IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN, *et al.*,
Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, *et al.*,
Defendants.

DEFENDANTS' RESPONSE IN OPPOSITION TO
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

I. INTRODUCTION

Plaintiffs' motion is based upon two flawed assertions that are contradicted by the record. First, Plaintiffs allege that West Virginia's Medicaid program ("Medicaid") discriminates on the basis of sex and transgender status. This is simply not correct. Plaintiffs have each confirmed that they personally have not been denied any coverage for gender-confirming care through Medicaid based on being transgender or having a transgender diagnosis. (ECF 252-4 Tr. pp. 142, 146; ECF 252-5 Tr. pp. 73-75). All medical claims submitted by Plaintiffs for gender-confirming care have been covered and paid. (ECF 252-1 Tr. pp. 117-119; ECF 252-6). Similarly, none of the Plaintiffs' requests for hormones have been denied by Medicaid based on transgender identity. (ECF 252-4 Tr. p. 142; ECF 252-5 Tr. pp. 62-63; ECF 252-7 Tr. pp. 82-83).

It is undisputed that Medicaid does not exclude, but in fact covers, psychiatric diagnostic evaluation, psychotherapy, psychological evaluation, counseling, office visits, hormones, and lab work as treatment related to gender-confirming care. (ECF 252-4 Tr. pp. 142, 146, 151, 161-162, 164; ECF 252-5 Tr. pp. 62-63, 65, 71, 73; ECF 252-6; ECF 252-7 Tr. pp. 28-30; ECF 252-1 Tr. pp. 168-169). This conclusively establishes that Medicaid does not "categorically deny transgender

people coverage for gender-confirming care" and it does not discriminate on the basis of sex or transgender status in connection with coverage for gender-confirming care.

Plaintiffs have not demonstrated that Medicaid has any exclusion of coverage that pertains categorically to transgender individuals. All services that are considered covered services by Medicaid are covered for transgender participants to the same extent and based on the same criteria as cisgender participants. Medicaid does not even designate whether an individual member has a transgender identity. (ECF 252-1 Tr. pp. 34, 100). No evidence has been produced in discovery indicating that any covered services are denied to members on the basis of transgender identity.

The second flawed premise in Plaintiffs' argument is that Medicaid does not cover gender-confirming surgical procedures when the same kinds of treatments are covered for cisgender participants who require that care for other reasons. Covered surgical care is covered for all participants, not limited to cisgender participants, who meet the criteria for covered services. Therefore, the distinction Plaintiffs attempt to draw between coverage available to transgender members as opposed to cisgender members simply does not exist.

Plaintiffs have not demonstrated that non-covered gender-confirming procedures are identical to procedures that are covered. In fact, the record shows that gender-confirming procedures are different procedures with different criteria than covered procedures. The policy does not discriminate on the basis of gender identity, but on the procedures, which are not covered for any member. The assumption that only transgender members would seek gender-confirming surgical services does not transform the policy into a discriminatory policy based on sex. It is simply part of the balancing that Medicaid must reasonably do in order to provide coverage in the best interests of all of its recipients, not preferring one particular group over another. It is conceivable that any number or combination of Medicaid members who share certain traits or

characteristics may have medical needs or desires specific to their specific traits or characteristics. However, "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs." *Alexander v. Choate*, 469 U.S. 287, 303 (1985). Instead, the federal Medicaid Act "gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in "the best interests of the recipients." *Id.*, citing 42 U.S.C. § 1396a(a)(19). Medicaid strikes this balance in an appropriate fashion by covering the vast majority of gender-confirming treatments that may be sought by its members, while not covering gender-confirming surgical treatments, which is one specialized category of treatments. The Constitution and federal law do not require more than this, and Plaintiffs' Motion for Summary Judgment should be denied.

II. FACTS[1]

Medicaid operates within the limits and constraints of its financial resources. (ECF 252-3 Tr. pp. 178-180). It cannot provide all conceivable medically necessary care for its members. (ECF 252-3 Tr. pp. 168-169). Medicaid has certain non-covered services that are applicable to all participants, which includes "[t]ranssexual surgery."[2] (ECF 252-1 Tr. p. 120, pp. 109-110). Gender-confirming surgery is simply one of numerous other services that are non-covered.

Not all transgender people are affected by the policy. Not all transgender individuals are diagnosed with gender dysphoria. Being transgender is an identity. (ECF 252-8 Tr. p. 8). Gender

[1] Defendants incorporate the facts and argument contained in their Motion for Summary Judgment and Memorandum of Law in Support of Defendants' Motion for Summary Judgment, ECF Nos. 252-253.

