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IN THE

Supreme Court of Iowa

No. 21-1977

AIDEN VASQUEZ and MIKA COVINGTON,

Petitioners-Appellees,

vs.

IOWA DEPARTMENT OF HUMAN SERVICES,

Respondent-Appellant.

On Appeal from the Iowa District Court
Case Nos. CVCV061729, CVCV062175

BRIEF OF *AMICI CURIAE* CHICAGO LAWYERS' COMMITTEE FOR CIVIL RIGHTS, IOWA SAFE SCHOOLS, AND PROFESSOR LEONARD A. SANDLER IN SUPPORT OF PETITIONERS-APPELLEES VASQUEZ AND COVINGTON

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IDENTITY AND INTEREST OF AMICI CURIAE

Through a variety of different missions, each Amicus Curiae supports broad access to health care, especially on behalf of members of historically marginalized communities, such as transgender and gender non-conforming people.

Amicus ***Chicago Lawyers' Committee for Civil Rights*** is a public interest law organization founded in 1969 that works to secure racial equity and economic opportunity for all. Chicago Lawyers' Committee for Civil Rights provides legal representation through partnerships with the private bar and collaborates with grassroots organizations and other advocacy groups throughout Illinois and Indiana. Through coalition work, litigation, and policy advocacy, Chicago Lawyers' Committee works to advance civil rights by implementing community-based solutions that promote transparency, accountability, and equity.

Amicus ***Iowa Safe Schools*** was founded in 2002. The mission of Iowa Safe Schools is to provide safe, supportive, and nurturing learning environments and communities for LGBTQ and allied youth through education, outreach, advocacy, and direct services. The organization provides comprehensive support, victim services, resources, and events for LGBTQ and allied youth. Serving over 4,500 youth annually, Iowa Safe Schools is the largest LGBTQ youth serving organization in the Midwest.

Amicus ***Professor Leonard A. Sandler*** is a Clinical Professor of Law at the

University of Iowa College of Law. Professor Sandler serves as the Director of the University of Iowa Law and Policy in Action Clinic. The Iowa Law and Policy in Action Clinic provides representation, technical assistance and advice, legislative advocacy, legal and policy research, training and other community-based services and initiatives to improve the quality of life of people in Iowa and other states. Law students and faculty provide no-cost consultant services to community groups, professionals, government officials, nonprofits, businesses, lawmakers, and institutions. Its Rainbow Health Clinic was established in 2013 as part of a multidisciplinary approach to support the community of patients, faculty and staff of the University of Iowa LGBTQ Health Clinic. Its mission is to protect and expand the rights of LGBTQ individuals, promote systems change, and improve access to health care, transportation, employment, health insurance, education, and other critical services for marginalized communities.

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

STATEMENT OF AUTHORSHIP OF BRIEF AND FUNDING

This brief was authored by legal counsel for Chicago Lawyers' Committee for Civil Rights, Iowa Safe Schools, and Professor Leonard A. Sandler. Legal counsel for the parties, and the parties themselves, have not contributed monetary funds to the preparation of this brief and have not authorized the brief in whole or in part. No third parties contributed any funds to the preparation or submission of this brief.

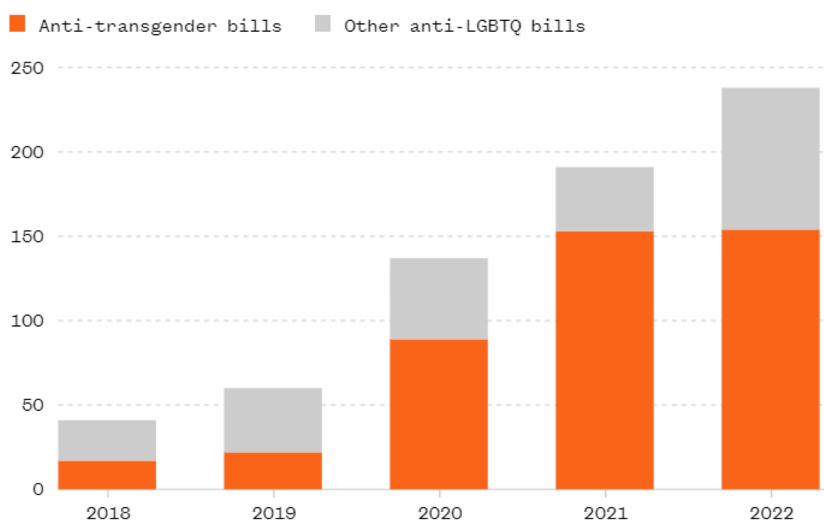
INTRODUCTION

The Iowa Constitution and its requirement of equal protection of the laws is the "foundation[al] principle" of Iowa's government. *Varnum v. Brien*, 763 N.W.2d 862, 877 (Iowa 2009). Equal protection provides a guarantee to every Iowan that "laws treat all those who are similarly situated with respect to the purposes of the law alike." *Id*. at 883. This Court has recognized that "times can blind us to certain truths and later generations can see that laws once thought necessary and proper in fact serve only to oppress." *Id.* at 876 (quoting *Lawrence v. Texas*, 539 U.S. 558, 578–79 (2003)). The Equal Protection Clause "looks forward, serving to invalidate practices that were widespread at the time of its ratification and that were expected to endure." *Id*. at 877 (internal citation omitted).

