend therapy. He reported a history of suicidal ideation but has not had any plans, intent, or attempts recently.

Substance Use History:

Aiden reported a history of alcoholism, but no longer drinks alcohol and this is not a current concern for him. He reported no other substance use disorders.

History of Trauma, Abuse, Domestic or Other forms of Violence:

[redacted]

Support in Work Environment:

Aiden reported that he is not currently working.

Coping Strategies:

When Aiden feels aggressive he takes his anger out at the gym and this has been a helpful outlet for him. Additionally, he enjoys biking and will talk to his wife, Tammy, to help process emotions and situations. Aiden is religious and has used his faith as another outlet and coping mechanism. Finally, the online support group for trans individuals in which Aiden takes part has been a great source of support.

Understanding of Risks and Benefits of Hormone Therapy or Surgery:

Aiden feels he understands the risks and benefits of bottom surgery and believes this step will make him "feel whole" again. He has spoken to several doctors about this process and is making an informed decision to have this treatment. Aiden would like a copy of his letters.

WPATH Standards (check box if "YES - client meets standard")

☑ Does client have persistent, well documented gender dysphoria?

☑ Does client have the capacity to make and informed decision?

☑ Are other significant mental health or medical concerns well controlled?

☑ Is the client over the age of 18?

Recommendation :

Aiden has met the WPATH Standards for receiving gender reaffirming bottom surgery. He has persistent, well-documented gender dysphoria and his other mental health concerns are well controlled. Additionally, he has the capacity to make an informed decision and is over the age of 18. I believe that receiving gender reaffirming bottom surgery will help Aiden to make significant progress in treating his gender dysphoria. Therefore, I recommend that Aiden receive gender reaffirming bottom surgery.

Signatures

Therapist:

Elizabeth Watters

Supervisor:

Armeda Wojciak, LMFT

Staff Signature: Armeda Wojciak
Armeda Wojciak, PhD, LMFT Supervisor
I approve this document
Signed: 05/28/2019 02:56 PM

E-FILED 2019 MAY 31 9:58 AM POLK - CLERK OF DISTRICT COURT

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

MIKA COVINGTON, AIDEN DELATHOWER, and ONE IOWA, INC., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA and IOWA DEPARTMENT OF HUMAN SERVICES, Respondents.	Equity Case No. _____ **AFFIDAVIT OF MIKA COVINGTON**

AFFIDAVIT OF MIKA COVINGTON

STATE OF IOWA)
)
COUNTY OF [redacted])

I, Mika Covington, being duly sworn, depose and state the following to the best of my recollection and under oath and penalty of perjury:

1. I am a United States citizen and I am twenty-eight years old.
2. I currently reside in central Iowa.
3. I am a woman. I am also transgender, having been assigned the male sex at birth.
4. The earliest memory I have of questioning my gender identity was in kindergarten at the age of six. I would carry around a purse and wear heels. At that time, I did not know or understand the meaning of being transgender. I thought that I must be gay because I did not act the way that other boys did, and some of my classmates frequently called me gay. I was bullied in high school.

5. Growing up, I often felt like a girl trapped in a boy's body. I would occasionally dress in more feminine attire and paint my nails even as a freshman in high school. However, at that time, I identified as a gay male, and it was not until much later that I understood that I am a transgender woman.
6. I realized that I was transgender in 2008 after a conversation with my therapist. She is the one that informed me of the terminology associated with being gender nonconforming and transgender.
7. I decided to come out as a transgender woman in 2009 at my workplace. After that, I began the process of social transition and began living as Mika. Since that time, I have used the pronouns “she,” “her,” and “hers.”
8. In 2014, I legally changed my name to reflect my identity as a woman.
9. I am a member of One Iowa’s Transgender Advisory Council.
10. The primary care provider overseeing my transition has been Dr. Nicole Nisly with the University of Iowa Hospital and Clinics.
11. In 2015, Dr. Nisly at the University of Iowa diagnosed me with gender dysphoria, and I began receiving my first dosages of estrogen. The estrogen dosages, which are sometimes referred to as hormone therapy, are intended to induce physiological changes that help my body better match of my female gender identity. Dr. Nisly continues to oversee the medically necessary treatment I receive for gender dysphoria.
12. I also have cystinosis, a rare genetic disease caused by a chromosomal mutation. Cystinosis is a metabolic disease that causes cells to crystallize causing early cell death. This happens because the amino acid cysteine accumulates in the cells, but has no

transporter out. Cystinosis slowly destroys the organs in the body including the kidneys, liver, eyes, muscles, and brain.

