

1 Brent P. Ray (*pro hac vice* forthcoming)
2 Andrew J. Chinsky (*pro hac vice* forthcoming)
3 KING & SPALDING LLP
4 353 N. Clark Street, 12th Floor
5 Chicago, Illinois 60654
6 T: +1 312 995 6333
7 F: +1 312 995 6330
8 Email: bray@kslaw.com
9 achinsky@kslaw.com

6 Daniel C. Barr (Bar No. 010149)
7 Janet M. Howe (Bar No. 034615)
8 PERKINS COIE LLP
9 2901 N. Central Avenue, Suite 2000
10 Phoenix, AZ 85012-2788
11 T: +1 602 351 8085
12 F: +1 602 648 7085
13 Email: dbarr@perkinscoie.com
14 jhowe@perkinscoie.com

11 *Counsel for Plaintiffs and the Class*
12 (Additional Counsel on Signature Page)

13 UNITED STATES DISTRICT COURT
14 DISTRICT OF ARIZONA

14 D.H., by and through his mother, Janice)
15 Hennessy-Waller; and John Doe, by his)
16 guardian and next friend, Susan Doe, on)
17 behalf of themselves and all others)
18 similarly situated,)

19 Plaintiffs,)

20 vs.)

19 Jami Snyder, Director of the Arizona)
20 Health Care Cost Containment System,)
21 in her official capacity,)

22 Defendant.)

No.

**COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF**

23 Plaintiffs D.H. and John Doe respectfully state and allege as follows

24 **PRELIMINARY STATEMENT**

25 1. D.H. is a seventeen-year-old transgender Arizona resident enrolled in
26 Arizona’s Medicaid program, known as the Arizona Health Care Cost Containment
27 System (“AHCCCS”). John Doe is a fifteen-year-old transgender Arizona resident
28 enrolled in AHCCCS. D.H. and John bring this lawsuit on behalf of themselves and

1 similarly situated individuals to challenge Arizona’s categorical prohibition of coverage
2 of medically necessary treatments for gender dysphoria, specifically, male chest
3 reconstruction surgery.

4 2. Gender dysphoria refers to the distress that can result from the incongruence
5 between a person’s gender identity and their assigned sex at birth. Gender dysphoria is a
6 serious medical condition that, if left untreated, can cause anxiety, depression, and even
7 self-harm or suicidal ideation.

8 3. Gender-confirming medical treatments—including male chest
9 reconstruction surgery—are safe, effective, and medically necessary to treat gender
10 dysphoria in many transgender individuals, including adolescents.

11 4. A longstanding Arizona regulation, promulgated in 1982 and enforced by
12 AHCCCS, expressly prohibits Medicaid coverage for “gender reassignment surgeries.”
13 Ariz. Admin. Code R9-22-205-B.4(a) (“Challenged Exclusion”). Because of the
14 Challenged Exclusion, D.H., John, and similarly situated individuals have been denied or
15 prevented from obtaining Medicaid coverage for medically necessary male chest
16 reconstruction surgery.

17 5. Both D.H. and John have been diagnosed with gender dysphoria. Although
18 identified as female at birth, D.H. and John are male and live as male in every aspect of
19 their lives.

20 6. D.H. first became aware of his male gender identity around the age of four.
21 Frustrated and angry at his inability to communicate that he was transgender to his mother,
22 D.H. developed significant psychological distress at an early age, including severe anxiety
23 and suicidal ideation. Concerned for his safety and well-being, D.H.’s mother, Janice,
24 placed him in a psychiatric treatment facility on several occasions.

25 7. At thirteen, D.H. developed the confidence to tell Janice that he is
26 transgender. Janice then arranged for D.H. to see a mental health provider with experience
27 working with transgender youth. With the recommendation and support of his health care
28 providers, D.H. began to transition to live in accordance with his gender identity. As part

1 of the treatment for his gender dysphoria, D.H. started taking testosterone to masculinize
2 his body

3 8. Just before turning thirteen, D.H. started wearing a binder to flatten his
4 chest, which alleviates his gender dysphoria, but significantly impairs his ability to
5 function. The pain and discomfort caused by wearing the binder interferes with D.H.'s
6 ability to focus on school and homework. The binder also prevents him from engaging in
7 prolonged or intense physical activity, especially dance, which had previously been a
8 source of relief for D.H.

9 9. Last year, D.H.'s pediatrician and his therapist recommended that he obtain
10 male chest reconstruction surgery to further alleviate his gender dysphoria. However, prior
11 authorization for this surgery was denied due to the Challenged Exclusion.

12 10. John started becoming aware of his male gender identity when he was about
13 eleven years old and his body began showing the first signs of puberty. Worried that his
14 family would reject him for being transgender, John kept everything he was going through
15 to himself and began to experience depression and suicidal ideation.

16 11. After about six months, John recognized that he needed help and reached
17 out to his sister, and then eventually told his grandmother, Susan, both of whom were
18 supportive. John started using a male name and pronouns, which helped to alleviate his
19 gender dysphoria to some degree.

20 12. In November 2018, John began seeing a specialist at the Gender Support
21 Program at Phoenix Children's Hospital.

22 13. Like D.H., John also wears a binder, which is very tight and restrictive. Even
23 with the binder, John feels uncomfortable being outside without layers of clothing. He
24 wears a hooded sweatshirt nearly every day, including in the summer. John's chest also
25 hinders his social interactions. For example, John wears his binder and a t-shirt when at
26 the pool, often having to answer uncomfortable questions about why he insists on wearing
27 a t-shirt in the water.

28

1 **THE PARTIES**

2 21. Plaintiff D.H. is a seventeen-year-old boy who has been diagnosed with
3 gender dysphoria. D.H. resides in Pima County, Arizona and brings this action through his
4 mother, Janice Hennessy-Waller. Due to his family's limited income, D.H. is eligible for
5 Arizona's Medicaid program. D.H. has been enrolled in Arizona's Medicaid program at
6 all relevant times.