In March 2019, this Court found that a Department of Human Services regulation prohibiting Medicaid coverage for gender-affirming surgeries discriminated on the basis of gender identity and thereby violated the Iowa Civil Rights Act. *Good v. Iowa Dep't of Hum. Servs.*, 924 N.W.2d 853, 863 (Iowa 2019) (declining to reach equal protection claim). Following that decision, the Iowa legislature enacted Iowa Code § 216.7(3), which has the intended effect of once again denying Medicaid coverage for life-saving, medically necessary surgery to a discrete category of our citizens. This denial of health care for transgender Iowans

represents a continuation of discrimination of the sort prohibited by our foundational principles.

Iowa Code § 216.7(3) is just one example of an unprecedented wave of legislation targeting transgender Americans' access to health care and participation in public life. CNN described 2021 as a "record-breaking year for anti-transgender legislation[.]" *See* Priya Krishnakumar, *This Record-Breaking Year for Anti-Transgender Legislation Would Affect Minors the Most*, CNN (Apr. 15, 2021), https://www.cnn.com/2021/04/15/politics/anti-transgender-legislation-2021/index.html. Lawmakers continue this wave in 2022: an average of more than three anti-LGBTQ bills have been proposed by state lawmakers for each day of 2022, most of them targeting transgender persons. *See* Matt Lavietes & Elliott Ramos, *Nearly 240 Anti-LGBTQ Bills Filed in 2022 So Far, Most of Them Targeting Trans People*, NBC News (Mar. 20, 2022), https://www.nbcnews.com/nbc-out/out-politics-and-policy/nearly-240-anti-lgbtq-bills-filed-2022-far-targeting-trans-people-rcna20418. As of March 15, 2022, 154 bills targeting the transgender community had been introduced across the country, compared to 22 in all of 2019 and 153 in all of 2021. *Id*. The data is illustrated below:



This legislative activity has unfolded against the backdrop of a remarkable increase in deadly violence against transgender and gender diverse Americans. According to Time Magazine, 2021 and 2020 were the deadliest and second deadliest years on record for trans and gender non-conforming people respectively. *See* Madeleine Carlisle, *Anti-Trans Violence and Rhetoric Reached Record Highs Across America in 2021*, Time (Dec. 30, 2021), https://time.com/6131444/2021-anti-trans-violence/.

All Americans will at some point require medically-necessary health care. As discussed below, history shows that access to such health care has been systematically denied to underrepresented populations such as racial minorities and

women as a result of transitory societal prejudice and biases. But this history is also instructive as to the critical role of the judiciary in reframing these issues in the context of our State's and Nation's overarching commitment to equality. Amici ask this Court to take such a role by looking to this history to ensure equal opportunity and access to health care to transgender Iowans. This brief first provides an overview of the historical background of the effort to ensure equal access to health care for racial minorities and women, despite legal and societal barriers, and the crucial role of the judiciary in that process, and then draws the connection between these efforts and the current need for such access for transgender Iowans.

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

Racial discrimination denied Americans equal access to health care, but our courts and laws have ensured that equal access can be enjoyed. Racial discrimination often has manifested in different health care treatment and outcomes for racial minorities than for the majority. Health care laws and systems denied treatment to non-white Americans and created a system of "separate but equal" for medical care access that was ratified by discriminatory regimes. It took a combination of judicial intervention and legislative change to address the problems. And despite revolutionary change, racial minorities still experience health care outcomes that lag behind those of their White counterparts.

African Americans for years have faced a dearth of health care access, no doubt a "function of explicitly racist black codes and Jim Crow laws." Vann R. Newkirk II, *America's Health Segregation Problem*, The Atlantic (May 18, 2016), https://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219/. The racist attitudes that were embodied in the black codes and Jim Crow laws of the South "prevented African Americans from having equal health facilities and equality under the law." Kerri L. Hunkele, *Segregation in United States Healthcare: From Reconstruction to Deluxe Jim Crow* (2014), Honors Theses and Capstones 188, 2, https://scholars.unh.edu/cgi/viewcontent.cgi?article=1189&context=honors ("the worst of these [segregation laws] affected the ability of African Americans to gain access to medical care that was equal to whites").