13. Cystinosis is a separate condition from gender dysphoria. However, my gender dysphoria exacerbates my already existing depression and anxiety from years of medical complications, including those from cystinosis.
14. I have experienced various periods of deep depression and suicidal ideation through my teens and twenties. These have stemmed from my gender dysphoria, cystinosis, and the isolation and rejection I've experienced as a result of being transgender. I have also attempted suicide on various occasions and have required inpatient hospital treatment following those attempts.
15. As part of my medical treatment for gender dysphoria, I continue to live full-time as female in every aspect of my life.
16. I have also recently amended my passport, Social Security card, and other federally issued documents to reflect my female gender and legal name.
17. I am in process of amending the gender marker on my driver's license to reflect my female gender identity.
18. I intend to amend the gender on my birth certificate and have already tried to do so, but I will be unable to complete this process until I have proof that I have completed gender affirming surgery. While Iowa allows transgender people to amend their birth certificates with a physician letter, Nebraska requires proof of completion of gender affirming surgery.

19. While I am glad about the physical changes to my body resulting from the hormone therapy, especially the development of breast tissue, I remain distressed and very uncomfortable with my remaining male genitalia.
20. When I heard that the Iowa Supreme Court recognized in March 2019 that gender affirming surgery is medically necessary, and that it is discriminatory to deny transgender Iowans coverage for medically necessary gender affirming surgery under Iowa Medicaid, I was very hopeful and began to move forward with steps to acquire the gender affirming surgery I desperately need.
21. I currently am enrolled in Iowa Medicaid. I have received coverage through Iowa Medicaid since 2012. My managed care organization ("MCO") is currently United Healthcare. However, this will change to Amerigroup on July 1, 2019.
22. I met with Dr. Nisly on March 6, 2019. During the appointment, we discussed a care plan for me to get my surgery, and the specific steps to seek preapproval for my gender affirming surgery. Dr. Nisly informed me I would need to schedule an appointment to be evaluated by psychologists as the next step.
23. Dr. Nisly has referred me for surgery, determining that the procedure is medically necessary to treat my gender dysphoria.
24. After I became aware of the Iowa Supreme Court's March 8, 2019 decision in the Good case, I immediately sent an email to Dr. Nisly to begin the process to get preapproval for Medicaid coverage for my gender affirming surgery.
25. On March 14, 2019 I received a response from Dr. Nisly's office stating that she had referred me for a psychological evaluation. Dr. Nisly's office asked that I complete those evaluations prior to my follow up appointment with her in July.

26. After receiving approval from the psychologists evaluating me and having my follow up appointment with Dr. Nisly in July, the plan was to seek preapproval of my gender affirming surgery. We intended to schedule my surgery to take place in September 2019, when University of Iowa surgeons will have completed the training necessary to conduct the procedure at the University of Iowa Hospitals and Clinics.
27. Now, I have had my psychological evaluation appointment, which took place on May 22, 2019 at the University of Iowa Hospitals and Clinics.
28. Two psychologists have determined that gender affirming surgery is clinically appropriate and medically necessary for treatment of my gender dysphoria.
29. My follow up appointment with Dr. Nisly is scheduled for July 30.
30. However, as a result of the new law enacted in May 2019, I expect that the pre-approval of surgery will be denied.
31. The new law therefore will cause me serious disruption in my treatment plan for gender dysphoria.
32. Knowing I will not be able to proceed with surgery in September has caused my depression and anxiety to intensify, and triggered some of my previous suicidal ideations. I have had to use my support network and coping mechanisms to continue moving forward.
33. I need to proceed with my gender affirming surgery in order to treat my severe gender dysphoria, but am unable to do so, because of the new law.

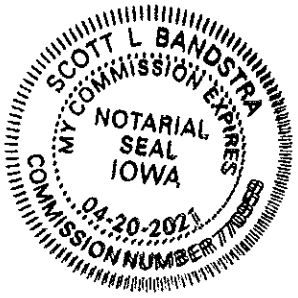
I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

Executed this 30 day of May, 2019.

Mika Covington, Affiant

Subscribed and sworn to me this 30th day of May, 2019.

NOTARY PUBLIC
SIGNATURE AND STAMP



UNIVERSITY of IOWA HEALTH CARE

UIHC Iowa River Landing
Primary & Specialty Care Services
Internal Medicine
105 East 9th Street
Coralville IA 52241
319-467-2000 Tel
319-467-2505 Fax

5/14/2019

RE: Mika J Covington "Mika" [redacted]

To Whom It May Concern:

I, Nicole Nisly, MD, am a licensed physician in the State of Iowa, and the primary care physician of Mika J Covington who is waiting to undergo gender affirming surgery to reflect a permanent change of gender identity from male to female, by reason of clinically appropriate treatments under my care. By way of background, I am a Doctor of Medicine and a primary care physician at the University of Iowa Hospitals and Clinics' Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Clinic.