7 22. Plaintiff John Doe is a fifteen-year-old boy who has been diagnosed with
8 gender dysphoria. John resides in Maricopa County, Arizona and brings this action through
9 his grandmother and legal guardian, Susan Doe. Due to his family's limited income, John
10 is eligible for Arizona's Medicaid program. John has been enrolled in Arizona's Medicaid
11 program at all relevant times.

12 23. Defendant Jami Snyder is the Director of AHCCCS, the single-state agency
13 that administers Arizona's Medicaid program. As such, she has a duty to ensure that the
14 AHCCCS program is administered in accordance with federal Medicaid law. Defendant
15 Snyder is sued in her official capacity.

16 **STATEMENT OF FACTS**

17 ***Gender Identity and Gender Dysphoria***

18 24. Gender identity is an innate, internal sense of one's sex—*i.e.*, being male or
19 female—and is a core, hard-wired aspect of a person's identity. Everyone has a gender
20 identity. Most people's gender identity is consistent with the sex they were assigned at
21 birth ("assigned sex"). Transgender people, however, have a gender identity that differs
22 from their assigned sex. A transgender man is a man who was assigned female at birth but
23 has a male gender identity. A transgender woman is a woman who was assigned male at
24 birth but has a female gender identity.

25 25. Gender identity and transgender status are inextricably linked to one's sex
26 and are sex-related characteristics.

27 26. Around the onset of puberty, many transgender youth experience a level of
28 psychological distress that significantly interferes with their overall wellbeing and ability

1 to function. For some transgender youth, that distress becomes debilitating and can lead
2 to a severe decline in mental health.

3 27. That distress stems, in part, from the visible physical changes that
4 accompany puberty. Those physical changes undermine a transgender young person's
5 ability to live in a manner consistent with their gender identity, exacerbating their
6 psychological distress. Even basic daily tasks, such as bathing and getting dressed, can
7 become emotionally paralyzing because those tasks are painful reminders of the
8 disconnect between a transgender young person's body and their gender identity. In
9 addition, a transgender boy who has begun to develop breasts is more likely to be mistaken
10 for female, a probability that serves as a constant source of anxiety. The psychological
11 distress transgender youth experience is further heightened by the reality that some of
12 those physical changes may be irreversible, permanently constricting their future
13 treatment options and negatively affecting their quality of life. Consequently, timely
14 treatment is critical.

15 28. This significant increase in distress causes many transgender youth who had
16 previously delayed disclosing that they are transgender to set aside their fears of rejection
17 and ask for help from family. With the permission of their parents or legal guardians, a
18 transgender young person can begin accessing the health care services needed to alleviate
19 their psychological distress. That distress is commonly referred to as gender dysphoria.

20 29. Gender dysphoria is a serious medical condition recognized by the
21 American Psychiatric Association. Am. Psychiatric Ass'n, *Diagnostic and Statistical*
22 *Manual of Mental Disorders* (5th ed. 2013) ("DSM-5").¹ Gender dysphoria refers to the

24 ¹ Earlier editions of the DSM included a diagnosis referred to as "Gender Identity
25 Disorder." The DSM-5 noted that Gender Dysphoria "is more descriptive than the
26 previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical
27 problem, not identity *per se*." Being diagnosed with gender dysphoria "implies no
28 impairment in judgment, stability, reliability, or general social or vocational capabilities."
Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender &*
Gender Variant Individuals (2012), at <https://goo.gl/iXBM0S>.

1 distress that can result from the incongruence between a person’s gender identity and their
2 assigned sex. If left untreated, gender dysphoria can cause anxiety, depression, and even
3 self-harm or suicidal ideation. Gender dysphoria is often heightened “when physical
4 interventions by means of hormones and/or surgery are not available.” *Id.* at 451. Access
5 to appropriate, individualized medical care can mitigate and often prevent all of those
6 symptoms.

7 30. Gender dysphoria is highly treatable. As with other medical conditions,
8 health care providers follow a well-established standard of care when working with
9 patients with gender dysphoria. The World Professional Association for Transgender
10 Health (“WPATH”), and its predecessors, has set those standards for over four decades.

11 31. WPATH is an international, multidisciplinary, professional association of
12 medical providers, mental health providers, researchers, and others, with a mission of
13 promoting evidence-based care and research for transgender health, including the
14 treatment of gender dysphoria. WPATH published the seventh and most recent edition of
15 the Standards of Care in 2011.

16 32. Building on those standards and incorporating the most current research and
17 clinical experience, the Endocrine Society released the Endocrine Treatment of Gender-
18 Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice
19 Guideline in September 2017. Those guidelines reaffirm the WPATH Standards of Care
20 and offer medical providers practical guidance on providing transition-related care to
21 patients with gender dysphoria, including young people.

22 33. The WPATH and the Endocrine Society standards have been adopted by
23 many major associations of healthcare professionals, including the American Medical
24 Association, American Psychiatric Association, and American Psychological Association,
25 as well as associations of healthcare professionals focused on youth and adolescents, such
26 as the American Academy of Pediatrics, American Association of Child and Adolescent
27 Psychiatrists, and the Pediatric Endocrine Society. Federal courts across the country have
28

1 also recognized the standards of these medical societies as setting the prevailing standard
2 of care for the treatment of gender dysphoria.

3 34. A key component of treating gender dysphoria is a “social transition,” in
4 which the individual lives in accordance with their gender identity in all aspects of life.
5 Though specific to each person, a social transition typically includes adopting a new first
6 name, using and asking others to use pronouns reflecting the individual’s true gender,
7 wearing clothing typically associated with that gender, and using sex-specific facilities
8 corresponding to that gender.