[2] Plaintiffs' attempt to characterize the non-covered service as anything other than gender-confirming surgery is contrary to the facts. Though not in the Amended Complaint, Plaintiffs now argue that a policy of excluding puberty-delaying treatment would also violate the law and is "part of the Exclusion." (ECF 251 p. 8 FN 38). Plaintiffs have not presented any facts that an "exclusion" for puberty-delaying treatment exists, or the terms of any such "exclusion." By Plaintiffs' admission, such treatment has been covered. (ECF 251 p. 8 FN 38). The Policy Manual clearly identifies "[t]ranssexual surgery" as a non-covered service, and Plaintiffs have no basis for arguing that anything else is "part of" the policy. Finally, Plaintiffs lack standing to assert a challenge in connection with puberty-delaying treatment.

dysphoria is a DSM-V disorder. (ECF 252-8 Tr. pp. 8-9). According to Dan Karasic, M.D., roughly one in 200 people identifies as transgender. (ECF 252-8 Tr. p. 10). About one in a thousand are in clinical care for gender dysphoria. (ECF 252-8 Tr. p. 10). Of those who receive care, Dr. Karasic did not specify a number who specifically receive or seek surgical care as opposed to other types of gender-confirming care. Plaintiffs agree that the record does not reveal the number of Medicaid participants who may seek gender-confirming surgery, and there is no evidence in the record that anyone other than Plaintiffs seek such treatment. (ECF 255 p. 19). The policy only potentially affects those who are diagnosed with gender dysphoria, seeking gender-confirming surgery, determined to be candidates for surgery, approved for surgery, and who actually submit a claim for such services to Medicaid, not "all transgender people."

Plaintiffs' characterization of certain data is not entirely accurate. Plaintiffs allege that the number of Medicaid participants during the pandemic expanded to 628,000. (ECF 251, p. 7).[3] They allege that 686 "participants [] submitted claims for gender-confirming care during the first nine months of 2021." (ECF 251, p. 7). Plaintiffs then assert that the 686 members represent "0.001% of all current participants." (ECF 251, p. 7). The number 686 captures all individuals who made claims for any reason during the first nine months of 2021 who also had a diagnosis code for transsexualism or certain gender identity disorders. (ECF 252-14, Tr. pp. 32-35). The number captured those who had made claims whether or not the transsexualism or gender identity disorder diagnosis was the primary diagnosis or the reason for the requested service. (ECF 252-14, Tr. pp. 32-35). Thus, 686 represents the number of members with a diagnosis related to gender dysphoria who made claims, but not necessarily for gender-confirming care, during this time.[4]

[3] The most recent data from March 2022 is 628,825. (ECF 252-3, Tr. p. 110).
[4] 686 out of 628,825 represents .1% of current participants, not "0.001%" as alleged by Plaintiffs.

"Transsexual surgery" has been designated as a non-covered service since at least 2004. (ECF 252-1 Tr. pp. 138-140; p. 98). Plaintiffs allege that it was adopted in "approximately 2004." (ECF 251, p. 9). While the policy dates at least as far back as 2004, it is unknown when the policy was adopted, as the policy adopted in 2004 was simply the earliest version where it appears that could be found. (ECF 252-1 Tr. pp. 138-140). The policy has been maintained year-to-year without change. (ECF 252-1 Tr. p. 140). Plaintiffs assert that Medicaid's "contract with each MCO states that the MCO is 'not permitted to provide' gender-confirming surgery." (ECF 251, p. 8). This language does not prohibit such coverage, but refers to the fact that such coverage is not included within the capitation rate paid by Medicaid to the MCO. (ECF 252-3 Tr. pp. 86-90; ECF 252-10 Tr. pp. 27-30). CMS, which oversees Medicaid, does not require coverage for this service. (ECF 252-1 Tr. pp. 34, 62, 74-75, 80, 84, 87-88, 161-162).

Medicaid is unable to add gender-confirming surgery to its covered services due to budgetary constraints, including a flat budget and projected deficits. (ECF 252-3 Tr. p. 179). Medicaid receives a federal match on state funds allocated to the Medicaid program, but is only allocated so many funds by the State Legislature. (ECF 252-1 Tr. p. 163). This limits what Medicaid can cover, because it has to be able to pay for existing coverages on an ongoing basis. (ECF 252-1 Tr. pp. 163-164). Medicaid is projecting a budget deficit within two years and does not have the funds to add additional services. (ECF 252-3 Tr. pp 179-180).

Plaintiffs mischaracterize the status of Medicaid's projected budget in an attempt to minimize the significance of projected deficits. Plaintiffs correctly state that Medicaid anticipates a budget surplus of roughly $343 million in 2022 and $117 million in 2023. (ECF 251, p. 10). Plaintiffs then suggest that these projected surpluses would be available to cover projected shortfalls beginning in 2024. (ECF 251 p. 10). Plaintiffs misunderstand the projections. The

