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

CHRISTOPHER FAIN, *et al.*, individually and on behalf of all others similarly situated,

*Plaintiffs*,

v.

WILLIAM CROUCH, *et al.*,

*Defendants.*

CIVIL ACTION NO. 3:20-cv-00740
HON. ROBERT C. CHAMBERS

**SUPPLEMENTAL DECLARATION OF WALT AUVIL**

I, Walt Auvil, do hereby declare as follows:

1. I am more than 18 years of age, have personal knowledge of the facts set forth herein, and am otherwise competent to testify to the matters set forth herein.

2. I am an attorney with and owner of The Employment Law Center, PLLC, and counsel for Plaintiffs in this matter. I submit this supplemental declaration in support of Plaintiffs' opposition to Defendants' motion for summary judgment.

3. Attached to this declaration are true and correct copies of the documents listed in the table below. Entries in the table indicate where documents have been excerpted.

4. Sensitive, protected, and/or irrelevant information has been redacted on certain pages of the attached exhibits in accordance with Federal Rule of Civil Procedure

5.1(a) and Local Rule of Civil Procedure 5.2.1.(a), with black boxes placed over the redacted text.

| Exhibit | Description |
|---|---|
| 34 | Inter ual, 2012.2 Procedures Adult Criteria, Reduction Mammoplasty, Male, DHHRBMS002781-84 |
| 35 | Inter ual, 2021 Reduction Mammoplasty, Male (Adolescent), DHHRBMS002772-77 |
| 36 | Excerpt of Dep. Tr. of Pltf. Shauntae Anderson |
| 37 | Slip op. for Mem. Op. and Order in *Kadel v. ol ell*, No. 1:19-cv-272 (M.D.N.C.) ( une 10, 2022) |

I declare under penalty of per ury under the laws of the United States of America that the foregoing is true and correct.

Dated this 14th day of une, 2022.

/s/ Walt Auvil
Walt Auvil

# 2012.2 Procedures Adult Criteria

## Reduction Mammoplasty, Male[1, 2*RIN, 3]

| | | | | |
|---|---|---|---|---|
| PATIENT: | Name | D.O.B. | ID# | GROUP# |
| CPT®/ICD: | Code | Facility | Service Date | |
| PROVIDER: | Name | | ID# | Phone# |
| | Signature | | Date | |

ICD-9:

ICD-10:

CPT®:

INDICATIONS (choose one and see below)

☐ 100 Gynecomastia, bilateral/unilateral
☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Gynecomastia, bilateral/unilateral **[All]**[4, 5]
- ☐ 110 Breast pain/tenderness[6]
- ☐ 120 Grade II/III/IV gynecomastia by PE[7, 8, 9]
- ☐ 130 Mammogram/US negative for cyst/tumor[10]
- ☐ 140 Contributory conditions excluded/treated ≥ 6 mos[11, 12]
- ☐ 150 Medication review **[One]**[13]
  - ☐ 151 Medications deemed noncontributory
  - ☐ 152 Contributory medications discontinued
  - ☐ 153 Requires medication that contributes to gynecomastia for which there is no acceptable alternative medication



## Notes

**(1)**
These criteria include the following procedures:
Breast Reduction, Male
Mastectomy for Gynecomastia
Mastectomy, Subcutaneous, Male

**(2)-RIN:**
**These criteria address surgical resection (e.g., reduction mammoplasty, subcutaneous mastectomy) of gynecomastia. If breast enlargement in male patients is due primarily to excess fatty tissue and not glandular hypertrophy, liposuction can be used for breast reduction. Since liposuction only removes fatty tissue and not breast tissue, liposuction is not covered by these criteria.**

**(3)**
In male patients, reduction mammoplasty is done for symptomatic gynecomastia and is performed as an open procedure or a combination of surgical excision and liposuction. The specific surgical technique will vary depending on the amount of glandular breast tissue and fat removed and the amount of skin resected. Surgical excision of breast tissue is used for true gynecomastia, as glandular tissue cannot be suctioned (Devalia and Layer, Surgeon 2009; 7(2): 114-119; Johnson and Murad, Mayo Clin Proc 2009; 84(11): 1010-1015). Reduction mammoplasty is indicated for gynecomastia not related to malignancy or caused by other treatable causes (Narula and Carlson, Endocrinol Metab Clin North Am 2007; 36(2): 497-519; American Society of Plastic Surgeons, Practice Parameters: Gynecomastia. 2004 [cited 2010]).

**(4)-DEF:**
True gynecomastia is a benign proliferation of the glandular component of male breast tissue and is caused by an excess of circulating estrogen, a deficiency of androgens, or an altered androgen-to-estrogen ratio. Pseudogynecomastia is breast enlargement due to fat or adipose accumulation. Mixed gynecomastia is breast enlargement secondary to both glandular and fat tissue.

**(5)**
Gynecomastia can occur in males of any age but is more commonly seen in puberty or in males over the age of 60 (Braunstein, N Engl J Med 2007; 357(12): 1229-1237; Hanavadi et al., Breast 2006; 15(2): 276-280). In more than half of all cases, gynecomastia occurs bilaterally. Carcinoma should be considered in cases of unilateral enlargement, induration, fixation, skin dimpling, bloody nipple discharge, or a hard, asymmetric mass (Johnson and Murad, Mayo Clin Proc 2009; 84(11): 1010-1015; Braunstein, N Engl J Med 2007; 357(12): 1229-1237; Narula and Carlson, Endocrinol Metab Clin North Am 2007; 36(2): 497-519).