9 35. Studies and anecdotal evidence demonstrate the tremendous mental health
10 benefits transgender youth experience following a social transition. One study found that
11 the mental health profile of transgender children who underwent a social transition was
12 nearly identical to that of their nontransgender peers. Kristina Olson et al., *Mental Health*
13 *of Transgender Children Who Are Supported in Their Identities*, 137 *Pediatrics* 1 (2016).
14 Another study found that transgender young people who were referred to by the correct
15 name and pronoun throughout their daily lives demonstrated a seventy-seven percent
16 decrease in severe depressive symptoms. Stephen Russell et al., *Chosen Name Use is*
17 *Linked to Reduced Depressive Symptoms, Suicidal Ideation and Behavior among*
18 *Transgender Youth*, 63 *J. of Adolescent Health* 503 (2018). The success of a social
19 transition hinges on parents, extended family, peers, and others in the community treating
20 the individual consistently with their gender identity.

21 36. Consistent with the standard of care, many transgender individuals also need
22 health care services that alter their physical characteristics to bring their outer appearance
23 into alignment with their gender identity. The purpose of the services is to enable a
24 transgender person to live consistently with their gender identity in every aspect of their
25 life. This alleviates a transgender individual’s gender dysphoria by reducing the
26 incongruence between their assigned sex and gender identity. Those treatments also ensure
27 that they are seen by others in a way that reflects their true gender, addressing a significant
28 source of distress.

1 37. For transgender youth who have entered puberty, these health care services
2 may include hormone-replacement therapy and surgery. Hormone-replacement therapy
3 ensures that transgender people develop physical sex characteristics typical of their gender
4 identity—not their assigned sex—such as facial and body hair in boys and breasts in girls.

5 38. The prevailing standards of care for the treatment of gender dysphoria
6 recognize that transgender males may need male chest reconstruction surgery before
7 turning eighteen. A prerequisite for male chest reconstruction surgery is a referral letter
8 from the young person’s treating mental health provider. That letter provides the surgeon
9 with a psychological assessment of the patient and the clinical rationale(s) for the referral
10 and confirms that the patient is capable of consenting to the procedure.

11 39. The purpose of the surgery is functional. Following the surgery, a
12 transgender male is more readily seen as male, improving the effectiveness of their social
13 transition because they are less likely to be mistaken for female, which can significantly
14 reduce the anxiety and dysphoria they experience. The surgery also improves their self-
15 image because they no longer have to see or wear a binder to hide a part of their body that
16 causes so much physical pain and psychological distress. As a result, transgender males
17 who have had male chest reconstruction surgery experience fewer barriers to engaging in
18 physical activity, among other physical and mental health benefits.

19 40. As with other treatments for gender dysphoria, both scientific research and
20 clinical evidence highlight the importance of male chest reconstruction surgery in the
21 treatment of gender dysphoria in transgender males.

22 ***The Federal Medicaid Act***

23 41. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-5, creates
24 the Medicaid program—a cooperative federal-state program that provides health care
25 services to specified categories of individuals meeting income and other criteria. The
26 objective of Medicaid is to enable states to “furnish [] medical assistance” to individuals
27 “whose income and resources are insufficient to meet the cost of necessary medical
28

1 services” and to provide “rehabilitation and other services to help such families and
2 individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1.

3 42. States are not required to participate in the Medicaid program. States that
4 choose to participate must comply with the federal Medicaid Act and its implementing
5 regulations.

6 43. In return, the federal government reimburses each participating state for a
7 substantial portion of the cost of providing medical assistance. *See id.* §§ 1396b(a),
8 1396d(b), 1396(c).

9 44. The Medicaid Act requires each participating state to establish or designate
10 a single state agency that is responsible for administering or supervising the administration
11 of the state’s Medicaid program. *Id.* § 1396a(a)(5); 42 C.F.R. § 431.10.

12 45. In addition, each participating state must maintain a comprehensive plan for
13 medical assistance approved by the Secretary of the U.S. Department of Health and
14 Human Services. *Id.* § 1396a. The plan must describe the state’s program and affirm its
15 commitment to comply with the Medicaid Act and its implementing regulations.

16 46. While a state is entitled to delegate certain of its responsibilities to other
17 entities, such as local agencies or Medicaid managed care plans, the single state agency is
18 ultimately responsible for ensuring compliance with all aspects of federal Medicaid law.
19 *See, e.g.,* 42 C.F.R. §§ 438.100(a)(2), 438.100(d).

20 47. Under the Medicaid Act, a participating state must provide medical
21 assistance to certain eligibility groups. *Id.* § 1396a(a)(10)(A)(i). One mandatory eligibility
22 category is children and adolescents under age 18 whose household income is below 133%
23 of the federal poverty level. *Id.* §§ 1396a(a)(10)(A)(i)(VI)-(VII), 1396a(l).

24 ***The Medicaid Early and Periodic Screening, Diagnostic and Treatment***
25 ***Requirements***

26 48. The Medicaid Act requires states to cover certain services and gives them
27 the option to cover other services. *Id.* §§ 1396a(a)(10)(A), 1396d.

28

1 49. Each participating state must cover Early and Periodic Screening,
2 Diagnostic and Treatment (“EPSDT”) for individuals under age 21. *Id.* §§
3 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

4 50. EPSDT’s fundamental purpose is to “[a]ssure that health problems are
5 diagnosed and treated early, before they become more complex and their treatment more
6 costly.” *Ctrs. for Medicare & Medicaid Servs., State Medicaid Manual* § 5010.B.