I have treated Mika J Covington since 03/31/2015 for the purpose of completing gender transition and a permanent sex designation change from male to female. These treatments and medical procedures included, but were not limited to, referral and/or coordination of mental health counseling session(s), treatment with estrogen and treatment with androgen blocking medications. The treatments irreversibly altered Mika's body in the following manner, development of breast tissue.

In my professional medical opinion and judgment the sex designation of Mika J Covington has been permanently changed. All of the treatments Mika J Covington received under my care were medically necessary, clinically appropriate, and in accord with the standards and guidelines for treatment of Gender Dysphoria, ICD-9 Code 302.85, by the World Professional Association for Transgender Health, American Medical Association, American Psychiatric Association, American Psychological Association, and the American College of Obstetricians and Gynecologists.

Gender affirming bottom surgery is medically necessary to treat Mika's gender dysphoria and I support this decision and referral. Please contact me if you have questions or need more information.

I declare under penalty of perjury under the laws of the United States and the State of Iowa that the forgoing is true and correct.

KIM BEATTIE
Commission Number 775333
My Commission Expires
10/17/2021

Kim Beattie

Nicole Nisly MD

Respectfully submitted,

Nicole Nisly, MD
Iowa License # 29145
University of Iowa Hospitals and Clinics -- Iowa River Landing
105 East 9th Street Level 4
Coralville, Iowa 52241
319-384-7444

STATE OF IOWA,

COUNTY OF JOHNSON.

Subscribed and sworn to before me, a Notary Public in and for the State of Iowa, on this 23rd day of May, 2019 by the person known to me to be Nicole Nisly, MD.

Kim Beattie
Notary Public

KIM BEATTIE
Commission Number 775333
My Commission Expires
5-17-2021

THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
Psychological and Quantitative Foundations
361 Lindquist Center
Iowa City, Iowa 52242-1529
319-335-5577 *Fax* 319-335-6145
pandq@uiowa.edu
www.education.uiowa.edu/pandq

LGBTQ Counseling Clinic

LGBTQ Psychosocial Assessment

Legal Name:

Mika Covington

Name:

Mika

Email Address:

[redacted]

Birthdate:

[redacted]

Assessment Date:

5/22/2019

Report

Referral and Background:

Dr. Nisely referred Mika referred to the LGBTQ Counseling Clinic for an assessment for gender reaffirming bottom surgery. Mika is a trans-woman and uses she/her/hers pronouns. Mika reported that she has been taking hormones for several years and is feeling ready and excited to take the next step in her medical transition.

Gender Identity and History of Gender Dysphoria:

Mika grew up with cystinosis and subsequently dealt with a lot of bullying as a child/teen related to this diagnosis as well as identifying as more feminine starting in fourth grade. At this age is when she started being called derogatory names. She was raised in a religious setting and would pray that God would change her feelings or change her into a girl. In high school, Mika learned about the LGBTQ+ community and began presenting as more feminine and then came out as gay. In 2009, Mika came out as transgender to both her workplace and high school. Mika was kept from graduating with the rest of the students in high school because she identified as transgender and there were concerns about her safety. Since 2009 she has used female pronouns and lives as a woman. Additionally, Mika legally changed her name and began hormones in 2014.

Meaningful Closer Relationships and Support of Gender Identity/Transistion:

Mika identified several close friends, two of whom she lives with. These people have been the primary source of support for her. One of her friends, [redacted] is also a transgender individual, and they have been able to process this transition together.

Mental Health History (including suicidality, diagnoses, and medications):

Mika reported that she has been diagnosed with Cystinosis. She also reported being diagnosed with

major depressive disorder, anxiety disorder, and borderline personality disorder. She reported a history of feeling suicidal, with the most recent attempt in the spring of 2017. Mika attended intensive outpatient care following that suicide attempt. Since 2016, her gender dysphoria has increased in intensity to the point of it being debilitating for her. This past spring Mika also experienced active suicidal thoughts, but has not had any current active plans or intent. She reported these thoughts have subsided over the past two weeks. Mika is currently taking medication for depression and would be interested in receiving a referral for ongoing therapy.

Substance Use History:

Mika did not report any history of substance use or abuse.

History of Trauma, Abuse, Domestic or Other forms of Violence:

[redacted] She has also reported severe bullying and discrimination throughout her life.