**(6)**
Gynecomastia is commonly associated with breast pain, which can range in intensity from mild tenderness or sensitivity to constant pain and pressure (Narula and Carlson, Endocrinol Metab Clin North Am 2007; 36(2): 497-519; Di Lorenzo et al., Lancet Oncol 2005; 6(12): 972-979). Surgical resection would only be done in symptomatic patients.

**(7)**
Gynecomastia can be differentiated from pseudogynecomastia by comparing the subareolar, glandular breast tissue with the adjacent adipose tissue (Johnson and Murad, Mayo Clin Proc 2009; 84(11): 1010-1015; Narula and Carlson, Endocrinol Metab Clin North Am 2007; 36(2): 497-519). True gynecomastia usually presents as a rubbery, discrete subareolar mass that is freely mobile and unattached to the skin (Braunstein, N Engl J Med 2007; 357(12): 1229-1237).

**(8)**
Symptomatic gynecomastia that does not respond to medical treatment may require surgical intervention. A grading system aids in determining the appropriate surgical intervention for treating gynecomastia.
The American Society of Plastic Surgeons has adapted the various classification systems for gynecomastia into a grading system (American Society of Plastic Surgeons, Practice Parameters: Gynecomastia. 2004 [cited 2010]):
- **Grade I:** Small breast enlargement with localized button of tissue that is concentric around the areola
- **Grade II:** Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest
- **Grade III:** Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present
- **Grade IV:** Marked breast enlargement with skin redundancy and feminization of the breast

**(9)**
The goal of surgical correction is to restore the normal male contour with minimal scarring, which can be accomplished in a variety of ways: by simple excision of breast tissue perhaps with removal of some subcutaneous fat or, in more advanced cases, subcutaneous mastectomy with resection of redundant skin (Johnson and Murad, Mayo Clin Proc 2009; 84(11): 1010-1015; Ratnam, Aesthet Surg J 2009; 29(1): 26-31; American Society of Plastic Surgeons, Practice Parameters: Gynecomastia. 2004 [cited 2010]; Simon et al., Plast Reconstr Surg 1973; 51(1): 48-52). Subcutaneous mastectomy, although generally reserved for higher grades of gynecomastia, may be appropriate for symptomatic gynecomastia when simple excision of breast tissue is deemed not adequate. Minimally invasive

procedures (e.g., laser therapy, mammotome, RFA) are still considered investigational (Devalia and Layer, Surgeon 2009; 7(2): 114-119).

**(10)**

Bilateral mammography and US are helpful in the evaluation of gynecomastia and are used as adjuncts to PE. These imaging modalities can distinguish true breast tissue from adipose tissue, as well as differentiate benign from malignant masses (Devalia and Layer, Surgeon 2009; 7(2): 114-119; Morakkabati-Spitz et al., Radiology 2006; 238(2): 438-445; Wise et al., J Am Coll Surg 2005; 200(2): 255-269).

**(11)**

Medical conditions associated with gynecomastia include hypogonadism, hyperthyroidism, renal disease, malnutrition, cirrhosis or liver disease, testicular or prostate tumors, Klinefelter's syndrome, and XXY males. Attempts should be made to address these underlying causes of gynecomastia prior to considering surgical resection.

**(12)**

Various medications have been used to treat gynecomastia. Medical treatment for gynecomastia involves blocking estrogen effects in the breast tissue using antiestrogens (e.g., tamoxifen), decreasing estrogen production using aromatase inhibitors (e.g., testactolone), or giving androgens (Narula and Carlson, Endocrinol Metab Clin North Am 2007; 36(2): 497-519; Hanavadi et al., Breast 2006; 15(2): 276-280). While tamoxifen is not approved by the FDA for the treatment of gynecomastia, it has been well studied and does reduce breast pain and swelling. Other medications are used less often, and there is little evidence to support their use (Johnson and Murad, Mayo Clin Proc 2009; 84(11): 1010-1015). Gynecomastia that has been present for longer than 1 year and is fibrotic does not generally regress spontaneously or resolve with medication (Braunstein, N Engl J Med 2007; 357(12): 1229-1237).

**(13)**

An integral component in the evaluation of gynecomastia is recognizing and discontinuing any drugs that can cause the disorder. Contributory medications should be discontinued or changed to an alternative medication if possible prior to surgical treatment, as the problem may recur after surgery if the drugs are continued. Medications that can cause breast enlargement include certain hormones, chemotherapeutic agents, psychoactive drugs, antibiotics, and antiulcer drugs, as well as drugs of abuse (e.g., marijuana, heroin, amphetamines, anabolic steroids) (Johnson and Murad, Mayo Clin Proc 2009; 84(11): 1010-1015; Cuculi et al., CMAJ 2007; 176(5): 620; Narula and Carlson, Endocrinol Metab Clin North Am 2007; 36(2): 497-519).