7 51. As part of providing EPSDT, states must:

- 8 a. Inform all persons in the state who are under the age of 21 and who
9 are eligible for Medicaid of the availability of EPSDT as described
10 in 42 U.S.C. § 1396d(r);
11 b. Provide or arrange for screening services in all cases where they are
12 requested as required by § 1396d(r)(5); and
13 c. Arrange for (directly or through referral) corrective treatment for any
14 conditions identified by the screening services as required by
15 § 1396a(a)(43)(C).

16 52. Pursuant to the EPSDT requirements, states must cover four specific,
17 separate categories of screening services: medical, vision, dental, and hearing. 42 U.S.C.
18 § 1396d(r)(1)-(4).

19 53. States also must cover “[s]uch other necessary health care, diagnostic
20 services, treatment, and other measures described in [§ 1396d(a)] to correct or ameliorate
21 defects and physical and mental illnesses and conditions discovered by the screening
22 services, whether or not such services are covered under the State plan.” *Id.* § 1396d(r)(5).
23 In other words, the EPSDT mandate requires states to cover all necessary Medicaid
24 services for individuals under age 21.

25 54. EPSDT services must be initiated in a timely manner, as the individual needs
26 of the child require, and must be consistent with accepted medical standards, no later than
27 six months from the date of request. 42 C.F.R. § 441.56(e).

28

1 55. Surgery to treat gender dysphoria, including male chest reconstruction
2 surgery, is an EPSDT service under § 1396d(r)(5).

3 ***The Medicaid Comparability Requirement***

4 56. Under the Medicaid Act, “the medical assistance made available to any
5 individual . . . shall not be less in amount, duration or scope than the medical assistance
6 made available to any other such individual.” *Id.* § 1396a(a)(10)(B)(i). *See also* 42 C.F.R.
7 § 440.240(b).

8 57. A state “Medicaid agency may not arbitrarily deny or reduce the amount or
9 scope of a required service . . . to an otherwise eligible recipient solely because of the
10 diagnosis, type of illness, or condition.” 42 C.F.R. § 440.230(c).

11 58. States must also ensure that “[e]ach service must be sufficient in amount,
12 duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b).

13 ***The Arizona Medicaid Program***

14 59. Arizona participates in Medicaid, calling its program the Arizona Health
15 Care Cost Containment System (“AHCCCS”). Ariz. Rev. Stat. §§ 36-2901 to 2972.

16 60. AHCCCS is also the name of the single-state Medicaid agency that is
17 responsible for administering and implementing Arizona’s Medicaid program consistent
18 with the requirements of federal law. *See* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

19 61. AHCCCS contracts with private managed care plans to provide health care
20 services to Medicaid enrollees. *See* AHCCCS, Available Health Plans,
21 [https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans](https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html)
22 [.html](https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html) (listing the eight Medicaid managed care plans operating in the State).

23 62. The federal government reimburses Arizona for approximately seventy
24 percent of its expenditures on health care services. U.S. Dep’t of Health & Human Servs.,
25 Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares
26 for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or
27 Disabled Persons for October 1, 2020 Through September 30, 2021, 84 Fed. Reg. 66204,
28 66204 (Dec. 3, 2019).

1 ***Arizona’s Exclusion on Surgical Care for Transgender Medicaid Beneficiaries***

2 63. Since 1982, an Arizona regulation (the “Challenged Exclusion”) has
3 prohibited AHCCCS coverage for “gender reassignment surgeries.” Ariz. Admin. Code
4 R9-22-205-B.4(a). The Challenged Exclusion has been applied since that time to deny
5 coverage to transgender AHCCCS beneficiaries seeking male chest reconstruction
6 surgery.

7 64. Arizona has singled out transition-related surgical care for an express
8 exclusion even though AHCCCS covers the same surgical services to treat other health
9 conditions. *See, e.g.*, Ariz. Admin. Code R9-22-2004(A)(4), AHCCCS Medical Policy
10 Manual, § 310-C Breast Reconstruction After Mastectomy (2018),
11 <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310C.pdf>.

12 65. The Challenged Exclusion has no medical or scientific basis. To the
13 contrary, for many transgender people, including adolescents, surgical care is medically
14 necessary to treat gender dysphoria.

15 66. Contrary to the prevailing standard of care for the treatment of gender
16 dysphoria, Defendant continues to enforce the Challenged Exclusion against transgender
17 Medicaid recipients, even those covered under EPSDT, including D.H. and John.

18 67. On information and belief, many transgender AHCCCS recipients have
19 been deterred from seeking prior authorization for transition-related surgeries because of
20 their knowledge, or the knowledge of their medical providers, that the Challenged
21 Exclusion would make such requests futile.

22 ***D.H.’s Gender Dysphoria and Need for Surgical Treatment***

23 68. D.H. was identified as female at birth but has known that he is male since
24 age four.

25 69. As a young child, D.H. struggled to express to his mother that he is male.
26 Nothing he said or did got the result he had hoped for; Janice, D.H.’s mother, continued
27 to treat him as a girl. As a result, D.H. began exhibiting signs of significant psychological
28

1 distress including depression, prolonged crying episodes, anxiety, and insomnia. The
2 severity of D.H.'s distress led his mother to seek the advice of mental health professionals.

3 70. When he was about eleven years old, the stress related to his gender
4 identity—combined with the other stressors D.H. was trying to navigate—was so
5 overwhelming that D.H. started losing his hair. He was eventually hospitalized for
6 intensive psychiatric treatment.

7 71. Following his hospitalization, Janice enrolled D.H. in dance class, hoping it
8 would provide D.H. a healthy way to cope with his distress. The movements were like
9 therapy to him. Dance also became a social outlet; he made friends and felt a sense of
10 belonging. It was the only thing in his life that could make him feel better. By the
11 following year, D.H. was enrolled in three different dance classes: ballet, modern, and
12 jazz.