Support in Work Environment:

Mika worked at JC Penny and she reported it was a very accommodating environment and helped her successfully transition. However, she did report experiencing discrimination when working with a delivery company and was fired because of her gender identity. Since then she reported she has been working in politics and has no issues relating to her identity in this environment.

Coping Strategies:

Mika reported that she uses her DBT workbook and does a lot of personal reflective writing. She also talks to a couple of close friends to process emotions and situations.

Understanding of Risks and Benefits of Hormone Therapy or Surgery:

Mika reported that she feels she understands the risks and benefits of gender reaffirming bottom surgery and is able to make an informed decision.

WPATH Standards (check box if "YES - client meets standard")

☑ Does client have persistent, well documented gender dysphoria?

☑ Does client have the capacity to make and informed decision?

☑ Are other significant mental health or medical concerns well controlled?

☑ Is the client over the age of 18?

Recommendation :

Mika has met the WPATH Standards for receiving gender reaffirming bottom surgery assessment. She has persistent, well-documented gender dysphoria and her other mental health concerns are well controlled. Additionally, she has the capacity to make an informed decision and is over the age of 18. In my opinion, I believe that having access to gender reaffirming bottom surgery will help Mika to make significant progress in treating her gender dysphoria. Therefore, I recommend that Mika have access to these services.

Signatures

Therapist: Hana-May Eadeh

Supervisor: Kayla Fitzke

Staff Signature: Kayla R Fitzke, PhD, LMFT
Kayla Fitzke, PhD Director
I approve this document
Signed: 05/28/2019 11:19 AM

THE UNIVERSITY OF IOWA

COLLEGE OF EDUCATION
Psychological and Quantitative Foundations
361 Lindquist Center
Iowa City, Iowa 52242-1529
319-335-5577 *Fax* 319-335-6145
pandq@uiowa.edu
www.education.uiowa.edu/pandq

LGBTQ Psychosocial Assessment

Legal Name:

Mika Covington

Name:

Mika

Email Address:

[redacted]

Birthdate:

[redacted]

Assessment Date:

5/22/2019

Report

Referral and Background:

Mika was referred to the LGBTQ Counseling Clinic by Dr. Nisely for a gender reaffirming bottom surgery assessment. Mika is a transgender woman and uses the pronouns she, her, hers. She reports that she has been taking hormones for several years. She reports feeling ready and excited to take the next step in her medical transition.

Gender Identity and History of Gender Dysphoria:

She reported growing up with cystinosis and dealing with a lot of bullying related to this and identifying as more feminine starting in fourth grade, where she said she started being called derogatory names. She also grew up very religious and prayed that God would change their feelings or that they would change them into a girl. In high school, they learned about the LGBTQ+ community and they started dressing more feminine and came out as gay. In 2009, they came out as transgender to their workplace and high school, and they were not allowed to graduate with the rest of the students because they were transgender. Since 2009 she has used female pronouns and lives as a woman, and got their name legally changed and began hormones in 2014.

Meaningful Closer Relationships and Support of Gender Identity/Transistion:

Close friends that she lives with, and a close friend [redacted] have been the primary source of support for her. [redacted]s also a transgender individual, and they have been able to process this transition together.

Mental Health History (including suicidality, diagnoses, and medications):

Mika reported that she has been diagnosed with Cystinosis. She also reported being diagnosed with major depressive disorder, anxiety disorder, and borderline personality disorder. She reported a history

of feeling suicidal, with the most recent attempt in the spring of 2017. She reported that she attended intensive outpatient care following the attempt. Since 2016, she also reported experiencing progressively worse with gender dysphoria to the point of it being debilitating for her. This past spring they have also experienced active suicidal thoughts, but have not had any current active plans or intent, and she reported these thoughts have subsided over the past two weeks. She reported that she is currently taking medication for depression and that she would be interested in receiving a referral for ongoing therapy.

Substance Use History:

Mika reported no history of substance use.

History of Trauma, Abuse, Domestic or Other forms of Violence:

[redacted] She has also reported severe bullying and discrimination throughout her life.

Support in Work Environment:

She reported JC Penny was very accommodating and helped her successfully transition. However, she reported experiences discrimination when working with a delivery company and was fired because of their gender identity. Since then she reported she has been working in politics and has no issues in this environment.

Coping Strategies:

Mika reported that she uses her DBT workbook and does a lot of personal reflective writing. She also reported that her self-care consists of talking to a couple of close friends to process emotions and situations.

Understanding of Risks and Benefits of Hormone Therapy or Surgery:

Mika reported that she feels she understands the risks and benefits of gender reaffirming bottom surgery and is able to make an informed decision.