The discriminatory attitudes imbued in codes and laws kept people's health care separate, solely because of skin color. For example, patients were kept separate in hospitals solely because of their race. 1916 Miss. Laws page 145, Ch. 108 § 8, https://play.google.com/store/books/details?id=7gZGAQAAIAAJ&rdid=book-7gZGAQAAIAAJ&rdot=1 ("The white and colored races shall be kept separate in said hospital, and suitable provisions made for their care and comfort by the board of trustees."). Health care workers were kept separate from patients solely because

of their race. *Jim Crow Laws*, National Park Service, https://www.nps.gov/malu/learn/education/jim_crow_laws.htm#:~:text=Nurses,which%20negro%20men%20are%20placed. ("Nurses / Alabama – No person or corporation shall require any white female nurse to nurse in wards or rooms in hospitals, either public or private, in which negro men are placed."). And even hospital entrances were reserved exclusively for certain people of certain races. *Id.* ("Mississippi: There shall be maintained by the governing authorities of every hospital maintained by the state for treatment of white and colored patients separate entrances for white and colored patients and visitors, and such entrances shall be used by the race only for which they are prepared.").

At the time that these codes and laws were in effect in the American South, others in the United States were ushering in a more equitable provision of health care. In 1959, a nationwide survey determined that 83 percent of Northern hospitals had fully integrated patient admissions, but that same survey recorded that only 6 percent of Southern hospitals had done the same. Emily Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*, Hospital & Health Networks (June 3, 2014), https://emilyfriedman.com/columns/2014-06-03-civil-rights.html. Of the remaining 94 percent of Southern hospitals, which did not have fully integrated admissions systems, 33 percent refused to treat African Americans. *Id.* This racial discrimination resulted in diminished quality of treatment for African American

patients. Hunkele, *Segregation in United States Healthcare: From Reconstruction to Deluxe Jim Crow* at 18.

In 1963, as change was sweeping over the nation and the theory of "separate but equal" was proving unjust, African American patients, doctors, and dentists (joined by the intervening United States Department of Justice) sued two hospitals in North Carolina, seeking to stop the hospitals from denying patients admission based on race and to stop the hospitals from preventing African American doctors and dentists from using the hospital. *See Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959, 961 (4th Cir. 1963) (en banc).

The two defendant hospitals had received federal funds from the Hill-Burton Act (Hospital Survey and Construction Act) 42 U.S.C. § 291 *et seq.*, which gave grants and loans to hospitals to aid increasing service volume and availability. Hill-Burton Free and Reduced-Cost Health Care, Health Resources & Services Administration, https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html. As a program of "cooperative federalism," states designated state agencies to administer the program, oversee health facilities, and develop state plans for health care under the Act. W. David Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, 16 J. Gender Race & Just. 139, 144 (2013), https://www.racism.org/articles/basic-needs/health/access/191-barrierstoaccess/1688-emtalaandaca?showall=1.

The Hill-Burton Act required hospitals receiving funds not to discriminate on the account of race. 42 U.S.C. § 291f(a)(4) (1944). But the Hill-Burton Act allowed the hospitals to meet the nondiscrimination requirement by providing "separate but equal" hospitals. 42 U.S.C. § 291e(f) (1944); *see also* 42 C.F.R. § 53.112 (implementing regulation). Thus, hospitals received government funds and the explicit approval to exclude Americans from fair access to health care.

The plaintiff patients sought access to a hospital that received funds under the Hill-Burton Act and that was allowed to discriminate against the patients. They requested relief that would declare unconstitutional the portions of the Hill-Burton Act (Hospital Survey and Construction Act), 42 U.S.C. § 291e(f), and its promulgated regulation, 42 C.F.R. § 53.112, that allowed the hospitals to be built with funds under the Hill-Burton Act and then distribute health care services under the doctrine of "separate but equal."

An *en banc* panel of the Fourth Circuit agreed with the plaintiffs, and the majority found that the government-authorized segregation in the hospitals was unconstitutional. *Simkins*, 323 F.2d at 969. Hospitals built or running with Hill-Burton Act funding were constructed to provide adequate health services to all people. *Id.* at 970. Separating patients into different groups who could or could not share the same services violated the law and was discriminatory. *See id.* at 969–70. The Fourth Circuit found the Hill-Burton Act's and its regulation's "separate but

equal" allowance unconstitutional and struck the provisions from the statute and regulation. *Id.* The United States Supreme Court denied the hospitals' petition for writ of certiorari, *Moses H. Cone Mem'l Hosp. v. Simkins*, 376 U.S. 938 (1964), and, effectively, *Simkins* became important precedent. *See Eaton v. Grubbs*, 329 F.2d 710, 715 (4th Cir. 1964) (holding hospitals could not discriminate on the basis of race against physicians and patients). Many hospitals receiving Hill-Burton Act funding desegregated. Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*.