13 72. That euphoria ended later that year once puberty began. Because of D.H.'s
14 increasing chest size, dance no longer provided the same psychological release it once
15 had. D.H. hated his body and everything that came with it. His thoughts and fears about
16 experiencing puberty—with its associated physical changes that would take his body even
17 further out of alignment with his gender identity—became all-consuming and significantly
18 affected his ability to function. D.H. hid his changing body under baggy clothes and hated
19 being perceived as a girl at school.

20 73. D.H. began using a variety of methods to flatten his chest, from multiple
21 sports bras and Ace bandages to duct tape, so that his appearance better aligned with his
22 gender identity. Those initial attempts were extremely uncomfortable and irritated his
23 skin. Needing a better and safer solution, D.H. secretly bought his first binder, an article
24 of clothing that compresses a person's chest, giving the appearance of a flat chest. Putting
25 on the binder gave D.H. a sense of relief that no amount of therapy or medication had ever
26 given him. It also eventually helped him gain the confidence to tell his mother what he
27 struggled to express as a child: "I am a boy."
28

1 74. Janice was supportive but sought out the advice of health care providers with
2 experience working with transgender youth before making any decisions regarding next
3 steps.

4 75. Soon after disclosing to his mother that he is transgender at age thirteen,
5 D.H. started seeing Tamar Reed, a therapist who specializes in treating gender dysphoria
6 in children and adolescents. After carefully assessing D.H.'s mental health, Ms. Reed
7 recommended that D.H. begin to transition to living as male. D.H. started using a male
8 name and asked that others refer to him using that name and masculine pronouns. He also
9 changed his hairstyle and started wearing boys' clothing.

10 76. D.H.'s social transition provided him with much-needed psychological
11 relief. He was regularly being referred to by a male name and pronouns and treated as
12 male by those around him.

13 77. Nevertheless, D.H.'s distress continued to build.

14 78. A few months before his fourteenth birthday, the depression and suicidal
15 ideation became overwhelming. Janice noticed a change in D.H.'s personality and that he
16 had started distancing himself from his peers and activities that had previously brought
17 him joy. Then, following a dance competition in January 2017, D.H.'s mental health
18 decompensated significantly. Out of concern for his safety and wellbeing, D.H. was
19 admitted to a ten-day intensive psychiatric treatment program.

20 79. Following that treatment program, his health care providers recommended
21 that he start hormone-replacement therapy to further his social transition—that treatment
22 would both halt the effects of estrogen and make his appearance more typically masculine.
23 D.H.'s pediatrician referred him to a pediatric endocrinologist for this treatment and
24 related specialty care. D.H. received his first shot of testosterone in November 2017.

25 80. The testosterone has caused D.H.'s voice to deepen, he has grown facial
26 hair, and he has developed a more masculine musculature. The testosterone, however,
27 cannot reverse the physical changes that had already occurred prior to D.H.'s transition,
28 particularly chest development.

1 81. Because of the prominent appearance of his chest, D.H.'s binder continues
2 to be one of his most important pieces of clothing. Although binders are not supposed to
3 be worn for more than seven to eight hours a day, D.H. regularly wears his binder for ten
4 hours a day, and at least twice per week D.H. wears it for longer than ten hours. On
5 occasion, D.H. has worn his binder for multiple consecutive days. He even struggles to
6 take the binder off at home, where feels the most comfortable being himself.

7 82. Keeping the binder on that long is uncomfortable and painful. The effort it
8 takes to ignore the pain interferes with D.H.'s ability to focus on school, particularly
9 homework, as D.H.'s discomfort compounds throughout the day. The compression from
10 the binder also prevents him from breathing too deeply. In fact, D.H.'s current
11 pediatrician, Dr. Andrew Cronyn, remarked that D.H.'s binder contributed to him
12 developing asthma in adolescence and needing an inhaler to engage in extended physical
13 activity.

14 83. While taking testosterone and using the binder have improved D.H.'s mental
15 health, D.H. continues to experience significant gender dysphoria because of his chest.
16 The benefits of using a binder were—and continue to be—temporary and imperfect. The
17 binder dampens the distress D.H. feels during the day, but once he removes the binder at
18 night, D.H.'s distress intensifies. And, even with the binder, D.H. continues to be mistaken
19 for female, exacerbating his anxiety around interacting with unfamiliar people.

20 84. D.H.'s distress began compounding again and, in September 2018, D.H. was
21 placed in an intensive psychiatric treatment program for a third time due to suicidal
22 ideation. D.H. was fifteen-years old at that time.

23 85. The mental health treatment D.H. received following that hospitalization
24 helped him develop more effective strategies for coping with the distress caused by gender
25 dysphoria and the appearance of his chest. Even with those strategies, D.H.'s distress still
26 has a significant effect on his mental health, daily life, and ability to function. D.H. still
27 struggles with an ever-present anxiety that the appearance of his chest will cause others to
28 treat him as female. This prevents him from participating in social activities with his

1 friends and caused him to quit dance over a year ago because he gets winded too easily to
2 dance with a binder, but the dysphoria is too great for him to dance without one. His
3 dysphoria also makes him extremely uncomfortable revealing his body even when he is
4 by himself or in a doctor's office.

5 86. In 2019, D.H.'s pediatrician referred D.H. to a surgeon, Dr. Ethan Larson,
6 who could perform male chest reconstruction surgery. D.H.'s health care providers
7 determined that the surgery was medically necessary to alleviate D.H.'s gender dysphoria.
8 Dr. Larson evaluated D.H. and agreed he would be a good candidate for the surgery.

9 87. Dr. Larson requested prior authorization for the surgery from
10 UnitedHealthcare, D.H.'s Medicaid managed care plan. UnitedHealthcare denied prior
11 authorization for the surgery. D.H. appealed the denial of the surgery, and on July 5, 2019,
12 UnitedHealthcare upheld its denial of coverage pursuant to the Challenged Exclusion.