projected surplus of $343,169,161 for 2022 is projected to be exhausted by 2024 as shown in the BMS Expenditure Estimate for the fiscal years 2022-2027. (ECF 252-12, pp. 53-54 of 89; 252-12 Tr. p. 41). The projected surplus for 2022 carries over to the following year and is included as the "Beginning Balance" for the "Net State Match Available" for 2023. (ECF 252-12, p. 53 of 89). After reducing the "Net State Match Available" for 2023 by the "State Match Required to meet estimated expenditures" for 2023, the anticipated surplus at the end of 2023 is reduced to $117,882,923. (ECF 252-12, p. 53 of 89). That surplus is then carried over to the following year and is included as the "Beginning Balance" for the "Net State Match Available" for 2024. (ECF 252-12, p. 53 of 89). The "State Match Required to meet estimated expenditures" exceeds the "Net State Match Available" in 2024, resulting in a projected deficit of $128,319,828 for 2024. (ECF 252-12 Tr. p. 41). That is the amount of additional money that Medicaid would require from the legislature in 2024 in order to be able to maintain services. (ECF 252-12 Tr. p. 42). There is no remaining surplus that could be used to pay the deficit, or any deficit in the following years, because the surplus was carried over year-to-year and exhausted.[5] The projections demonstrate an inability to maintain services at the current level beginning in fiscal year 2024, with projected deficits for 2024, 2025, 2026, and 2027 each well exceeding 100 million dollars.

[5] The budget outlook gets worse in the following years. For 2025, current projections show that the "State Match Required to meet estimated expenditures" exceeds the "Net State Match Available" in 2025, resulting in a projected deficit of $133,665,427 for 2025. This assumes that Medicaid receives the amount of the funding deficit for the prior year, as reflected in the "Increase in State Match needed from prior year." (ECF 252-12, p. 53 of 89). In other words, the budget projection anticipates Medicaid receiving the $128,319,828 needed to cover 2024 expenses, so that the deficit is not carried forward to future years. (ECF 252-12, Tr. p. 43). If the $128,319,828 needed to cover 2024 is not received, the true deficit for 2025 is the compound deficit of $261,985,255, which is the amount that the state match portion of expenses exceeds available state funds for the years 2024 and 2025 combined. See footnote d), stating "[i]f funding for deficit amount from prior year is not received, then the deficit in the following year will be higher. (Ex. If SFY2024 showed a deficit of $227.3M. If $227.3M of funding is not received for SFY2025, then the deficit for SFY2025 will be $227.3M plus the deficit showing in SFY2025.)" (ECF 252-12, p. 54 of 89). The projected deficits continue to grow in similar fashion in 2026 and 2027.

Plaintiffs cavalierly suggest that the budget is not a valid consideration because the federal government has "previously provided assistance for shortfalls." (ECF 251, p. 10). This is sheer speculation on Plaintiffs' part. The assistance to which Plaintiffs refer is the fact that the federal match was increased by 6.2% in connection with the public health emergency "to provide some additional relief to states who were currently struggling." (ECF 252-12 Tr. pp. 44-45). The increase was for the specific purpose of providing relief for the public health emergency. Plaintiffs have presented no facts to suggest that the federal government would consider further increasing its match and if so, under what circumstances, and any suggestion that it would do so is sheer conjecture. Moreover, the increase in the federal match has not eliminated the State's obligation to provide matching funds. (ECF 252-12 Tr. pp. 44-45). The State must continue to cover a portion of expenses, and this is what drives the deficit projections. There is no guarantee that the agency will get funding from the legislature, and there is no guarantee that the state will have the funds. (ECF 252-12 Tr. pp. 43-44). Absent receiving necessary funds, Medicaid will "have to make decisions about what will be cut and where." (ECF 252-12 Tr. p. 44).

Approval for surgical coverage under Medicaid is based on many factors other than the diagnosis, such as medical history, previous treatment, severity of diagnosis, and combination of other symptoms and conditions. (ECF 252-13). Coverage is determined by Medicaid's utilization management vendor, Kepro, which uses guidelines from InterQual, a nationally recognized utilization management software, to determine medical necessity for services. (ECF 252-14 Tr. pp. 16-18, 20, 60). Transgender Medicaid members seeking to access covered services who meet Kepro's coverage criteria are not denied services based on transgender status.[6] Plaintiffs allege

[6] Mr. Fain's coverage history is instructive on this point. In 2018, he had a hysterectomy, which was not a gender-confirming surgery, that was covered by Medicaid. (ECF 252-5 Tr. pp. 52-53). In that instance,

that cisgender Medicaid participants can access "the same kinds of treatments" as the non-covered gender-confirming services. (ECF 140, ¶ 164). However, these are not "the same kinds of treatments." InterQual has guidelines that are specific to gender-affirming surgical services. (ECF 252-1 Tr. pp. 110-116; ECF 252-14 Tr. pp. 26, 60, 63). Those guidelines are distinct from the guidelines that relate to surgical services covered by Medicaid and have different criteria than covered services. (ECF 252-1 Tr. pp. 110-116; ECF 252-14 Tr. pp. 26, 60, 63).[7]

According to Dr. Schechter, transgender individuals are the only individuals that seek access to gender-confirming surgeries. (ECF 252-15 Tr. pp. 65-66, 70). He further reiterated, "cisgender individuals may undergo mastectomy, as we've said, oophorectomy, and so forth. But those aren't considered to be sex transformation procedures in cisgender individuals." (ECF 252-15 Tr. pp. 70-71). This is further clarified by Dr. Schechter's explanation of what is involved in a vaginoplasty for gender-affirming surgery. (ECF 252-15 Tr. pp. 127-129). Similarly, "[t]here is a wide range of indications or techniques used to perform mastectomy, whether for gender-affirming mastectomy or for a mastectomy pertaining to oncologic reasons or for risk reduction mastectomies, meaning removing a breast that is not cancerous but may have an increased predilection or risk of breast. There are different ways to perform that mastectomy, so as to how it

Mr. Fain was "similarly situated" "in all relevant respects" to other individuals meeting the criteria for that covered service and was treated in the same manner by receiving coverage.