The actions of the Fourth Circuit coincided with and had a meaningful impact on the legislative and executive branches. Title VI of the Civil Rights Act, 42 U.S.C. § 2000d *et seq.*, was partly enacted to end racial segregation in health care facilities. *See* Kimani Paul-Emile, *Patient Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. Rev. 462, 489 (2012), http://ir.lawnet.fordham.edu/faculty_scholarship/503; Civil Rights Act of 1964, Legislative History and scope of H.R. 7152: Title VI, 1–2, n.2, https://www.jfklibrary.org/Asset-Viewer/Archives/BMPP-029-009.aspx (noting elimination of any racially discriminatory effect in the Hill-Burton Act and recognizing that Simkins "enjoined non-profit hospitals which received Hill-Burton funds from excluding Negro patients and doctors"). To the framers of Title VI, discrimination at hospitals was "contrary to national policy, and to the moral sense of the nation." *Id.* at 34. In the words of one Senator, Title VI "would

eliminate that kind of confusion [posed by discriminatory laws] and override all such separate-but-equal provisions for the future." 4 Legislative History of the Civil Rights Act of 1964, at 6842 (1964).

With Title VI prohibiting discrimination in federally funded programs on the basis of race, "color," or national origin, President Lyndon B. Johnson's administration attacked "the greatest of all discriminatory evils, differential treatment towards [African Americans] with respect to hospital facilities." Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*. Civil rights proponents pushed for the enforcement of Title VI in Southern hospitals, a push supported by the executive branch. Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, at 145. The Surgeon General encouraged hospitals to comply with Title VI of the Civil Rights Act. Friedman, *U.S. Hospitals and the Civil Rights Act of 1964*, at 5. Hospitals took heed, and, as federal inspectors checked hospital compliance with Title VI, the inspectors noted moderate improvements. *Id.* at 5–6.

When the Medicare and Medicaid programs were put into law in 1965 with the amendment of Social Security, more hospitals dropped discrimination against admission of African Americans at the threat of losing Medicare funding. *Id.* at 6. By the time that Medicare became effective, States had largely agreed to accept Medicare, and by doing so, those States had agreed to accept African American

patients without discrimination. *Id.* (noting that "the day before Medicare became effective" in "all but five Southern states, 80 percent of hospital beds would be available for Medicare patients"). And once again, the courts had an important role to play: those who refused to accept the terms of Title VI became the subjects of enforcement actions that further desegregated hospitals. *See, e.g.*, *Rackley v. Bd. of Trs. of Orangeburg Reg'l Hosp.*, 238 F. Supp. 512, 520 (E.D.S.C. 1965) (enjoining hospital from segregated rooms because the hospital received federal funding and the segregation practice violated Title VI of the Civil Rights Act).

All of this has had a direct and meaningful impact on public health. There is measurable evidence that civil rights progress has had "beneficial effects on the health or on other social determinants of health of racial and ethnic minority populations." R.A. Hahn, B.I. Truman, and D.R. Williams, *Civil rights as determinants of public health and racial and ethnic health equity: Health care, education, employment, and housing in the United States*, SSM – Population Health 4, 17 (2018), https://www.ncbi.nlm.nih.gov/pubmed/29250579. Between 1965 and 1971, the infant mortality rate among non-white Americans fell by 40% while the infant mortality rate for white Americans changed little. *Id.* at 20. The timing and specifics of the non-white infant mortality rate suggests that Civil Rights Act was the cause of the rate drop. *Id.* Researchers believe that the Civil Rights Act of 1964 prevented 38,600 African American infant deaths between

1965 and 2002. *Id.* In a study of African American children born in any state with segregationist policies that were reversed by the Civil Rights Movement, African American children were born healthier after the imposition of the Civil Rights Act of 1964. *Id.* African American women born in the late 1960s and later had higher birthweights and lesser indications of a need for immediate medical care than African American women born earlier did. *Id.* A commitment to equality and fairness—legislatively mandated, judicially enforced—literally improved lives by ensuring full access to health care.

The elimination of explicit racial discrimination in health care has not solved more subtle impacts from health care problems arising from race. Race still affects the quantity and quality of health care provided to racial minorities. Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 San Diego L. Rev. 135, 136 (1998). That includes African Americans, Hispanics and the Latinx community, African immigrants, and Asian and Pacific Islander groups. *Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage*, Centers for Medicare & Medicaid Services (Apr. 2018), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/2018-National-Level-Results-by-Race-Ethnicity-and-Gender.pdf. Stakeholders and allies continue to work towards leveling the field of care for racial and ethnic minorities. *E.g.*, *Racial and Ethnic*

Disparities in Health Care, American College of Physicians (2010), https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf.