13 88. Due to her income, Janice cannot afford to pay for John to undergo male
14 chest reconstruction surgery without AHCCCS covering the procedure.

15 ***John's Gender Dysphoria and Need for Surgical Treatment***

16 89. John was identified as female at birth. His grandmother, Susan, has cared
17 for him since he was two years old and continues to be his legal guardian.

18 90. As a child, John did not like dresses or typical girl toys, but was never able
19 to pinpoint a reason.

20 91. Approximately three years ago, just before John turned twelve, he started
21 experiencing the first signs of puberty. Those signs were coupled with an almost
22 immediate and significant decline in his mental health. He experienced symptoms of
23 severe depression, such as a constant and overwhelming sadness, distancing himself from
24 his friends, and suicidal ideation. Unable to describe his feelings and uncertain about how
25 Susan would respond even if he could, John kept those emotions bottled up.

26 92. Worried about how Susan and others in his family might react, especially
27 given their strong religious faith, John waited nearly six months before telling his older
28 sister that he is transgender. He eventually told Susan as well.

1 93. Over the course of the following year, John’s 7th grade year, Susan and John
2 had many extensive conversations to help her better understand what he was experiencing
3 and how she could help him.

4 94. John continued to experience significant gender dysphoria throughout his
5 7th grade year. Although John continued to wear the boys’ clothes he always had and
6 started using a male name, his peers, teachers, and family did not consistently refer to him
7 by that name and male pronouns. Not being consistently treated as male caused John to
8 be stressed the entire school year.

9 95. Wanting to prevent a repeat of the prior year, in the summer prior to starting
10 8th grade, John e-mailed each of his teachers to inform them that he is transgender and
11 ask that they refer to him as John and by male pronouns. This helped set the tone; in 8th
12 grade, John was more regularly referred to by the correct name and pronouns—both in
13 school and out.

14 96. Around that same time, at thirteen years old, John’s pediatrician referred
15 him to the Gender Support Program at Phoenix Children’s Hospital, a clinic specializing
16 in healthcare services for transgender young people.

17 97. John had his first appointment at Phoenix Children’s Hospital in November
18 2018, where he began to see Dr. Veenod Chulani, an adolescent-medicine specialist. Dr.
19 Chulani referred John to a mental health provider, who formally diagnosed John with
20 gender dysphoria. Soon thereafter John started taking medication to stop his menstrual
21 cycle, which helped relieve some of the gender dysphoria he was experiencing at the time.
22 In May 2019, Dr. Chulani and John’s therapist determined that it was medically necessary
23 for him to start taking testosterone, which he started the following month. John is pleased
24 with how the testosterone therapy has changed his voice and other aspects of his body.
25 Transitioning has also boosted his confidence, and now far fewer people mistake him for
26 female.

27 98. His transition and testosterone treatment, however, have not lessened the
28 intense dysphoria he experiences regarding the appearance of his chest. Starting in 2018,

1 John began binding his chest using a variety of methods, such as multiple sports bras and
2 constrictive undergarments. He bought his first binder in December 2019.

3 99. Every morning, the first thing John does is to put on a binder, which he often
4 wears for longer than the recommended eight-hour maximum. Even with the binder, John
5 still feels uncomfortable being outside without multiple layers of clothing, including a
6 hooded sweatshirt that he wears nearly every day. The binder constricts his breathing,
7 which in combination with his asthma, requires him to take far more breaks than his peers
8 when engaging in physical activity.

9 100. Although the binder sometimes allows him to forget about his chest—a
10 sense of relief he treasures—the hardest part of John’s daily routine is removing his binder.
11 The dysphoria John experiences regarding his chest comes flooding back, a difficult
12 reminder that his body still does not match who he is. John’s chest-related dysphoria keeps
13 him awake at night at least once a week; putting on his binder temporarily is the only way
14 he can calm his distress, a task he often tries to do without opening his eyes or turning on
15 the lights so that he does not have to see his bare chest.

16 101. Having top surgery would have a significant positive impact on John’s life.
17 John would finally be able to look at himself in the mirror and be in public without having
18 to wear so many layers of clothing on top of his binder, which would benefit both his
19 mental and physical health. John would gain confidence that will help improve his social
20 functioning and broaden his horizons, challenging himself to try to new things.

21 102. Around February 2020, Dr. Chulani recommended that John undergo male
22 chest reconstruction surgery to alleviate the dysphoria caused by the shape and appearance
23 of his chest. At that time, Dr. Chulani also referred John to another mental health provider
24 to assist John with the increased psychological distress he was experiencing and to
25 evaluate John for male chest reconstruction surgery as required by the prevailing standards
26 of care.

27 103. On July 2, 2020, John received a referral letter from his mental health
28 provider for the surgery, as required by the standards of care.

1 applicable to the Class. This action raises questions of law common to all members of the
2 Class, including: (a) whether the Challenged Exclusion, facially and as applied to
3 members of the Class, violates the EPSDT and comparability provisions of the federal
4 Medicaid Act; (b) whether the Challenged Exclusion, facially and as applied to members
5 of the Class, violates the prohibition on sex discrimination under Section 1557 of the
6 Patient Protection and Affordable Care Act; and (c) whether the Challenged Exclusion,
7 facially and as applied to members of the Class, violates the Equal Protection Clause of
8 the Fourteenth Amendment to the U.S. Constitution. All members of the Class share a
9 common question of fact: Would their male chest reconstruction surgery be covered by
10 AHCCCS but for Defendant's continuing enforcement of the Challenged Exclusion?