[7] A comparison of the Interqual criteria for covered services and for gender-confirming procedures illustrates the differences. The services identified in the InterQual criteria for covered services include, for example, "Hysterectomy +/- Salpingo-Oophorectomy or Salpingectomy for Endometriosis," "Hysterectomy + BSO for BRCA gene mutation," "Hysterectomy +/- BSO or Bilateral Salpingectomy for Endocervical adenocarcinoma in situ," and "Hysterectomy + BSO for Endometrial cancer." (Ex. 19, attached). Coverage for these services is equally available to all members meeting the criteria. The specific services in the InterQual criteria relied upon by Plaintiffs are identified as "Penectomy for Gender Affirmation Surgery," "Phalloplasty for Gender Affirmation Surgery," "Orchiectomy for Gender Affirmation Surgery," "Ovariectomy / Salpingo-oophorectomy for Gender Affirmation Surgery," "Vaginoplasty for Gender Affirmation Surgery," and "Hysterectomy for Gender Affirmation Surgery." (ECF 250-30). The procedures are distinct to the purpose of gender-affirmation.

would be performed compared to a gender affirming mastectomy, again, would depend upon the specific situation." (ECF 252-15 Tr. pp. 155-156).[8]

III. STANDARD OF REVIEW

For purposes of summary judgment, the moving party has the initial burden of "pointing out to the district court . . . that there is an absence of evidence to support the non-moving party's case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). If the moving party satisfies this burden, then the non-moving party must set forth specific facts, admissible in evidence, that demonstrate the existence of a genuine issue of material fact for trial. *See id.* at 322-23; Fed. R. Civ. P. 56(c), (e). A "genuine" dispute of material fact exists if, in viewing the record and all reasonable inferences drawn therefrom in a light most favorable to the non-moving party, a reasonable fact-finder could return a verdict for the non-moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Here, Defendants have moved for summary judgment based upon the absence of facts in support of Plaintiffs' claims. However, if the Court concludes that Plaintiffs have presented facts which could support a verdict for Plaintiffs, fact questions remain to be resolved by a jury as to the merit of each of Plaintiffs' claims. Therefore, Plaintiffs' Motion should be denied.

IV. ANALYSIS

A. Plaintiffs Have No Standing.

In order to establish standing, "a plaintiff must show (1) it has suffered an 'injury in fact' that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *South*

[8] Similarly, Dr. Olson-Kennedy describes one such surgery as "masculinizing chest surgery." (ECF 252-18 Tr. p. 130). Again, this is extremely distinct from a mastectomy that would be sought by a cisgender woman.

Carolina v. U.S., 912 F.3d 720, 726 (4th Cir. 2019) (additional citation omitted). Neither Ms. Anderson nor Mr. Fain has submitted a claim to Medicaid to cover gender-confirming surgery to date and been denied. (ECF 252-4 Tr. pp. 170-171); (ECF 252-5 Tr. pp. 86-89). Mr. Fain testified that he is not willing to undergo surgery until he has kicked his smoking habit, which has not yet occurred. (ECF 252-5 Tr. pp. 87-88). Ms. Anderson has never had a treating physician find that she requires gender-affirming surgery to treat her gender dysphoria. Thus, neither Plaintiff has established a concrete and particularized injury that is actual or imminent, and both lack standing.[9]

B. Plaintiffs Are Not Entitled to Summary Judgment for violation of Equal Protection.

"To succeed on an equal protection claim, a plaintiff must first demonstrate that he has been treated differently from others with whom he is similarly situated and that the unequal treatment was the result of intentional or purposeful discrimination." *Morrison v. Garraghty*, 239 F.3d 648, 654 (4th Cir. 2001). If so, "the court proceeds to determine whether the disparity in treatment can be justified under the requisite level of scrutiny." *Id.* (additional citations omitted).