WPATH Standards (check box if "YES - client meets standard")

☑ Does client have persistent, well documented gender dysphoria?

☑ Does client have the capacity to make and informed decision?

☑ Are other significant mental health or medical concerns well controlled?

☑ Is the client over the age of 18?

Recommendation :

Mika has met the WPATH Standards for receiving gender reaffirming bottom surgery assessment. She has persistent, well-documented gender dysphoria and her other mental health concerns are well controlled. Additionally, she has the capacity to make an informed decision and is over the age of 18. I believe that receiving gender reaffirming top surgery will help Mika to make significant progress in treating his gender dysphoria. Therefore, I recommend that Mika receive gender reaffirming bottom surgery.

Signatures

Therapist:

Elizabeth R. Watters

Supervisor:

Kayla Fitzke

Staff Signature: Kayla R Fitzke, PhD, LMFT
Kayla Fitzke, PhD Director
I approve this document
Signed: 05/24/2019 02:18 PM

IN THE IOWA DISTRICT COURT FOR POLK COUNTY

MIKA COVINGTON, AIDEN DELATHOWER, and ONE IOWA, INC., Petitioners, v. KIM REYNOLDS ex rel. STATE OF IOWA and IOWA DEPARTMENT OF HUMAN SERVICES, Respondents.	Equity Case No. _____ **AFFIDAVIT OF RANDI ETTNER**

AFFIDAVIT OF RANDI ETTNER

STATE OF ILLINOIS)
)
COUNTY OF COOK)

I, Randi Ettner, being duly sworn, depose and state the following to the best of my recollection and under oath and penalty of perjury:

1. I have been asked to provide an expert opinion regarding Gender Dysphoria and its treatment.

Qualifications

2. I received my doctorate in psychology from Northwestern University in 1979. I was chief psychologist at the Chicago Gender Center from 2005-2016 when it moved to Weiss Memorial Hospital. Since that time, I have held the sole psychologist position at the Center for Gender Confirmation Surgery at Weiss Memorial Hospital.

3. I have expertise working with children, adolescents and adults with Gender Dysphoria. I have been involved in the treatment of gender dysphoric individuals since 1977, when I was an intern at Cook County Hospital, and, in the course of my

EXHIBIT 10

career, I have evaluated and/or treated 2,500 to 3,000 individuals with Gender Dysphoria and mental health issues related to gender variance.

4. I have published four books related to transgender healthcare including the medical text entitled Principles of Transgender Medicine and Surgery (co-editors Monstrey and Eyler; Routledge, 2007) and the 2nd edition (co-editors Monstrey and Coleman; Routledge, 2016). I have authored numerous articles in peer-reviewed journals regarding the provision of health care to this population. I served as a member of the University of Chicago Gender Board, and am a member of the editorial boards of the *International Journal of Transgenderism* and *Transgender Health.*

5. I am the Secretary of the World Professional Association for Transgender Health (WPATH) (formerly the Harry Benjamin International Gender Dysphoria Association) a member of the Executive Board of Directors, and an author of the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th version). The WPATH-promulgated *Standards of Care* are the internationally recognized guidelines for the treatment of persons with Gender Dysphoria and serve to inform medical treatment in the United States and throughout the world.

6. I have lectured throughout North America, Europe and Asia on topics related to Gender Dysphoria. On numerous occasions, I have given grand rounds presentations on Gender Dysphoria at medical hospitals. I am the honoree of the Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota.

7. I have been an invited guest at the National Institutes of Health to participate in developing a strategic research plan to advance the health of sexual and gender minorities, and was invited to address the Director of the Office of Civil Rights of

the United States Department of Health and Human Services regarding the medical treatment of Gender Dysphoria in November 2017.

8. I received a commendation from the United States Congress House of Representatives on February 5, 2019, recognizing my work for WPATH and Gender Dysphoria in Illinois.

9. I have been retained as an expert regarding Gender Dysphoria and its treatment in numerous court cases in state and federal courts, as well as administrative proceedings. I have also been a consultant to policy makers regarding appropriate care for transgender inmates.

Opinions

What does it mean to be transgender?

10. Transgender refers to a diverse group of individuals who cross or transcend culturally defined categories of gender and sex. For these individuals, their gender identity--the innate sense of being male or female--differs from the category they were assigned at birth. Gender identity is different than sexual orientation.

11. Although the term "transgender" is a recent addition to the medical lexicon, the condition of gender incongruity is not. Accounts of individuals who displayed cross-gender behavior first appeared in German medical literature in 1877, and biological attempts to manipulate gender date as far back as the Iron Age.