**ICD-9:** 85.31, 85.32, 85.34, 85.36
**ICD-10-PCS:** 0HBT0ZZ, 0HBT3ZZ, 0HBU0ZZ, 0HBU3ZZ, 0HBV0ZZ, 0HBV3ZZ
**CPT®:** 19300, 19304, 19318

**InterQual®**

# 2021, July 2021 Release CP:Procedures

**Subset:** Reduction Mammoplasty, Male (Adolescent) (1, 2, 3, 4, 5, 6, 7, 8, 9)

**Requested Service:** Reduction Mammoplasty, Male (Adolescent)

**Age:** Age ≥ 13 and < 18

| | | | | |
|---|---|---|---|---|
| Patient: | Name: | DOB: | ID #: | GROUP #: |
| | Sex (circle): M / F | Height: | Weight: | |
| Provider/PCP: | Name: | Fax #: | Phone #: | |
| | NPI/ID #: | Signature: | | Date: |
| Servicing: | Vendor/Facility: | | Phone #: | |
| | Diagnosis/ICD: | Service Date: | Authorization: / / to / / | |



ICD-10:

CPT®:

**INSTRUCTIONS:** Answer the following questions

☐ 10. Gynecomastia

1. Choose one:
   - ☐ A) Symptomatic gynecomastia
   - ☐ B) Asymptomatic gynecomastia (10)
   - ☐ C) Other clinical information

   • If option A selected, then go to question 2
   • No other options lead to the requested service

2. Choose all that apply:
   - ☐ A) Breast pain or tenderness (11)
   - ☐ B) Grade I or grade II or grade III or grade IV gynecomastia by physical examination (12, 13, 14)
   - ☐ C) Contributory conditions excluded or treated ≥ 6 months (15, 16)
   - ☐ D) Gynecomastia persists beyond 2 years of onset (17)
   - ☐ E) Other clinical information (add comment)

   • If the number of options selected is 4 and option E not selected, then go to question 3
   • No other options lead to the requested service


DHHRBMS002772

**Reduction Mammoplasty, Male (Adolescent)**

*Gynecomastia (continued...)*

3. Choose one: (18)
   - ☐ A) Medications deemed noncontributory
   - ☐ B) Contributory medications discontinued
   - ☐ C) Requires medication that contributes to gynecomastia for which there is no acceptable alternative medication
   - ☐ D) Other clinical information (add comment)

   • If option A, B or C selected, then the rule is satisfied; you may stop here **(Outpatient)**
   • No other options lead to the requested service

## Reference

Ltd - This requested service is designated as 'Limited Evidence' in this clinical scenario. Criteria cannot be met.

2nd - Secondary review required. Criteria cannot be met.

*Off-label* - Use of a drug for an indication not approved by the U.S. Food and Drug Administration (FDA).

## Notes:

**1:**
Gynecomastia is commonly seen in newborns, adolescents and men older than age 60, yet spontaneous resolution frequently occurs in newborns and adolescents and does not require intervention. Males whose gynecomastia does not resolve on its own and who are symptomatic may be candidates for reduction mammoplasty to remove glandular breast tissue (Dickson, Am Fam Physician 2012, 85: 716-22).

**2:**
POL: It is a matter of local medical policy whether to require submission of photographs prior to approval of the procedure.

**3:**
These criteria address surgical resection (e.g., reduction mammoplasty, subcutaneous mastectomy) of gynecomastia, including mixed gynecomastia. If breast enlargement in male patients is due primarily to excess fatty tissue and not glandular hypertrophy, liposuction can be used for reducing breast size. Since liposuction only removes fatty tissue and not breast tissue, liposuction is not covered by these criteria.

**4:**
These criteria include the following procedures:
Breast Reduction, Male
Mastectomy for Gynecomastia
Mastectomy, Subcutaneous, Male

**5:**
InterQual® content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including, but not limited to, gender identity and gender affirmation via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.

**6:**
Nearly 50% to 65% of adolescent males will experience some degree of gynecomastia at Tanner stage 3 or 4. When spontaneous resolution does not occur, some males will pursue surgery due to physical symptoms, or because of significant emotional distress (Rew et al., J Adolesc 2015, 43: 206-12; Dickson, Am Fam Physician 2012, 85: 716-22). A large systematic review states that adolescent males with gynecomastia are often overweight or obese, yet do not experience significantly higher rates of complications after surgery than those who are normal weight. Weight loss prior to surgery may be advised in some cases to achieve normal weight for overall health reasons, but is not always necessary prior to reduction mammoplasty to prevent complications. Delaying surgery in symptomatic patients until weight loss is achieved is not advised as it may perpetuate emotional distress (Rew et al., J Adolesc 2015, 43: 206-12).

**7:**
This is a procedure that can be performed for either medically necessary or cosmetic purposes. The criteria as written are intended solely for use in determining the medical appropriateness of this procedure and do not cover this procedure when performed for cosmetic reasons.

**8:**
InterQual® Procedures criteria are derived from the systematic, continuous review and critical appraisal of the most current evidence-based literature and include input from our independent panel of clinical experts. To generate the most appropriate recommendations, a comprehensive literature review of the clinical evidence was conducted. Sources searched included PubMed, ECRI Guidelines Trust®, Agency for Healthcare Research and Quality (AHRQ) Comparative Effectiveness Reviews, the Cochrane Library, Choosing Wisely, Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations, and the National Institute of Health and Care Excellence (NICE). Other medical literature databases, medical content providers, data sources, regulatory body websites, and specialty society resources may also have been used. Relevant studies were assessed for risk of bias

following principles described in the Cochrane Handbook. The resulting evidence was assessed for consistency, directness, precision, effect size, and publication bias. Observational trials were also evaluated for the presence of a dose-response gradient and the likely effect of plausible confounders.