In recent years, critics have noted an unequal access to health care. *See* Kay Van Wey, *Unequal Access to Healthcare: The More Things Change, The More Things Stay the Same*, The National Law Review (Aug. 11, 2020), https://www.natlawreview.com/article/unequal-access-to-healthcare-more-things-change-more-things-stay-same. Observers have noted that Title VI "should have" but failed to give equal access to quality health care. *Id.* For racial minorities, their health care access, bias, socioeconomic status, and health have each reacted with one another to create inequity in the provision of health care. *See id.*

This played out for all to see as Americans combated the COVID-19 pandemic. "Black, Hispanic, and Asian people have [had] substantially higher rates of infection, hospitalization, and death compared with White people." Leo Lopez III, MD, et al., *Racial and Ethnic Health Disparities Related to COVID-19*, JAMA Network (Jan. 22, 2021), https://jamanetwork.com/journals/jama/fullarticle/2775687. That is because once infected with COVID-19, marginalized persons have a greater risk for hospitalization due to their increased risk of having a chronic medical comorbidity such as hypertension, obesity, and diabetes and a poorer access to health care. *Id.* It is these roadblocks that have increased the danger of COVID-19 to racial

minorities. “After adjustment for differences in life experiences, the differences in mortality were not statistically significant.” *Id.* “However, unlike in statistical analysis, the differences in life experiences that accrue across racial lines cannot be adjusted away” where “[r]acial or ethnic minority patients in the US often lack health insurance, have greater comorbidities, predominantly live in low-income and often violent neighborhoods, and are dependent on care from less well-funded safety net institutions.” *Id.* In short, despite the reduction or elimination of formal discrimination in the provision of health care, fundamental factors that impact racial minorities continue to invade fair access to health care. The progress in eliminating explicit racial bias in the provision of health care is tempered by the other roadblocks to the fair provision of health care. Nevertheless, the experience of racial minorities in seeking equal access to health care shows that intentional barriers to equal health care access must be eliminated to ensure progress on the other factors that also prevent fair access to health care.

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

Women have also long faced discrimination in the cost and coverage for medical care in the United States. They have been charged more for health coverage based only on gender (a practice known as “gender rating”), and individual marketplace health plans often exclude coverage for services that only women need, such as maternity coverage. Moreover, women have faced—and continue to face—

sexism in receiving treatment, with medical providers ignoring or discounting female complaints based on unsupported views of women as the emotional sex. Even so, while discrimination continues to exist, significant progress has been made in preventing and prohibiting discrimination based on gender in the provision of medical care. And once again, the courts have played a critical role.

In particular, Iowa has progressed to provide greater protections for women's civil rights. In 1966, Iowa enacted the Iowa Civil Rights Act and later amended the Act to explicitly prohibit discrimination on the basis of sex. 1970 Iowa Acts ch. 1058 (codified at Iowa Code ch. 105A (1971)); *see* Iowa Code § 105A.7 (1966). Shortly thereafter, two teachers brought claims of pregnancy discrimination based on their school district's maternity leave policy, which required that teachers could not teach after five months of pregnancy. *Cedar Rapids Cmty. Sch. Dist. v. Parr,* 227 N.W.2d 486 (Iowa 1975). This Court held that pregnancy constituted a temporary disability and that the district's policy that treated pregnant employees differently from disabled employees regarding the imposition and use of leave constituted discrimination under the Iowa Civil Rights Act. *Id.* at 493, 495-96; *cf. Franklin Mfg. Co. v. Iowa Civil Rights Comm'n*, 270 N.W.2d 829, 834 (Iowa 1978) (rejecting a group insurance plan that did not cover pregnancy because it was not an illness or injury); *Quaker Oats Co. v. Cedar Rapids Human Rights Comm'n*, 268 N.W.2d 862, 864, 867 (Iowa 1978) (rejecting a plan that specifically excluded pregnancy from

coverage), *superseded on other grounds by statute*, 1978 Iowa Acts ch. 1179, § 21 (codified at Iowa Code § 601A.19 (1979)). In 1987, the legislature codified *Parr* and its progeny by amending the Iowa Civil Rights Act to prohibit discrimination in the employment context based upon pregnancy. Iowa Code § 601A.6(2) (1989).

Not only have federal and state laws served to guarantee women more equal access to medical care, but courts have continued to defend women's rights to health care, particularly when the government has unconstitutionally restricted access to care in violation of federal or state equal protection law. In 1972, the United States Supreme Court in the seminal case of *Eisenstadt v. Baird* held unconstitutional a Massachusetts state law which allowed married persons to obtain contraceptives to prevent pregnancy but prohibited distribution of contraceptives to unmarried persons. 405 U.S. 438 (1972). In holding the law violated the United States' Constitution's equal protection clause, the Court reaffirmed that the States do not have the "power to legislate that different treatment be accorded to persons placed by a statute into different classes on the basis of criteria wholly unrelated to the objective of that statute." *Id.* at 447. "A classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike." *Id.* (internal quotation and citation omitted). Ultimately, the rights of an unmarried woman's access to contraception must be the same as the

rights of married women.

In sum, courts have often served a pivotal role to ensure women's access to health care. Importantly, courts have struck down laws which limit such access as unconstitutional. And in particular, this Court has long recognized that laws that burden or inhibit access to health care and provide limited health benefits cannot stand in Iowa.