What is Gender Dysphoria?

12. Gender Dysphoria, formerly known as Gender Identity Disorder, is a serious medical condition codified in the *International Classification of Diseases* (10th revision; World Health Organization) and the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-5th edition.* The condition is

characterized by a strong and persistent incongruence between one's experienced and/or expressed gender identity and sex assigned at birth, resulting in clinically significant distress or impairment in functioning. The suffering that arises from this condition has often been described as 'being trapped in the wrong body." "Gender Dysphoria" is also the psychiatric term used to describe the severe and unremitting emotional pain associated with the condition.

13. The diagnostic criteria for Gender Dysphoria in adults are as follows:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(DSM-5 p. 452).

14. Adults who manifest a severe degree of the condition were previously referred to as being "transsexual."

15. Without treatment, gender dysphoric individuals experience anxiety, depression, suicidality and other attendant mental health issues. They are also frequently isolated, because they carry a burden of shame and low self-esteem attributable to the feeling of being inherently "defective." This leads to stigmatization, and over time, ravages healthy personality development and interpersonal relationships. As a result, without treatment many individuals are unable to function effectively in daily life. Studies show a 41-43% rate of suicide attempts among this population without treatment, far above the baseline of 4.6% for North America (Haas et al., 2014).

How is Gender Dysphoria treated?

16. The standards of care for treating Gender Dysphoria are set forth in the *World Professional Association for Transgender Health's Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (WPATH Standards of Care). The WPATH *Standards of Care* are recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association (see AMA:2008; Resolution 122 [A-08]; American Psychiatric Association DSM-5; American Psychological Association Policy Statement on Transgender, Gender Identity, and Gender Expression Non-discrimination; 2009).

17. The *Standards of Care* are universally accepted, evidence-based, best-practice medical protocols, and have been translated into many languages. They articulate professional consensus to guide health care professionals in the medical management of Gender Dysphoria, and the parameters within which they may provide care to individuals with the condition.

18. The *Standards of Care* identify the following therapeutic options for treatment of individuals with Gender Dysphoria:

- Changes in gender expression and role, consistent with one's gender identity (social role transition).
- Counseling for purposes such as addressing the negative impact of stigma, enhancing social and peer support, improving body image, promoting resiliency, etc.
- Hormone therapy to masculinize or feminize the body.
- Surgery to alter primary and/or secondary sex characteristics.

19. Of those individuals who seek treatment for Gender Dysphoria, only a subset requires surgical intervention. The *Standards of Care* explicitly specifies the necessary elements of assessment, the essential qualifications of referring mental health and medical providers, and the criteria for initiation of medically indicated surgical treatments.

Can psychotherapy replace surgery as treatment for Gender Dysphoria?

20. In 2001, the WPATH *Standards of Care Version 6* no longer required psychotherapy as a necessary prerequisite to medical and/or surgical treatment for Gender Dysphoria, and, in 2010, WPATH issued the following "de-pathologizing statement:"

> The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth, is a common and culturally diverse human phenomenon, which should not be judged as inherently pathological or negative. The psychopathologisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalization and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people.

21. By 2011, consensus regarding the notion that a person with Gender Dysphoria is not suffering from a disordered identity or pathological condition had crystallized and that the nomenclature itself was pathologizing. The *DSM-5* changed the Gender Identity Disorder nomenclature to Gender Dysphoria, in recognition that an individual's *identity* is not disordered, but that one experiences distress as a result of the incongruence of identity and anatomy and the attendant social problems. This change in taxonomy acknowledged that the condition requires medical treatment but doesn't impugn the patient's mental health.

22. As recently as June 16, 2018, the World Health Organization ("WHO") likewise reclassified the gender incongruence diagnosis in the forthcoming International Classification of Diseases-11 ("ICD-11"). This is significant because it removes gender incongruence from the chapter on mental and behavioral disorders, recognizing that it is not a mental illness.

Can gender identity be altered?

23. Gender identity cannot be altered, either for transgender or for non-transgender individuals. Past attempts to "cure" transgender individuals and change their gender identity to match their birth-assigned gender were ineffective and caused extreme psychological damage. Such efforts are now considered unethical. Medical science recognizes that transgender individuals represent a normal variation of the diverse human population.

24. Current scientific research strongly suggests that gender identity is innate or fixed at an early age and has a strong biological basis. Both post-mortem and functional brain imaging studies in living persons show that transgender persons have

areas of the brain that differ from the brains of non-transgender individuals. Additionally, research has shown that the probability of a sibling of a transgender person also being transgender was almost five times higher than the general public, and twins have a 33.3% concordance rate for being transgender, even when reared apart. This suggests a genetic component to the condition, and some researchers are looking at specific genes that are implicated in the genesis of gender incongruity.