There is abundant evidence that Plaintiffs have not been treated differently from others with whom they are similarly situated based upon Medicaid's policy, either facially or as applied. "The Clause 'does not take from the States all power of classification,' but 'keeps governmental decision makers from treating differently persons who are in all relevant respects alike.'" *Morrison,* 239 F.3d at 654 quoting *Pers. Adm'r of Mass. v. Feeney*, 442 U.S. 256, 271 (1979) and *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). Here, "similarly situated" individuals who are "in all relevant respects alike" can only refer to other Medicaid participants with gender dysphoria who seek gender-confirming surgery. Though Plaintiffs seek comparison with cisgender individuals

[9] Additionally, to the extent that Plaintiffs seek any relief based upon any alleged policy regarding coverage for puberty-delaying treatment, Plaintiffs are not seeking puberty-delaying treatment and have no standing to assert any claims related to coverage or non-coverage for puberty-delaying treatment on behalf of themselves or any putative class. (ECF 251 p. 3 FN 1, p. 8 FN 38).

who seek coverage for surgical care such as mastectomy for reasons other than gender-confirmation, those individuals are not "in all relevant respects alike" because the procedures sought by cisgender individuals are not gender-confirming procedures, and transgender individuals also have access to those procedures.[10] [11] *See Williams v. Kelly*, 2018 U.S. Dist. LEXIS 158119 at *29 (E.D. La. Aug. 27, 2018) (adopted by *Williams v. Kelly*, 2018 U.S. Dist. LEXIS 157002 (E.D. La. Sept. 14, 2018).

Plaintiffs argue that Medicaid's policy facially discriminates based on sex and transgender status, precluding the need to show intent. However, because the policy does not facially discriminate based on sex or transgender status, Plaintiffs must demonstrate discriminatory intent, and there is no evidence of intention on the part of Defendants Crouch or Beane to discriminate. The subject policy predated Secretary Crouch's appointment and Commissioner Beane's selection. (ECF 252-2 Tr. p. 12; ECF 252-3 Tr. pp. 15-16). The policy has been maintained year-to-year without change, and CMS does not require coverage for this particular service. (ECF 252-1 Tr. pp. 140, 162). Health and Human Services ("HHS") evaluated the evidence in 2016 and refused to mandate coverage for transgender surgeries, leaving it up to the individual states to decide, due to lack of evidence of long-term benefits. (ECF 252-11, ¶ 24). Medicaid and the officials who administer the state program are acting reasonably in also declining to mandate such coverage, as they rely upon guidance from HHS and CMS to determine required coverages.

[10] Medicaid has not had any claims or requests for vaginoplasty going at least as far back as 2016. (ECF 252-14 Tr. p. 31). No members are similarly situated for the purposes of making any comparison, and certainly none that are "in all relevant respects alike."

[11] Medicaid does not provide surgical coverage for any DSM-V diagnosis, so its policy regarding gender-confirming surgery is consistent in its approach. (ECF 252-19). If the gender-confirming surgeries were to be covered, it would be the only covered surgery based on a DSM-V diagnosis. Dr. Olson-Kennedy suggested that a comparable procedure for a cisgender woman would be a procedure to treat distress caused from failure to develop breasts known as hypomastia. (ECF 252-18 Tr. pp. 139-140). Medicaid does not cover surgery for hypomastia, regardless of gender identity. (ECF 252-19).

Plaintiffs argue that Medicaid's policy facially discriminates based on sex and transgender status, such that intermediate scrutiny applies. However, Defendants dispute this assertion because the classification at issue is not based on sex or transgender status. Instead, it is related to the specific services sought, so rational basis applies. The "classification" is not directed at individuals at all, but a specific procedure. It potentially affects only individuals who share a DSM-V diagnosis of gender dysphoria and seek specific surgical care for that diagnosis. *Toomey v. Arizon*a, 2020 U.S. Dist. LEXIS 224159, *13 (U.S.D.C. D. Ariz. Nov. 30, 2020) ("a policy that "discriminates against some natal females but not all . . . is not, on its face, discrimination on the basis of sex."). Likewise, a policy that affects some, but not all, transgender individuals, is not discrimination on the basis of sex or transgender identity. *Id.* at *14 ("the Plan exclusion [for 'gender reassignment surgery'] is not facially discriminatory against all transgender individuals.") (additional citations omitted); *Lange v. Houston Cty., Georgia*, 499 F. Supp. 3d 1258 (M.D. Ga. 2020) (healthcare plan exclusion for "sex change surgery" facially neutral for purposes of the Equal Protection Clause under analysis in *Geduldig v. Aiello*, 417 U.S. 484 (1974)). Such a classification is not a suspect or quasi-suspect class; therefore, rational basis review applies, and there is ample evidence from which a jury could conclude that Medicaid has a rational basis for its policy.[12]

The instant case is analogous to *Geduldig v. Aiello*, 417 U.S. 484 (1974)[13], where the Supreme Court considered a challenge to a provision in a California disability insurance program that excluded coverage for disability that accompanies normal pregnancy and childbirth. *Id.* at 492.

[12] To the extent that Plaintiffs rely upon case law decided under Title VII, such as *Fletcher v. Alaska*, 443 F. Supp. 3d 1024 (D. Alaska 2020) and *Boyden v. Conlin*, 341 F.Supp.3d 979 (W.D. Wisc. 2018), they are inapposite.

[13] Congress amended Title VII in 1978 to prohibit discrimination on the basis of pregnancy, childbirth, or related medical conditions. *See Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 678-79, 103 S. Ct. 2622 (1983). However, the Court's analysis in *Geduldig* related to whether an insurance exclusion based on a health condition is facially discriminatory under the Equal Protection Clause remains intact. *Lange v. Houston Cty., Georgia*, 499 F. Supp. 3d 1258, 1276 (M.D. Ga. 2020).