3. Discrimination Against Transgender Americans in Access to and Provision of Health Care, Both Historically and in Light of the COVID-19 Pandemic.

The history of racial and gender discrimination in health care has special resonance for transgender Americans, whose struggles against significant obstacles to access medically necessary care largely mirror the fight for racial and gender equity in health care discussed above. Transgender people experience discrimination in the form of legislative barriers, long delays, and outright denials of medically necessary care. In many areas of the country, medical services are simply unavailable to transgender people. Twenty-nine percent of transgender respondents in a nationwide study reported that a health care provider had refused to see them because of their gender identity. Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Center for American Progress (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimina

tion-prevents-lgbtq-people-accessing-health-care. *See also* Sandy E. James, et al., *The Report of the 2015 U.S. Transgender Survey*, Nat'l Ctr. for Transgender Equality 10, 95–96 (Dec. 2016), https://bit.ly/30aogFp (surveying nearly 28,000 respondents and finding that one in three who saw a provider in the past year had at least one negative experience, such as being refused care, harassed, physically or sexually assaulted, or having to teach the provider about transgender people in order to receive appropriate care); Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* (2010) at 5–6, https://bit.ly/34609Jq (noting that 70% of transgender and gender non-conforming respondents reported having a provider who refused needed care, refused to touch the respondent or used excessive precautions, used harsh or abusive language, blamed the respondent for their health status, or was physically rough or abusive). Over one-quarter of respondents (28%) in another study "reported verbal harassment in a doctor's office, emergency room or other medical setting[.]" Jaime M. Grant, et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, National Center for Transgender Equality and National Gay and Lesbian Task Force (2011).

As a result of this discrimination, one-quarter to one-third of transgender Americans avoid or delay medical care. *See* Mirza, et al. (23% of transgender respondents avoided or delayed medical care as a result of health care

discrimination); Kim D. Jaffee, et al., *Discrimination and Delayed Healthcare Among Transgender Women and Men: Implications for Improving Medical Education and Health Care Delivery*, 54(11) Med Care 1010 (2016), https://pubmed.ncbi.nlm.nih.gov/27314263/ (over 30% of transgender individuals delayed or did not seek health care due to discrimination); Grant, et al. (roughly one-third of transgender Americans delayed both preventative and urgent care due to discrimination/disrespect from health care professionals, while one-half postponed necessary medical care due to inability to afford it). One example of the compounding impact of health care discrimination is that transgender patients who experience discrimination are more likely to attempt suicide, *see also* Jody L. Herman et al., *Suicide Thoughts and Attempts Among Transgender Adults: Findings From the 2015 U.S. Transgender Survey* 21 (2019), https://bit.ly/2HZPp82 (13.4% of respondents who experienced discrimination due to gender identity in the prior year attempted suicide, as compared to 6.3% of those who had not experienced such discrimination). At the same time, transgender people are significantly less likely to receive medical attention and treatment after a suicide attempt. *See* James, et al. (finding that only 45% of transgender survey respondents received medical care following a suicide attempt compared to 60% of the general U.S. population).

Transgender patients were particularly hard-hit by the COVID-19 pandemic, which exacerbated existing gaps in transgender health care access and overall wellbeing. Almost a year to the day after *Good* was decided, the COVID-19 pandemic brought the deadly impact of health care inequality to the forefront of our national consciousness. One recent global study found that "[a]ccess to transgender health care services was restricted for 50%" of transgender respondents during the pandemic. Andreas Koehler, et al., *How the COVID-19 Pandemic Affects Transgender Health Care—A Cross-Sectional Online Survey in 63 Upper-Middle-Income and High-Income Countries*, International Journal of Transgender Health (2021) (preprint version awaiting peer review), https://www.tandfonline.com/doi/epub/10.1080/26895269.2021.1986191?needAccess=true&cookieSet=1. At the same time, as many as 50% of transgender adults "had risk factors for a severe course of a COVID-19 infection and were at a high risk of avoiding COVID-19 treatment due to the fear of mistreatment or discrimination." *Id. See also* Claire M. Burgess, et al., *Impact of the COVID-19 Pandemic on Transgender and Gender Diverse Health Care*, 9(11) The Lancet Diabetes and Endocrinology 729 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8463012/ (finding it "apparent that the pandemic has resulted in exacerbated disparities for transgender and gender diverse people across several crucial determinants of health."); Jody L.

Herman & Kathryn O'Neill, UCLA Sch. L. Williams Inst., *Vulnerabilities to COVID-19 Among Transgender Adults in the U.S.* 1 (2020), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-COVID19-Apr-2020.pdf [https://perma.cc/ZA6D-V4TM] (acknowledging severe impact of novel coronavirus and higher risk for COVID-19 infection among the transgender community).