**9:**
I/O Setting: Outpatient

**10:**
Breast asymmetry, hypomastia, macromastia and gynecomastia can have significant psychosocial impact, not only in adolescent males and females, but also in adults. Retrospective and prospective studies using the Rosenberg Self-Esteem Scale state that these individuals often suffer from low self-esteem and seek surgery to relieve emotional instability (Nuzzi et al., Plast Reconstr Surg 2014, 134: 1116-23; Nuzzi et al., Plast Reconstr Surg 2013, 131: 890-6; Neto et al., Aesthetic Plast Surg 2012, 36: 223-5).

**11:**
Gynecomastia is commonly associated with breast pain, which can range in intensity from mild tenderness or sensitivity to constant pain and pressure.

**12:**
True gynecomastia can present as a rubbery or firm, subareolar mass that can be unattached or adherent to the skin.

**13:**
The American Society of Plastic Surgeons has adopted the following grading system for gynecomastia (American Society of Plastic Surgeons, Practice Parameters: Gynecomastia. 2004). :
• Grade I: Small breast enlargement with localized button of tissue that is concentric around the areola
• Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest
• Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are distinct from the chest with skin redundancy present
• Grade IV: Marked breast enlargement with skin redundancy and feminization of the breast

**14:**
InterQual® consultants agree that adolescent males with grade I gynecomastia that has persisted for at least two years, who have discontinued all possible contributory medications, and who have breast pain or tenderness are candidates for medically necessary reduction mammoplasty.

**15:**
Medical conditions associated with gynecomastia include hypogonadism, hyperthyroidism, renal disease, malnutrition, cirrhosis or liver disease, testicular or prostate tumors, Klinefelter syndrome, and XXY males. Attempts should be made to address these underlying causes of gynecomastia prior to considering surgical resection.

**16:**
Medical treatment for gynecomastia involves blocking estrogen effects in the breast tissue using antiestrogens (e.g., tamoxifen), decreasing estrogen production using aromatase inhibitors (e.g., testactolone), or giving androgens (Morcos and Kizy, J Fam Pract 2012, 61: 719-25). While tamoxifen is not approved by the U.S. Food and Drug Administration for the treatment of gynecomastia, it has been well studied and does reduce breast pain and swelling. Gynecomastia that has been present for longer than 1 year and is fibrotic does not generally regress spontaneously or resolve with medication (Morcos and Kizy, J Fam Pract 2012, 61: 719-25).

**17:**
Spontaneous resolution of gynecomastia in adolescent males tends to occur within six months to two years of onset. If gynecomastia persists after two years, surgery can be considered (Dickson, Am Fam Physician 2012, 85: 716-22).

**18:**
An integral component in the evaluation of gynecomastia is recognizing and discontinuing or changing any drugs

that can cause the disorder, as the problem may recur after surgical correction if the drugs are continued. Medications that can cause breast enlargement include certain hormones, chemotherapeutic agents, psychoactive drugs, antibiotics, and antiulcer drugs, as well as drugs of abuse (e.g., marijuana, heroin, amphetamines, anabolic steroids) (Morcos and Kizy, J Fam Pract 2012, 61: 719-25).

Reduction Mammoplasty, Male (Adolescent)

**ICD-10-CM (circle all that apply):** N62, Other _____

**ICD-10-PCS (circle all that apply):** 0H0T0JZ, 0H0T3JZ, 0H0U0JZ, 0H0U3JZ, 0H0V0JZ, 0H0V3JZ, 0HBT0ZZ, 0HBT3ZZ, 0HBU0ZZ, 0HBU3ZZ, 0HBV0ZZ, 0HBV3ZZ, 0HRT0JZ, 0HRT3JZ, 0HRU0JZ, 0HRU3JZ, 0HRV0JZ, 0HRV3JZ, Other _____

**CPT® (circle all that apply):** 19300, 19318, Other _____

IN THE UNITED STATES DISTRICT COURT
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CHRISTOPHER FAIN and SHAUNTAE ANDERSON individually and on behalf of all others similarly situated,

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*Defendants*.

CIVIL ACTION NO. 3:20-cv-00740
HON. ROBERT C. CHAMBERS

**PLAINTIFFS REPLY MEMORANDUM OF LA IN SUPPORT OF MOTION TO EXCLUDE EXPERT TESTIMONY OF STEPHEN B. LEVINE, M.D.**

**TABLE OF CONTENTS**

## I. INTRODUCTION

Defendants opposition fails to meaningfully grapple with the deficiencies described in Dr. Levine s testimony. Instead, Defendants attempt to shift, or in some cases, remove the legal goal posts altogether. Specifically, Defendants suggest that what is at issue is not whether their discriminatory exclusion violates the Equal Protection Clause, Section 1557 ("Section 1557") of the Patient Protection and Affordable Care Act ("ACA") or the Medicaid Act's Comparability and Availability requirements but whether gender affirming surgeries are "medically necessary," and claim this justifies admitting Dr. Levine's opinions wholesale. ECF No. 260 at 3. Defendants misconstrue the relevant *Daubert* standard and willfully ignore the Fourth Circuit's most recent and relevant affirmation of "the indispensable nature of district courts' Rule 702 gatekeeping function in all cases in which expert testimony is challenged." *ardis v. verhead Door Cor .*, 10 F.4th 268, 284 (4th Cir. 2021). Finally, Defendants attempt to rehabilitate Dr. Levine's testimony from the damage done by his own concessions at deposition by rewriting the record. But even this attempt at revisionist history cannot overcome the witness's myriad inconsistencies, methodological failures and scientifically unsupported conclusions. The Court should disregard Defendants' plea for lackadaisical gatekeeping and instead exclude the challenged expert's testimony because of his lacking qualifications, and the fact that his testimony is neither relevant nor scientifically reliable.