25. Given that gender identity is biologically based, it cannot be altered. Historical attempts to manipulate gender identity included, in addition to psychoanalysis, faith healing, exorcism, electroshock and other forms of reparative therapy, all of which were unsuccessful, harmful, and are now considered unethical.

Does being transgender affect an individual's ability to contribute to society?

26. With appropriate treatment and social acceptance, transgender people are fully capable of leading healthy, happy and productive lives. Being transgender does not affect a person's ability to be a good employee, parent, or citizen.

Is surgery an effective treatment for Gender Dysphoria?

27. Surgeries are considered "effective" from a medical perspective if they "have a therapeutic effect" (Monstrey et al. 2007). More than three decades of research confirms that surgery to modify primary and/or secondary sex characteristics and align gender identity with anatomy is therapeutic and therefore effective treatment for Gender Dysphoria. Indeed for appropriately assessed severely gender dysphoric patients, surgery is the *only* effective treatment.

28. In a 1998 meta-analysis, Pfafflin and Junge reviewed data from 80 studies, spanning 30 years, from 12 countries. They concluded, "…reassignment procedures were effective in relieving gender dysphoria. There were few negative consequences, and all

aspects of the reassignment process contributed to overwhelmingly positive outcomes." (Pfafflin & Junge 1998).

29. Numerous subsequent studies confirm this conclusion. Researchers reporting on a large-scale prospective study of 325 individuals in The Netherlands concluded that after surgery there was "a virtual absence of gender dysphoria" in the cohort and "results substantiate previous conclusions that sex reassignment is effective" (Smith et al. 2005). Indeed, the authors of the study concluded that the surgery "appeared therapeutic and beneficial" across a wide spectrum of factors and "[t]he main symptom for which the patients had requested treatment, gender dysphoria had decreased to such a degree that it had disappeared."

30. In 2007, Gijs and Brewayes analyzed 18 studies published between 1990 and 2007, encompassing 807 patients. The researchers concluded: "Summarizing the results from the last two decades, the conclusion that [sex reassignment surgery] is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands: Ninety-six percent of the persons who underwent [surgery] were satisfied and regret was rare."

31. Studies conducted in countries throughout the world conclude that surgery is an extremely effective treatment for Gender Dysphoria. For example, a 2001 study published in Sweden states: "The vast majority of studies addressing outcome have provided convincing evidence for the benefit of sex reassignment surgery in carefully selected cases" (Landen). Similarly, urologists at the University Hospital in Prague, Czech Republic, in a *Journal of Sexual Medicine* article concluded, "Surgical conversion of the genitalia is a safe and important phase of treatment. . . " (Jarolim 2009).

32. Studies have shown that by alleviating the suffering and dysfunction caused by Gender Dysphoria, surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning (Rehaman et al. 1999; Johansson et al. 2010; Hepp et al. 2002; Ainsworth & Spiegel 2010; Smith et al. 2005); improving self-image and satisfaction with body and physical appearance (Lawrence 2003; Smith et al. 2005; Weyers et al. 2009; and greater acceptance and integration into the family (Lobato et al. 2006). Studies have also shown that surgery improves patients' abilities to initiate and maintain intimate relationships (Lobato et al. 2006; Lawrence 2005; Lawrence 2006; Imbimbo et al 2009; Klein & Gorzalka 2009; Jarolim 2009; Smith et al 2005; Rehman et al. 1999; DeCuypere et al 2005).

33. Over the past two decades, a large body of research has documented the efficacy of surgery in long-term follow up of patients. These studies confirm that surgery is an effective treatment with low complication rates. For example, see "Transsexualism in Serbia: a twenty-year follow-up study" (Vujovic et al 2009); "Long-term assessment of the physical, mental, and sexual health among transsexual women (Weyers 2009); "Treatment follow-up of transsexual patients" (Hepp et al. 2002); "A five-year follow-up study of Swedish adults with gender identity disorder" (Johansson et al 2010); "A report from a single institute's 14 year experience in treatment of male-to-female transsexuals" (Imbimbo et al. 2009); "Follow-up of sex reassignment surgery in transsexuals: a Brazilian cohort" (Lobato et al. 2006).