The national experience with the COVID-19 pandemic tested the rationality of a law intended to improve public health by *denying* medically necessary surgical care. Early in the COVID-19 pandemic, shortages of personal protective equipment (PPE) and other necessary supplies led states and municipalities across the country to prohibit "elective" or "nonessential surgeries."[1] Many hospitals

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[1] On March 26, 2020, Iowa's Governor Kim Reynolds issued a Proclamation to stop all "nonessential or elective surgeries and procedures," https://governor.iowa.gov/sites/default/files/documents/Public%20Health%20Proclamation%20-%202020.03.26.pdf. On April 9, 2020, the Iowa Department of Public Health issued a PPE Shortage Order ordering compliance with the earlier proclamation. https://htv-prod-media.s3.amazonaws.com/files/signed-ppe-shortage-order-final-1586541373.pdf. On April 24, 2020, Governor Reynolds issued another proclamation allowing certain procedures on a very limited basis. https://www.mcguirewoods.com/ client-resources/Alerts/2020/10/state-governors-stay-at-home-prohibition-elective-procedures-orders. *See also* Centers for Medicare & Medicaid Services, *Non-Emergent, Elective Medical Services, and Treatment Recommendations* (Apr. 7 2020), https://www.cms.gov/sites/default/files/2020-04/CMS%20recommendations%20Non-emergent%20Elective%20Medical%20Service.%202%20final_.508C-rev.pdf.

renewed these restrictions on surgical care in response to the Delta and Omicron surges. *See* Andréa Becker, *It's Time to Stop Describing Lifesaving Health Care as "Elective,"* Vox (Sept. 20, 2021), https://www.vox.com/22678393/elective-surgery-nonessential-trans-gender-affirming-hysterectomy; Will Stone, *Americans Get Sicker as Omicron Stalls Everything From Heart Surgeries to Cancer Care*, National Public Radio (Feb. 4, 2022), https://www.npr.org/sections/health-shots/2022/02/04/1078029696/americans-get-sicker-as-omicron-stalls-everything-from-heart-surgeries-to-cancer. The consequences of forcing millions of Americans to participate in a natural experiment testing the rationality of withholding medically necessary surgical care with the goal of protecting public health were dire.

COVID-19 surgical restrictions, intended to promote public health by conserving resources, "affected everything from hip replacements to cataract surgeries to colonoscopies[.]" *See* Becker, *It's Time to Stop Describing Lifesaving Health Care as "Elective"* (explaining that "[t]he term 'elective care' can be misleading… doctors use the word to describe pretty much any procedure that can be scheduled in advance."). In some instances, the mandates even impacted heart surgeries. *See* Islam Shehata, et al., *Elective Cardiac Surgery During the COVID-19 Pandemic*, 34(3) Best Practice & Research Clinical Anaesthesiology 643 (2020), https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC7368150/. As a result of

these policies, preventable cancers progressed, suffering was prolonged, mortality increased, and long-term public health costs soared. *See, e.g.*, Sue J. Fu, et al., *The Consequences of Delaying Elective Surgery*, 272(2) Annals of Surgery 79 (2020), https://www.ncbi.nlm.nih.gov/pmc/ articles/PMC7224620/; Brett A. Johnson, et al., *Impact of Surgery Delays on Cancer Survival Rates: A Systematic Review and Meta-Analysis of Surgery Delays and Survival in Breast, Lung and Colon Cancers: Implication for Surgical Triage During the COVID-19 Pandemic*, 222(2) American Journal of Surgery 311 (2021), https://doi.org/10.1016/j.amjsurg. 2020.12.015 (finding that "[d]elaying breast, lung and colon cancer surgeries during the COVID-19 pandemic may decrease survival."); *see also* Reed Abelson, *'I Just Cry All the Time': Non-Covid Patients Despair Over Delayed Care*, New York Times (Sept. 22, 2021), https://www.nytimes.com/2021/ 09/22/health/covid-hospitals-elective-surgeries.html; Stone, *Americans Get Sicker as Omicron Stalls Everything From Heart Surgeries to Cancer Care*. COVID-19 resource shortages essentially forced a facially non-discriminatory application of Appellant's stated reasoning in this case to the general population, and the results demonstrated unequivocally that denying medically necessary surgical care *harms* public health and increases public health costs.