The Court held that the program exclusion did not constitute invidious discrimination on the basis of sex under the Equal Protection Clause because it did "not discriminate with respect to the persons or groups which are eligible for disability insurance protection under the program." *Id.* at 494. Notably, the Court explained:

> The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition – pregnancy – from the list of compensable disabilities. While it is true that only women can become pregnant, it does not follow that every legislative classification concerning pregnancy is a sex-based classification . . . [.] Normal pregnancy is an objectively identifiable physical condition with unique characteristics. Absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other, lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation such as this on any reasonable basis, just as with respect to any other physical condition.
>
> The lack of identity between the excluded disability and gender as such under this insurance program becomes clear upon the most cursory analysis. The program divides potential recipients into two groups – pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes.

Id., at 496 FN 20. The Court applied rational basis review and acknowledged the state's ability to insure some risks and not others, and specifically found that the state "has an interest in distributing the available resources in such a way as to keep benefit payments at an adequate level for disabilities that are covered, rather than to cover all disabilities adequately." *Id.* at 494-495. A state is not required to "choose between attacking every aspect of a problem or not attacking the problem at all." *Id.* at 495, quoting *Dandridge v. Williams*, 397 U.S. 471, 486-487 (1970).[14] By the same analysis, Medicaid's policy does not create a sex-based classification, because it divides potential

[14] Similarly, the Supreme Court applied rational basis review when addressing the Hyde Amendment, which restricted the availability of certain medically necessary abortions under Medicaid, finding that the amendment was not predicated on a constitutionally suspect classification. *Harris v. McRae*, 448 U.S. 297, 322-324, 100 S. Ct. 2671 (1980). The Court found it was rational to authorize "federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions" because of the inherent difference from other medical procedures. *Id.* at 325.

recipients into two groups – those with gender dysphoria who seek gender-confirming surgery, and all other persons. While the first group is expected to be exclusively comprised of transgender individuals, the second group includes all other persons, whether cisgender, transgender, or other identity, who do not seek gender-confirming surgery.

Under rational basis review, it is Plaintiffs' burden "to negate every conceivable basis which might support" the alleged unequal treatment, and Defendants have "no obligation to produce evidence to support the rationality of the [classification], which may be based on rational speculation unsupported by any evidence or empirical data." *Giarratano v. Johnson*, 521 F.3d 298, 303 (4th Cir. 2008) (citation omitted). The policy complained of by the Plaintiffs is rationally related to the State's interests in providing coverage consistent with what is required by CMS and in conserving financial resources available to the Medicaid program for the benefit of providing services to its members on an ongoing basis. There is also evidence in the record with respect to the disputed medical necessity of gender-confirming surgery, as well as the lack of evidence of long-term benefits as determined by HHS in 2016. Thus, Plaintiffs are not entitled to summary judgment on their Equal Protection Claim.

Even if intermediate scrutiny were applied, there is evidence to support a finding that the classification is not unlawful. Intermediate scrutiny "does not demand that the challenged law 'be the least intrusive means of achieving the relevant government objective, or that there be no burden whatsoever on the individual right in question.'" *Md. Shall Issue, Inc. v. Hogan*, 2021 U.S. Dist. LEXIS 159168, *34 (D. Md. Aug. 23, 2021) quoting *U.S. v. Masciandaro*, 638 F.3d 458, 470 (4th Cir. 2011) (citation omitted). Plaintiffs rely on "the handful of documents purportedly considered by those responsible for maintaining the Exclusion" to argue that the cost of care is "negligible." (ECF 251 p. 18). However, no witness has been identified who could testify as to the accuracy or

reliability of the cost information contained in those "handful of documents."[15] Medicaid's means are substantially related to important purposes because it cannot add additional covered services without potentially jeopardizing coverage for existing services on an ongoing basis. Thus, even under intermediate scrutiny, there are factual questions and Plaintiffs' Motion should be denied.

C. Plaintiffs Are Not Entitled to Summary Judgment for violation of the ACA.

Plaintiffs assert that they were subjected to sex discrimination in the provision of healthcare services in violation of the Affordable Care Act. Historically in terms of Title IX jurisprudence, the term "sex" referred to the binary sex of male and female, and "gender identity" was understood as a distinct concept. *See* 20 U.S.C. § 1681 (referring to "students of one sex," "both sexes," "students of the other sex"). Plaintiffs do not allege classification based upon binary sex and therefore state no claim that has been recognized by the Supreme Court in the Title IX context. Even based upon Plaintiffs' argument, the Defendants have not drawn a classification that discriminates based on gender identity.[16] There is ample evidence in the record from which a finding can be made that Medicaid's policy does not discriminate based on sex or gender identity, but rather, is based upon non-discriminatory factors, and Plaintiffs' Motion should be denied.[17]