## II. ARGUMENT

Though Defendants would have this Court ignore Fourth Circuit precedent, it is well established that when considering expert testimony, " t he party offering the expert carries the burden of establishing admissibility by a preponderance of the evidence." *Coo er v. mith e he , n .*, 259 F.3d 194, 199 (4th Cir. 2001); *see also mith v. yeth Ayerst Lab ys Co.*, 278

F. Supp. 2d 684, 691 (W.D.N.C. 2003) ("The proponent of expert testimony has the burden of establishing its admissibility by a preponderance of proof.") Defendants fail to meet this burden, however, and are unable to overcome Plaintiffs' specific challenges to Dr. Levine's qualifications and the scientific reliability of his methods and proffered opinions.

As Plaintiffs noted in their opening brief in support of the instant motion, other federal courts have resoundingly dismissed Dr. Levine's opinions about transgender people and the treatment of gender dysphoria. This occurred as recently as 11 days ago, by a federal district court within the Fourth Circuit. On June 10, 2022, Judge Loretta C. Biggs of the Middle District of North Carolina issued a ruling in the *Kadel v. ol ell*, No. 1:19-CV-272, 2022 WL 1046313 (M.D.N.C. Apr. 7, 2022), where transgender plaintiffs challenged a similar exclusion of coverage of gender affirming care within the North Carolina State Employee Health Insurance Plan. Ruling on a motion to exclude the expert testimony of Dr. Levine, the Court held that "notably, Levine does not testify that medical and surgical care for gender dysphoria is categorically inappropriate." Memorandum Opinion and Order at 33, Kadel v. Folwell, No. 1:19-CV-272, 2022 WL 1046313 (M.D.N.C. Apr. 7, 2022), ECF No. 234. The Court also held that "Levine's testimony regarding desistance rates does not appear to be based on reliable methodology." *d*. at 36. Like Levine's testimony in this case, the Court found that:

> I t does not appear that he offers any *ategori al o inion* as to the medical necessity of medical and surgical treatments of gender dysphoria, nor does he testify that healthcare providers are prescribing such treatment without due caution and informed consent beyond his anecdotal "experience." To the extent that Defendants seek to introduce testimony from Levine to that effect, he has not provided the Court with any data or methodology from which such claims could be made. Levine has conducted no research to identify which physicians are proceeding as he does, and which do not, rendering any broader opinion about the practice of such healthcare providers pure speculation. *d*. at 37 (emphasis added).

Finally, *Kadel* also found that Levine's references to a " Transgender Treatment Industry'

does not appear to be based on any science whatsoever" and is "nothing more than rank speculation designed to distract or inflame the jury and has no business in expert testimony." *d*. at 37, 32.[1] After narrowing the scope of admissible testimony by Dr. Levine, *Kadel* rejected Defendants' argument Levine's testimony created "a genuine issue of material fact as to whether the Plan's exclusion substantially excludes ineffective treatments." *d*. at 50. There, as here, Defendants pointed to Dr. Levine's testimony to argue that medical treatments for gender dysphoria are categorically ineffective. But the Court rejected that argument based on *Levine s o n testimony*:

> T hat is not Levine's testimony. He testifies that the available research is not sufficiently reliable to prove that treatments are effective, but repeatedly and emphatically testifies that this lack of high-level research is not reason to justify withholding treatment from all gender dysphoric patients. Rather he testifies that doctors and patients, when fully aware of the risks and elusive benefits of available treatments, should decide if medicine or surgery is necessary, as he does *in his o n ra ti e*. This is Plaintiffs' request: that they and their doctors, not their sex or transgender status, determine when their treatments are appropriate. Levine does not and cannot reliably testify as to how often doctors prescribe unnecessary treatments or fail to obtain informed consent. *d*. (emphasis in original).

So too here, Levine's proposed opinions are undercut by his own testimony under oath, a blow from which Defendants cannot recover. Dr. Levine Fain Dep. Tr. 88:10-13, ECF No. 254-03; Dr. Levine Kadel Dep Tr. at 73:4-7 ("Q: Is the worrisomeness about a patient's future health, is that a reason to ban all medical care for gender dysphoria? A: Absolutely not."); 84:21-85:1 ("Q: Given all those concerns you have, is that a reason to deny all medical interventions to people with gender dysphoria? A: No …."); 85:4-11 ("Q: Are those concerns you raised justifications in your mind for denying medical interventions to people who have gender dysphoria? A: You know, I'm not advocating denying endocrine treatment or surgical treatment."); 152:1-6 ("Q: Do you think

[1] Dr. Levine's similar proposed testimony here lacks any scientific basis and should be excluded by this Court as similarly based on nothing more than "conspiratorial accusations": "There is also an entire industry of mental health clinicians, hormone prescribers, surgeons and even hospitals who have built lucrative lines of business from scaling the costly transgender healthcare' model." Dr. Levine Expert Disclosure 10, ECF No. 254-02.

because that study showed that some people committed suicide after gender affirming surgery that no patient should be able to access gender affirming surgery? A: That would be illogical"); 154:3-5 ("Q: But you're not recommending total bans on gender affirming surgery? A: I'm not recommending total bans."); 160:23-25 ("I did not say that gender affirming treatment in general should be stopped. I've never said that."), ECF No. 254-04. Thus, Levine s testimony also does not create a genuine issue of material fact as to whether the Plan s exclusion substantially excludes ineffective treatments.