COVID-19 surgical delays inadvertently previewed the devastating and deadly effects that a law denying medically necessary surgical care will have on

transgender patients. These policies "effectively closed the door on all gender-affirming procedures and further delayed access to medically necessary procedures for transgender and gender diverse people." *See, e.g.*, Burgess, et al., *Impact of the COVID-19 Pandemic on Transgender and Gender Diverse Health Care*; *see also* CBC, *COVID-19 Delaying Life-Saving Transgender Surgeries, Doctor Warns* (Oct. 9, 2021), https://www.cbc.ca/news/canada/ edmonton/covid-19-delaying-life-saving-transgender-surgeries-doctor-warns-1.6199069. Even these temporary surgical pauses directly contributed to negative health outcomes for transgender patients, and researchers predict that the delays will continue to disrupt access to transgender health care for years to come. Medical professionals and medical research organizations have long recognized the deadly consequences of delaying or denying care to transgender patients. Even before the pandemic, a comprehensive survey of 27,000 transgender individuals found that an astonishing 40 percent had reported a suicide attempt. *See* James et al. at 114; Len Sandler, et al., *Where Do I Fit In? A Snapshot of Transgender Discrimination in Iowa*, Rainbow Health Clinic University of Iowa Law and Policy in Action Clinic (2016) at 15 (finding that 46% of Midwestern transgender respondents attempted suicide, compared to 1.6% of the general population). After the start of the pandemic, the Trans Lifeline reported an 89% *increase* in calls related to suicidal ideation. *See* Trans Lifeline, *Trans Lifeline's Data During a Pandemic* (June 12, 2020),

https://translifeline.org/trans-lifelines-data-during-a-pandemic/. Calls from transgender people unable to access medical care doubled. *Id*. Surgical bans also made treatment more dangerous, as transgender patients lost surgery dates that would have allowed them to avoid pay gaps and arrange care. Kaye Loggins, *As Hospitals Prepare for Covid-19, Life-Saving Trans Surgeries Are Delayed*, Vice (Mar. 19, 2020), https://www.vice.com/en/article/wxekyz/ transgender-surgeries-delayed-coronavirus-hospitals. It is "likely that access to care will be substantially delayed for all [transgender] individuals seeking gender-affirming care in the coming years. This causes many [transgender] individuals to live in the difficult twilight zone between assigned sex and experienced gender identity for an extended period." Anna I.R. van der Miesen, et al., *"You Have to Wait a Little Longer": Transgender (Mental) Health at Risk as a Consequence of Deferring Gender-Affirming Treatments During COVID-19*, 49 Archives of Sexual Behavior 1395 (2020), https://doi.org/10.1007/s10508-020-01754-3. This "twilight zone," in turn, makes it difficult for transgender individuals to maintain employment, obtain housing, avoid harassment in public spaces, travel, and even exercise their right to vote.

The judiciary has an important role to play in ensuring that these harms are not magnified by legislation that singles out and targets a politically vulnerable minority group. Multiple studies confirm that when discrimination against

marginalized communities is state-sanctioned, the harm is particularly acute. A study examining Title VII complaints alleging sexual orientation and gender identity discrimination found that, in states with no state law protections specific to such discrimination, people reported more overt forms of employment discrimination- such as discharge or harassment-than counterparts in states with such protections. Amanda K. Baumle et al., *New Research on Sexual Orientation and Gender Identity Discrimination: Effect of State Policy on Charges Filed at the EEOC*, 67 J. Homosexuality 1135, 1140–42 (2020), https://bit.ly/3nlp4kT. Another study found that LGBT people living in states with no state-level sexual orientation and gender identity protections experienced larger disparities in health insurance coverage and household income than LGBT people living in states with such protections. Amira Hasenbush et al., *The LGBT Divide: A Data Portrait of LGBT People in the Midwestern, Mountain & Southern States* at 13, 15–16 (2014), https://bit.ly/3kR3Yc8.

The national experience with the COVID-19 pandemic demonstrates that denying medically necessary care *harms* public health and is particularly damaging to transgender Americans and Iowans. Short-term, good-faith triage efforts guided by experienced medical professionals already resulted in inadvertent but serious harms to transgender patients during the COVID-19 response. These harms will be multiplied many times over by a blanket denial of such surgical care by the state

through a law which specifically singles out transgender Iowans with the sole purpose of denying them medical care.

CONCLUSION

Discrimination against vulnerable minorities does not improve public health. State-sanctioned denial of medically necessary surgeries will not lead to a healthier Iowa. And it is irreconcilable with Iowa's and our Nation's deep and abiding commitment to equal protection of all citizens. Courts have historically played a critical role in ensuring that this commitment is honored, even in the face of societal prejudices and biases. Amici urge this Court to fulfill its role in ensuring that Iowa lives up to the promises of equal protection and treatment enshrined in the Iowa Constitution and to affirm the ruling of the district court.

CERTIFICATE OF COMPLIANCE

This brief complies with the typeface requirements and type-volume limitation of Iowa Rs. App. P. 6.903(1)(d) and 6.903(1)(g)(1) or (2) because:

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_*/s/ Devin C. Kelly*_______________ ___6/24/2022_______
Signature Date

CERTIFICATE OF SERVICE

I hereby certify that on June 24, 2022, I electronically filed the foregoing document with the Clerk of the Supreme Court by using the Iowa Judicial Branch electronical filing system which will send a notice of electronic filing to the following:

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