D. Defendants Have Not Violated the Medicaid Act's Comparability Requirements.

Plaintiffs argue that the Defendants have violated the Medicaid Act's Comparability Requirements, relying upon *Flack v. Wisconsin Dep't of Health Servs.*, 395 F. Supp. 3d 1001

[15] It has been stipulated by the parties that the "handful of documents" referenced by Plaintiffs were not considered in adopting and/or maintaining the policy regarding gender-confirming surgery. (ECF 258).
[16] *See Hennessy-Waller v. Snyder*, 529 F. Supp. 3d 1031, 1045 (D. Ariz. 2021) (*aff'd by Doe v. Snyder*, 2022 U.S. App. LEXIS 6217 (9th Cir. Mar. 10, 2022) (Plaintiff unlikely to succeed on claim under Section 1557 where the challenged policy "only excludes gender reassignment *surgery*—it does not exclude coverage for other treatments for gender dysphoria such as hormone therapy")(emphasis in original).
[17] Plaintiffs' Motion further acknowledges that Plaintiffs may not recover damages for emotional distress under the ACA. Because the only compensatory damages sought by Plaintiffs were for emotional distress, any recovery of compensatory damages by Plaintiffs in this matter is foreclosed by *Cummings v. Premier Rehab Keller, P.L.L.C.*, 142 S. Ct. 1562 (2022).

(W.D. Wis. 2019), *Davis v. Shah*, 821 F.3d 231 (2d Cir. 2016), and *White v. Beal*, 555 F.2d 1146 (3d Cir. 1977). *Flack*, *Davis*, and *White* incorrectly interpret the Medicaid Act.

The Medicaid Act states, in relevant part,

> [a] State plan for medical assistance must … (10) provide … (B) that the medical assistance made available to any individual described in subparagraph (A)—
>
> (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and
>
> (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A)[.]

42 U.S.C. § 1396a(a)(10)(B). The comparability requirements of the Medicaid Act also have accompanying regulations:

> Except as limited in § 440.250—
>
> (a) The plan must provide that the services available to any categorically needy beneficiary under the plan are not less in amount, duration, and scope than those services available to a medically needy beneficiary; and
>
> (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group:
>
> (1) The categorically needy.
>
> (2) A covered medically needy group.

42 C.F.R. § 440.240. Thus, the plain language of the regulations prohibits three types of discrimination: (1) against the categorically needy, (2) among the categorically needy, and (3) among the medically needy. *See Schott v. Olszewski*, 401 F.3d 682, 686 (6th Cir. 2005) ("Under the Act, states must provide comparable medical assistance to all Medicaid recipients within each classification, so long as the medically needy do not receive greater benefits than the categorically needy (although the reverse is permitted)."). In other words, the comparability requirements prohibit distinctions between groups of Medicaid recipients as determined by eligibility. Here, Plaintiffs do not allege that they are treated differently than other Medicaid recipients based on their status as categorically needy, and thus they do not state any claim.

Plaintiffs' argument was advanced and correctly rejected in *Rodriguez v. City of New York*, 197 F.3d 611, 615-16 (2nd Cir. 1999). The Court described the plaintiffs' argument as follows:

> [T]hey claim that, because safety monitoring is "comparable" to the … services already provided … the failure to provide such monitoring violates Section 1396a(a)(10)(B). [They] attempt to graft a new requirement on this Section: If two different benefits are "comparable" and one is provided, the other must be as well.

Id. at 615-16 (internal citation omitted). Rejecting the plaintiffs' argument, the Court stated,

> However, **Section 1396a(a)(10)(B) does not require a state to fund a benefit that it currently provides to no one. Its only proper application is in situations where the same benefit is funded for some recipients but not others.** A holding to the contrary would both substantially narrow the "broad discretion" the Medicaid Act confers "on the States to adopt standards for determining the extent of medical assistance," and create a disincentive for states to provide services optional under federal law lest a court deem other services "comparable" to those provided -- an elastic concept -- thereby increasing the costs of the optional services. The Act therefore "requires only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." Appellants' decision to distinguish between safety monitoring and other tasks thus does not implicate Section 1396a(a)(10)(B).

Id. at 616 (internal citations omitted). This same reasoning was later applied to gender-affirming surgeries in *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008). There, the plaintiff argued that, "because a mastectomy is an indicated and reimbursable treatment for breast cancer, then a female-to-male transsexual with a diagnosis of [gender identity disorder] would be entitled to reimbursement for the same treatment." *Id.* at 244. The Court rejected the plaintiff's argument and adopted *Rodriguez*, stating, "[i]f Congress had intended to compel a state to provide a treatment for all diagnoses if the treatment were provided for any diagnosis, one would have expected it to have done so in clear language." *Id.* at 245 (internal citation omitted). In order to prevail on this claim, Plaintiffs must prove that Defendants' policy discriminates among categorically needy beneficiaries, and there is no such evidence. There is ample evidence in the record from which a finding can be made that Medicaid's policy does not violate the comparability requirements, and Plaintiffs' Motion should be denied.