11 110. The Class satisfies the typicality requirements of Fed. R. Civ. P. 23(a)(3)
12 because the named Plaintiffs' claims are typical of the claims of the Class. Plaintiffs are
13 members of the Class, are individuals who have been unable and will be unable to obtain
14 AHCCCS coverage for medically necessary male chest reconstruction surgery because of
15 the Challenged Exclusion, and as a result, have faced or will face delayed or denied access
16 to these medically necessary treatments. Plaintiffs and members of the Class share the
17 same legal claims under Section 1557, the Medicaid Act, and the Equal Protection Clause
18 of the Fourteenth Amendment to the U.S. Constitution.

19 111. The Class satisfies the adequacy requirements of Fed. R. Civ. P. 23(a)(4)
20 because the class representatives will fairly and adequately represent the interests of the
21 Class. The named Plaintiffs seek the same declaratory and injunctive relief as the other
22 members of the Class: a declaratory judgment that the Challenged Exclusion violates the
23 Medicaid Act, Section 1557, and the Equal Protection Clause, and preliminary and
24 permanent injunctions enjoining Defendant from enforcing the Challenged Exclusion. The
25 named Plaintiffs seek this relief to benefit themselves and to protect other low-income
26 transgender Arizona residents who are or will be enrolled in AHCCCS. In asserting their
27 own rights, the named Plaintiffs will vindicate the rights of all members of the Class fairly
28

1 and adequately. The class representatives have no interests that are antagonistic to the
2 interests of other members of the Class.

3 112. The Class further satisfies the requirements of Fed. R. Civ. P. 23(a)(4)
4 because counsel for the Class will fairly and adequately represent the interests of the Class.
5 The Class is represented by counsel from King & Spalding LLP and Perkins Coie LLP,
6 two of the largest law firms in the country; the National Center for Lesbian Rights
7 (“NCLR”), a legal organization dedicated to advancing the civil and human rights of the
8 LGBTQ community; and the National Health Law Program (“NHLP”), a non-profit law
9 firm dedicated to protecting and advancing the health rights of low-income and
10 underserved individuals and families. Collectively, counsel has significant experience
11 litigating civil rights cases, including transgender rights cases, Medicaid EPSDT cases,
12 and complex class actions in federal court.

13 113. The Class also satisfies the requirements of Fed. R. Civ. P. 23(b)(2) because
14 Defendant has acted or refused to act on grounds that apply generally to the Class, so that
15 final injunctive or corresponding declaratory relief is appropriate respecting the class as a
16 whole. The Class exhibits sufficient cohesiveness because its members have suffered
17 group, as opposed to individual, injuries, namely, the Challenged Exclusion’s categorical
18 denial of male chest reconstruction surgery. Members of the Class are bound together by
19 the significant common traits that they are all transgender, they have gender dysphoria,
20 and they need male chest reconstruction surgery to treat their gender dysphoria.

21 114. Further, by definition, members of the Class are low-income individuals
22 who would otherwise have difficulty affording counsel to individually challenge the
23 Challenged Exclusion. Therefore, a class action is the ideal—and the only—method by
24 which the Class may vindicate the denial of their civil rights.

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COUNT I

**(Violation of the Medicaid Act’s EPSDT Requirements,
42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A)-(C), 1396d(a)(4)(B), and 1396d(r)(5))**

115. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

116. The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), and Defendant’s refusal, based on the Challenged Exclusion, to provide coverage for surgical treatments and services for gender dysphoria to Plaintiffs and members of the Class, violate the Medicaid Act’s EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A)-(C), 1396d(a)(4)(B), and 1396d(r)(5), which are enforceable by Plaintiffs under 42 U.S.C. § 1983.

COUNT II

**(Violation of the Medicaid Act’s Comparability Requirement,
42 U.S.C. § 1396a(a)(10)(B))**

117. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

118. The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), and Defendant’s refusal, based on the Challenged Exclusion, to provide coverage for surgical treatments and services for gender dysphoria to Plaintiffs and members of the Class, while covering the same services for other AHCCCS beneficiaries with different diagnoses, violate the Medicaid Act’s comparability requirement, 42 U.S.C. § 1396a(a)(10)(B), which is enforceable by Plaintiffs under 42 U.S.C. § 1983.

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COUNT III

(Unlawful Discrimination on the Basis of Sex in Violation of Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116)

119. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

120. Under Section 1557 of the Affordable Care Act, “an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)” on the basis of sex. 42 U.S.C. § 18116.

121. Section 1557’s prohibitions on sex discrimination are enforceable by Plaintiffs in a judicial action under 20 U.S.C. § 1683, which Section 1557 incorporates by reference. 42 U.S.C. § 18116(a). The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs and members of the Class, violates Section 1557’s prohibition against discrimination on the basis of sex in a health program or activity receiving federal financial assistance.

122. Plaintiffs and the Class have been and are continuing to be injured by Defendants’ application of the Challenged Exclusion to deny them AHCCCS coverage for surgical treatments for gender dysphoria.

COUNT IV

(Violation of the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution)

123. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

124. First, the Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs and members of the Class, impermissibly discriminates against Plaintiffs and members of the Class on the basis of sex and violates

1 their right to equal protection of the laws under the Equal Protection Clause of the
2 Fourteenth Amendment to the United States Constitution.

3 125. Second, the Challenged Exclusion, Arizona Administrative Code R9-22-
4 205-B.4(a), on its face and as applied to Plaintiffs, impermissibly discriminates against
5 Plaintiffs and members of the Class for being transgender and violates their right to equal
6 protection of the laws under the Fourteenth Amendment to the United States Constitution.

7 126. Defendant's promulgation and continued enforcement of the Challenged
8 Exclusion did not, and does not, serve any rational, legitimate, important, or compelling
9 state interest. Rather, the Challenged Exclusion serves only to prevent Plaintiffs and
10 members of the Class from obtaining medically necessary surgical care and services to
11 treat their gender dysphoria, complete their gender transitions, and live as their authentic
12 selves.