**A. Defendants Attempt to Re rite Dr. Levine s Report in Their Response, Mis uote Plaintiffs Memorandum of La , and Mischaracteri e Fourth Circuit Precedent Does Not Make Dr. Levine s Testimony Admissi le.**

Defendants' opposition grasps for straws in response to Plaintiffs' motion to exclude Dr. Levine's irrelevant opinions about how a person is "biologically defined," his personal and scientifically unsupported opinions "gender exploratory psychotherapy" as a treatment for gender dysphoria, and the Fourth Circuit's observations about the medical community's consensus about appropriate treatment protocols for gender dysphoria. In response, Defendants attempt to rewrite their own expert witness's testimony, including by suggesting his opinions are scientifically supported when they are not, misquoting Plaintiffs' arguments, and mischaracterize the controlling Circuits Court of Appeals decision.

First, Defendants argue that Dr. Levine's scientifically unsupported opinion that biology is defined only by chromosomes, regardless of any other sex related characteristics, is relevant because it is the basis for another of his opinions. ECF No. 260 at 10. Putting aside Defendants' assertion that Dr. Levine relies on an unsupported opinion of *his o n* for another of his opinions, Defendants then troublingly state that Dr. Levine has offered the opinion that "gender affirming surgeries do not and cannot fully achieve the results desired by patients." *d*. But Defendants cite

no portion of Dr. Levine s report or deposition to support this assertion. To the extent they intend to invoke Dr. Levine s distasteful suggestion that no transgender person can ever become a complete man or a complete woman, that is scientifically unsupported and rooted in disrespectful stereotypes that transgender men are not men, and that transgender women are not women. This is not expert testimony. Nor could Dr. Levine purport to offer such an opinion given that he cannot possibly assert specialized knowledge about what results are desired by Plaintiffs here, the class they represent, or even any patients with whom he has not directly discussed the matter.[2]

Second, instead of meaningfully confronting Dr. Levine's admitted lack of scientific evidence for his assertions that "gender exploratory psychotherapy" is the only appropriate treatment for gender dysphoria, Defendants employ several unsuccessful arguments. First, Defendants mischaracterize Plaintiffs' motion to accuse Plaintiffs of "attempting to make Dr. Levine a pariah." ECF No. 260 at 11. Such an ad hominem attack is unfounded and not reflected anywhere in Plaintiffs' brief. Dr. Levine's meaning of the term "gender exploratory psychotherapy" as set out in his testimony is wholly at odds with the way that other professional agencies and behavioral health organizations define that term, such as the Substance Abuse and Mental Health Services Administration ("SAMHSA")[3] and the American Academy of Child and

[2] Defendants make the first of several peculiar attempts to respond to Plaintiffs' well-supported arguments by suggesting that if certain opinions of Dr. Levine's must be excluded, so too must Plaintiffs' experts on the same category. ECF No. 260 at 10, 19-20. By doing so, Defendants suggest this "tit for tat" is the standard by which the Court should evaluate the exclusion of Dr. Levine's opinions. This is also not the appropriate venue for such arguments about Plaintiffs' experts. Defendants could have filed similar motions to exclude the testimony of Plaintiffs' experts, but notably, did not. These arguments are therefore untimely and improperly raised.

[3] Substance Abuse and Mental Health Servs. Admin., Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth (2015), available at https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4928.pdf

Adolescent Psychiatry. Those agencies and professional organizations recognize that, properly done, such therapies "foster healthy development, especially for sexual and gender diverse youth, as they *integrate their se ual orientation, gender identity, and or gender e ression, into their overall identity ithout any re determined out ome*." *Conversion hera y*, https://www.aacap.org/aacap/Policy_Statements/2018/Conversion_Therapy.aspx (last visited June 20, 2022). In stark opposition, Dr. Levine clearly favors placing a thumb on the scale to try to persuade younger patients through "gender exploratory therapy" to no longer be transgender, or that the cause of their gender dysphoria is related to their race, developmental disability, their residence in a foster home, their status as an adoptee, their history of psychiatric illness, or even having been assigned female at birth, rather than simply their being transgender. Dr. Levine Expert Disclosure 10, 87, 88, 156, 157, 160, 164, ECF No. 254-02. Notably, "conversion therapy" is defined by the American Academy of Child and Adolescent Psychiatry as "any therapeutic intervention operating under the premise that a specific gender identity and/or expression is pathological" and "imposed with the intent of promoting a particular…gender as a preferred outcome." That is Dr. Levine's preferred outcome as well. Indeed, in each of the articles that Dr. Levine cites to about the supposed impact of "gender exploratory therapy" each young person's gender dysphoria is treated by the young person "reinvesting" in their assigned sex at birth, not by continuing to assert a gender identity different from the one they were assigned at birth. ECF No. 254-02 Dr. Levine Expert Disclosure 37. If Dr. Levine's characterization of "gender exploratory therapy" were in line with its widely accepted clinical meaning, he would not rely on sources that have as their goal causing the patient to identify with their birth assigned sex. These unreliable opinions present by Dr. Levine throughout his testimony do not pass the rigorous gatekeeping requirements of FRE 702 and *Daubert* standards.