E. Defendants Have Not Violated the Medicaid Act's Availability Requirements.

Plaintiffs argue that the Defendants have violated the Medicaid Act's Availability Requirements, however, Plaintiffs have not identified under which provision of Section 1396d gender-affirming surgery allegedly falls. Regardless, "nothing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care." *Beal v. Doe*, 432 U.S. 438, 444, 97 S. Ct. 2366, 53 L. Ed. 2d 464 (1977). "Indeed, the statute expressly provides: 'A State plan for medical assistance must… include reasonable standards… for determining eligibility for and the extent of medical assistance under the plan which… are consistent with the objectives of this [Title]….' 42 U.S.C. § 1396a (a)(17) (1970 ed., Supp. V)." *Id.*[18]

The Supreme Court's decision in *Beal* is consistent with the Medicaid Act's accompanying regulations. HHS regulations implement the statutory requirements of "Section 1902(a)(10), regarding comparability of services for groups of beneficiaries, and the amount, duration, and scope of services described in section 1905(a) of the Act that the State plan must provide for beneficiaries[.]" 42 C.F.R. § 440.200(a)(1). The regulations set forth the criteria for availability:

> (a) The plan must specify the amount, duration, and scope of each service that it provides for—
>
> (1) The categorically needy; and
>
> (2) Each covered group of medically needy.
>
> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
>
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.
>
> (d) **The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.**

[18] This language appears in the current version of 42 U.S.C. § 1396a(a)(17), though additional language has been added to this section of the statute.

42 C.F.R. § 440.230 (emphasis added). Thus, it is clear that the regulations permit a State Medicaid plan to place limits on services even if those services are required to be covered. *See Casillas v. Daines*, 580 F. Supp. 2d 235, 245-46 (S.D.N.Y. 2008).

Here, however, Plaintiffs have not demonstrated that gender-affirming care is a service that is required to be covered under the Medicaid Act. Plaintiffs appear to argue that any State plan deeming any service as non-covered violates the Medicaid Act's availability requirement, and do not identify under which regulation gender-affirming care allegedly falls. Because gender-affirming surgery is not a mandatory service under the Medicaid Act and its accompanying regulations, it is an optional service. "Any of the services defined in subpart A of this part that are not required under §§ 440.210 and 440.220 may be furnished under the State plan at the State's option." 42 C.F.R. § 440.225. Defendants have chosen to not furnish coverage for gender-affirming surgery to the State's beneficiaries as is permitted under the Medicaid Act and its accompanying regulations.[19]

Even if gender-affirming care falls into one of the mandatory covered service categories, State plans are permitted to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. 42 C.F.R. § 440.230(d), *Alexander v. Choate*, 469 U.S. 287, 303 (1985). Numerous courts, consistent with *Choate*, have held that states retain broad discretion to determine the extent of medical assistance offered in their Medicaid programs.[20]

[19] Plaintiffs selectively quote one portion of *Beal* for the proposition that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage." (ECF 251 p. 22). However, the Supreme Court has acknowledged that not all medically necessary services are covered by Medicaid, nor are they required to be covered. *Harris v. McRae*, 448 U.S. 297, 308-310, 325, 325 FN 28, 100 S. Ct. 2671 (1980).

[20] *See Mennonite Gen. Hosp. v. Molina Healthcare of P. R.*, 319 F. Supp. 3d 587, 591 (D.P.R. 2018); *DeSario v. Thomas*, 139 F.3d 80, 96 (2nd Cir. 1998).

To prevail on their claim for alleged violation of the Medicaid Act's availability requirements, Plaintiffs must prove that Defendants have failed to make available to them care that is required to be covered. Medicaid has exercised its discretion and chosen the proper mix of amount, scope, and duration limitations on coverage for gender-affirming care. As set forth in the Memorandum of Law in Support of Defendants' Motion for Summary Judgment (ECF 253), medical necessity of gender-affirming surgery is still being debated, is not settled science, and the assumption of such carries significant risks. There is a factual basis to find that the Defendants do not violate the availability requirements, and therefore Plaintiff's Motion should be denied.

IV. CONCLUSION

Plaintiffs have not shown an absence of any factual basis for a jury to find in favor for the Defendants with respect to Plaintiffs' claims that Defendants have engaged in discrimination against them, or violated any right afforded Plaintiffs under the ACA or the Medicaid Act, and therefore Plaintiff's Motion for Summary Judgment should be denied.

WILLIAM CROUCH, CYNTHIA BEANE, and WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

CHRISTOPHER FAIN and **SHAUNTAE ANDERSON;** individually and on behalf of all others similarly situated,

Plaintiffs,

Civil Action No. 3:20-cv-00740
Hon. Robert C. Chambers, Judge

v.

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; **CYNTHIA BEANE,** in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; and **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

Defendants.

CERTIFICATE OF SERVICE

Now come Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources Bureau for Medical Services, by counsel, and do hereby certify that on the 14th day of June, 2022, a true and exact copy of **"DEFENDANTS' RESPONSE IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT"** was served on counsel via electronic means as follows:

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