34. While the gold standard of scientific research is "controlled" studies, which yield reliable baseline data by eliminating and isolating variables in two comparable groups, this is not easily implemented in surgical research. It is unethical to

randomize patients in a trial where only one group receives surgical intervention, and extremely difficult to recruit patients willing to "not receive" a known, desirable treatment. However, Mate-Kole et al. successfully designed such an investigation. Patients who qualified for surgery were randomly assigned either to immediately undergo surgery, or be placed on a waiting list for two years. The two groups were matched for family and psychiatric histories and severity of Gender Dysphoria. The patients who underwent surgery demonstrated dramatically improved psychosocial outcomes compared to the still-waiting controls. The post-surgery patients were more active socially and had significantly fewer psychiatric symptoms (1990).

35. Kockott & Fahrner (1987) employed a different strategy, which also utilized controls. They conducted a retrospective study comparing gender dysphoric patients who had undergone surgery with those who had not, but were otherwise matched. At follow-up, 4.6 years after surgery, the patients who underwent surgery were better adjusted psychosocially, had improved financial circumstances, and reported increased satisfaction with sexual experiences, as compared to the un-operated group.

36. The corpus of studies increases yearly as access to gender confirmation surgery increases. For example, a group at Cornell University conducted a recent literature review of 56 studies from 1991 to June 2017 on the outcomes of gender confirming surgery in transgender individuals. The results verify the efficacy of surgery: 52 studies (93%) reported beneficial effects, 4 studies reported mix or null effects, and no studies showed that gender confirming surgery causes harm. The review also indicates that rates of regret are exceedingly rare events, as surgical techniques and access to social support have improved. (What We Know: The Public Policy Research Portal, *What does the scholarly research say about transition on transgender well-being?*, Cornell Univ.

(2019), https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/).

Is surgical treatment considered experimental?

37. Surgery for Gender Dysphoria is not experimental. These same surgeries are routinely performed in other contexts such as in the treatment of individuals with 46XY gonadal dysgenesis, defects in testicular development, vaginal atresia, Mayer-Rokitansky-Kuster-Hauser (MRKH) syndrome, ambiguous genitalia and other Disorders of Sexual Development (DSD).

38. Indeed, such surgeries are performed routinely for disease and trauma. Breast reduction surgery for non-transgender women with back problems or male gynecomastia, hysterectomy and other uro-genital surgeries, such as phalloplasty for non-transgender men, are often medically indicated and routinely performed.

39. Surgeries for Gender Dysphoria have been performed for many decades and such surgeries are part of the WPATH established standards of care for patients with severe Gender Dysphoria. The American Medical Association (Resolution 122 A-08) states:

> Health experts in GID, including WPATH, have rejected the myth that these treatments are "cosmetic" or "experimental" and have recognized that these treatments can provide safe and effective treatment for a serious health condition.

40. WPATH is explicit in this regard. In 2008, WPATH issued a "Medical Necessity Statement" for insurance coverage for medical treatment, stating:

> These medical procedures and treatment protocols are not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient.

41. Surgery to treat Gender Dysphoria is not "experimental" or "investigational."

When medically indicated for severe Gender Dysphoria, is surgery the only effective treatment?

42. Surgery is the only effective treatment for severely gender dysphoric patients. Only reconstruction of the primary and/or secondary sex characteristics can create body congruence and eliminate anatomical dysphoria. Achieving an authentic physical appearance is crucial to a patient's ability to live safely and comfortably. Studies have repeatedly demonstrated that surgery creates functional and normal physical appearance enabling the patient to function in everyday life. This alleviates the suffering and dysfunction caused by Gender Dysphoria and improves virtually every facet of a patient's life.

Is there controversy in the medical community regarding the efficacy or appropriateness of surgery when medically necessary for the treatment of Gender Dysphoria?

43. There is no controversy amongst mainstream medical professionals regarding the appropriateness and necessity of surgical care for Gender Dysphoria. Professional medical associations such as *The American Medical Association, The Endocrine Society, The American Psychiatric Association, The American Psychological Association, The World Health Organization, The American Academy of Family Physicians, The National Commission of Correctional Health Care, The American Public Health Association, The National Association of Social Workers, The American College of Obstetrics and Gynecology* and *The American Society of Plastic Surgeons* all endorse the established standards of care described in Section 3 and in the WPATH standards.

I certify under penalty of perjury and pursuant to the laws of the state of Iowa that the preceding is true and correct.

Executed this 29 day of May, 2019.

Randi Ettner

Randi Ettner, Affiant

Subscribed and sworn to me this 29th day of May, 2019.

NOTARY PUBLIC
SIGNATURE AND STAMP

ERNAD HALILIC
Official Seal
Notary Public – State of Illinois
My Commission Expires Sep 28, 2021