Third, Defendants return to their tried-and-true strategy of rewriting Dr. Levine's testimony and misrepresenting which of his opinions have scientific support in the hopes the Court will ignore its gatekeeping obligations in this dispute. Defendants allege that Dr. Levine "cites to peer-reviewed literature showing … a growing consensus supporting the use of psychotherapy as a first treatment modality for gender dysphoria." But whether therapy is an initial treatment option for transgender people says nothing about the categorical ban Defendants maintain on surgical care, and indeed, Dr. Levine has testified repeatedly that he does not support such bans. Dr. Levine Fain Dep. Tr. 88:10-13, ECF No. 254-03; Dr. Levine Kadel Dep Tr. at 73:4-7 ("Q: Is the worrisomeness about a patient's future health, is that a reason to ban all medical care for gender dysphoria? A: Absolutely not."); 84:21-85:1 ("Q: Given all those concerns you have, is that a reason to deny all medical interventions to people with gender dysphoria? A: No …."); 85:4-11 ("Q: Are those concerns you raised justifications in your mind for denying medical interventions to people who have gender dysphoria? A: You know, I'm not advocating denying endocrine treatment or surgical treatment."); 152:1-6 ("Q: Do you think because that study showed that some people committed suicide after gender affirming surgery that no patient should be able to access gender affirming surgery? A: That would be illogical"); 154:3-5 ("Q: But you're not recommending total bans on gender affirming surgery? A: I'm not recommending total bans."); 160:23-25 ("I did not say that gender affirming treatment in general should be stopped. I've never said that."), ECF No. 254-04. Contrary to Defendants' suggestion, Dr. Levine provided no other citation or scientific support for this assertion in his report or elsewhere. Dr. Levine Expert Disclosure 160, ECF No. 254-02. Regardless, this opinion is simply irrelevant both to Dr. Levine s own clinical practices, and to the issues in the case. Dr. Levine himself does not preclude his own patients from receiving this care and writes letters of authorization so they can obtain it. Dr. Levine Fain Dep. Tr. at 84:4-85:4;

139:14-19, ECF No. 254-03; Dr. Levine Kadel Dep. Tr. at 55:13-17; 56:2-5; 112:16-21; 176:8-16, ECF No. 254-04; Soneeya Bench Trial Day 1 Tr. at 1-100:15-22, ECF No. 254-05. Additionally, as Plaintiffs explained in their summary judgment opposition brief, concerns about medical necessity are indisputably post-hoc, and therefore irrelevant under the heightened scrutiny Grimm requires for Plaintiffs Equal Protection claims, and for Plaintiffs' Medicaid Act claims. Pls.' Summ. J. Opp. at 12-13, ECF No. 262; see also *la v. is onsin De t of ealth ervs.*, 395 F. Supp. 3d 1001, 1020-21 (W.D. Wis. 2019) (finding that lack of evidence of any systematic review of medical necessity before or after adopting exclusion renders the concern post-hoc), 1021 n.28 (same for expert testimony constructed for litigation and not considered by decision-makers).

Finally, Defendants would have this Court ignore Fourth Circuit precedent about "the indispensable nature of district courts' Rule 702 gatekeeping function" as well as its persuasive and informative observations about accepted treatment protocols. As such, the Fourth Circuit has observed in *rimm* that,

> Fortunately, we now have modern accepted treatment protocols for gender dysphoria. Developed by the World Professional Association for Transgender Health (WPATH), the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (7th Version 2012) (hereinafter "WPATH Standards of Care") represent the *onsensus a roa h of the medi al and mental health ommunity*, Br. of Medical Amici 13, and have been recognized by various courts, *in luding this one*, as the authoritative standards of care, *see De lonta v. ohnson*, 708 F.3d 520, 522–23 (4th Cir. 2013); *see also dmo*, 935 F.3d at 769; *Keohane v. ones*, 328 F. Supp. 3d 1288, 1294 (N.D. Fla. 2018), vacated sub nom. *Keohane v. la. De t of Corrs. e y*, 952 F.3d 1257 (11th Cir. 2020). "There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups." *dmo*, 935 F.3d at 769 (quoting *dmo v. daho De t of Corr.*, 358 F. Supp. 3d 1103, 1125 (D. Idaho 2018)).

*rimm v. lou ester Cnty. h. d.*, 972 F.3d 586, 595-96 (4th Cir. 2020) (emphasis added). Ultimately, Defendants' attempts to shoehorn Dr. Levine's irrelevant testimony within the zone of admissibility fail and must be denied.

**B. Defendants Attempts to Reha ilitate Dr. Levine s Methodologically Unrelia le and Scientifically Unsupported Testimony Fail.**

Defendants "say so" that Dr. Levine's opinions should be admitted, and that his proposed testimony will survive the Court's gatekeeping duties under Rule 702 and *Daubert* and its progeny, including *ardis*, is not enough.

**. Dr. Levine s Unsupported Criticisms of the PATH SOC Make Him An Outlier in This Field and Render His Proposed Testimony Unrelia le.**

It is worth noting at the outset that the only Fourth Circuit case Defendants cite in their response to Plaintiffs' instant motion runs contrary to their arguments about Dr. Levine's criticisms of the WPATH SOC. ECF No. 260 at 2-3. Specifically, a challenged expert's disagreement with what is otherwise the recognized medical and scientific consensus calls into question *their reliability* because general acceptance in the relevant scientific community is an important element of reliability. *ee ease v. ord Motor Co.*, 848 F.3d 219, 229 (4th Cir. 2017). As Plaintiffs have explained at length in their opening brief, the WPATH SOC are the generally accepted and recognized protocols for the treatment of gender dysphoria in the United States and elsewhere, and Dr. Levine testified in this case and others[4] that he generally abides by them in his clinical practice. ECF No. 255 at 5. Even still, Defendants argue that because Dr. Levine's report mischaracterizes the findings of the Dahlen et al. article, quotes statements from the incoming WPATH president Dr. Marci Bowers that she has since clarified and disavowed, and "includes citations" that his testimony about WPATH SOC is reliable. These arguments simply do not survive this Court's gatekeeping inquiry, or the standards set forth in FRE 702 and *Daubert.*

[4] Contrary to Defendants' assertion, the previous testimony given under oath of any expert witness, including Dr. Levine, in other similar cases is directly relevant to the reliability of the opinions he proposes to offer in this case.