13 **PRAYER FOR RELIEF**

14 WHEREFORE, Plaintiffs respectfully request that this Court:

15 A. Certify a Class consisting of: All transgender individuals under age 21 who
16 are or will be enrolled in AHCCCS, have or will have a diagnosis of gender dysphoria,
17 and are seeking or will seek male chest reconstruction surgery following a determination
18 by their respective health care providers that the procedure is necessary to treat their
19 gender dysphoria.

20 B. Name D.H. and John as representatives of the Class, and appoint Plaintiffs'
21 counsel as King & Spalding LLP, Perkins Coie LLP, the NCLR, and NHeLP;

22 C. On behalf of Plaintiffs and all similarly situated individuals, issue
23 preliminary and permanent injunctions prohibiting Defendant from any further
24 enforcement or application of the Challenged Exclusion, Arizona Administrative Code
25 R9-22-205-B.4(a), and directing Defendant and their agents to provide Medicaid coverage
26 for medically necessary male chest reconstruction surgery;

27 D. On behalf of Plaintiffs and all similarly situated individuals, enter a
28 declaratory judgment that the denial of coverage for male chest reconstruction surgery:

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1. Violates the Medicaid Act’s EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A), (C), 1396d(a)(4)(B), and 1396d(r)(5);
2. Violates the Medicaid Act’s comparability requirement, 42 U.S.C. § 1396a(a)(10)(B);
3. Violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex; and
4. Violates the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex (including sex stereotyping, gender identity, being transgender, and undergoing a gender transition), and for being transgender;

- E. Waive the requirement for the posting of a bond of security for the entry of temporary and preliminary relief;
- F. Award Plaintiffs their reasonable attorneys’ fees, costs, and expenses under 42 U.S.C. § 1988 or other applicable statutes; and
- G. Award such other and further relief as the Court may deem just and proper.

Respectfully submitted,

DATED: AUGUST 6, 2020

PERKINS COIE LLP

/s/ Daniel C. Barr
Daniel C. Barr (Bar No. 010149)
Janet M. Howe (Bar No. 034615)
PERKINS COIE LLP
2901 N. Central Avenue, Suite 2000
Phoenix, AZ 85012-2788
T: +1 602 351 8085
F: +1 602 648 7085
Email: dbarr@perkinscoie.com
jhowe@perkinscoie.com

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Brent P. Ray*
Andrew J. Chinsky*
KING & SPALDING LLP
353 N. Clark Street, 12th Floor
Chicago, Illinois 60654
T: +1 312 995 6333
F: +1 312 995 6330
Email: bray@kslaw.com
achinsky@kslaw.com

Asaf Orr*
NATIONAL CENTER FOR LESBIAN
RIGHTS
870 Market Street, Suite 370
San Francisco, CA 94102
T: +1 415 392 6257
F: +1 415 392 8442
Email: aorr@nclrights.org

Abigail K. Coursolle*
Catherine McKee*
NATIONAL HEALTH LAW PROGRAM
3701 Wilshire Boulevard, Suite 750
Los Angeles, CA 90010
T: +1 310 204 6010
Email: coursolle@healthlaw.org
mckee@healthlaw.org

Attorneys for Plaintiffs and the Class

** Pro hac vice forthcoming*

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Civil Cover Sheet

This automated JS-44 conforms generally to the manual JS-44 approved by the Judicial Conference of the United States in September 1974. The data is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. The information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is authorized for use only in the District of Arizona.

The completed cover sheet must be printed directly to PDF and filed as an attachment to the Complaint or Notice of Removal.

Plaintiff
(s): **D. H. ; John Doe**

Defendant
(s): **Jami Snyder , Director
of the Arizona Health
Care Cost Containment
System, in her official
capacity**

County of Residence: Pima

County of Residence: Maricopa

County Where Claim For Relief
Arose: Pima

Plaintiff's Atty(s):

Defendant's Atty(s):

**Daniel C. Barr
Perkins Coie LLP
2901 N. Central Avenue, Suite 2000
Phoenix, Arizona 85012
602-351-8085**

**Janet M. Howe
Perkins Coie LLP
2901 N. Central Avenue, Suite 2000
Phoenix, Arizona 85012
602-351-8187**

Brent P. Ray

King & Spalding LLP
353 N. Clark Street, 12th Floor
Chicago, Illinois 60654
312-995-6333

Andrew J. Chinsky
King & Spalding LLP
353 N. Clark Street, 12th Floor
Chicago, Illinois 60654
312-995-6333

Asaf Orr
National Center For Lesbian Rights
870 Market Street, Suite 370
San Francisco, California 94102
415-392-6257

Abigail K. Coursolle
National Health Law Program
3701 Wilshire Boulevard, Suite 750
Los Angeles, California 90010
310-204-6010

Catherine McKee
National Health Law Program
3701 Wilshire Boulevard, Suite 750
Los Angeles, California 90010
310-204-6010

II. Basis of
Jurisdiction:

3. Federal Question (U.S. not a party)

III. Citizenship of
Principal Parties

(Diversity Cases Only)

Plaintiff:- **N/A**

Defendant:- **N/A**

IV. Origin : **1. Original Proceeding**

V. Nature of Suit: **440 Other Civil Rights**

VI. Cause of Action: **Arizona Administrative Code R9-22-205-B.4(a) violates the Medicaid Act's EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A), (C), 1396d(a)(4)(B), and 1396d(r)(5); the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B); Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116; and the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution.**

VII. Requested in
Complaint

Class Action: **Yes**

Dollar Demand:

Jury Demand: **No**

VIII. This case is not related to another case.

Signature: Daniel C. Barr

Date: 8/6/2020

If any of this information is incorrect, please go back to the Civil Cover Sheet Input form using the *Back* button in your browser and change it. Once correct, save this form as a PDF and include it as an attachment to your case opening documents.

Revised: 01/2014