Defendants repetition of Dr. Levine's mischaracterization of the Dahlen et al. article is not a rebuttal to Plaintiffs' argument. ECF No. 260 at 14. Plaintiffs take issue with, and Defendants have no response for, Dr. Levine's inaccurate characterization that " a recently published systematic review found the current WPATH SOC7 (sic) guidelines to be of very low quality and unfit tools for clinical decision making," a statement found nowhere in the Dahlen article, nor a conclusion supported by the article itself. *d*. Defendants notably have no response to the article's significant qualification that "evaluations of clinical practice guidelines in other medical areas including cancer, diabetes, pregnancy, and depression" "tend to show room for improvement," and that "finding poor quality CPGs is not confined to this area of healthcare." Dahlen Article at 8-9, ECF No. 254-08. Dr. Levine's suggestion that this is somehow uniquely true for the WPATH SOC is unsupported, and it simply cannot be that such a methodologically unsound conclusion is admissible under FRE 702 and *Daubert*. The article's authors also note that " i ncluding gender minority/trans people in guidelines can be considered a matter of health equity, where CPGs have a role to play. GRADE suggests that CPG developers consider equity at various states in creating guidelines..." *d*. This recommendation runs directly counter to Dr. Levine's assertion that because attendance at WPATH's "biennial meetings has been open to trans individuals who are not licensed professionals" that "WPATH can no longer be considered a purely professional organization." Dr. Levine Expert Disclosure at 68, ECF No. 254-02. Indeed, the Dahlen et al. article does not support the reliability of Dr. Levine's testimony in the ways that Defendants allege.

" A reliable expert would not ignore contrary data, misstate the findings of others, make sweeping statements without support, and cite papers that do not provide the support asserted." *yree v. oston i. Cor* ., 54 F. Supp. 3d 501, 520 (S.D.W. Va. 2014). And yet, Defendants attempt to justify Dr. Levine's ignoring the subsequent statements of Dr. Marci Bowers that

disavow statements quoted by Dr. Levine for the purpose of undermining WPATH. Dr. Bowers' Statement, ECF No. 254-09. Dr. Bowers says that what she hopes for "most of all, is that my out-of-context comments will not be excerpted to weaponize ongoing attacks on transgender persons," and that "we are best served by our support of WPATH and its goal of establishing evidence-based care that affirms gender identity as another important aspect of global diversity." *d*. at 3. Defendants believe Dr. Levine's failure to account for these subsequent statements by Dr. Bowers has "no bearing on the admissibility of Dr. Levine's opinions." ECF No. 260 at 14. This Court disagrees. *yree*, 54 F. Supp. 3d at 520 (cleaned up) ("An expert's opinion may be unreliable if he fails to account for contrary scientific literature and instead "selectively chooses his support from the scientific landscape.").

Finally, Defendants misunderstand their burden in submitting reliable and methodologically sound expert testimony when they assert that Dr. Levine's opinion that "a growing number of countries are deviating from WPATH and Endocrine Society guidelines" should not be excluded because "Dr. Levine's report includes citations[5] to support his opinions." ECF No. 260 at 14-15. Plaintiffs have already explained that the citations Dr. Levine provides are not from peer-reviewed, scientific sources, and the even *the sour es themselves* do not stand for the proposition Dr. Levine alleges. In fact, those sources admit instead that Sweden, Finland, and the UK still allow access to puberty blockers, hormone therapy and other medical interventions, which Dr. Levine also conceded when pressed at deposition. Dr. Levine Fain Dep. Tr. 106:4-

[5] Defendants assert that the number of citations Dr. Levine includes in his report helps to establish Dr. Levine as qualified and his testimony as reliable and relevant under FRE 702 and *Daubert* standards. ECF No. 260 at 7, 13 ("Dr. Levine's opinions are supported by 242 citations"). Defendants point to no authority for this assertion, including nothing within Rule 702, *Daubert,* or its progeny. Indeed, quantity is not the same as quality in the admissibility of proposed expert testimony.

108:8;191:20-192:16, ECF No. 254-03. Likely because Dr. Levine's citations fail to support his opinion, Defendants cite in their reply to a source Dr. Levine did not identify in his report or at deposition as a source upon which he relied in forming his opinions. ECF No. 260 at 15. Defendants' untimely inclusion of this source should not be allowed as it violates the expert witness' obligation under Rule 26 that their expert disclosure include all sources upon which they have relied in forming their opinions. However, even if the Court found this source admissible at this juncture, the article simply does not support Dr. Levine's asserted opinion. It states that the Swedish National Board of Health and Welfare "recommends restraint when it comes to hormone therapy," but defendants omitted the sentence that immediately follows: " a t the same time, it is important that children and young people suffering from gender dysphoria are taken seriously, well treated and offered adequate care measures." ECF No. 252-07. It is worth noting that Defendants already provide coverage for hormone therapy in their Medicaid program, so this articles' recommendations have no relevance to the surgical care exclusion at the center of this case. Finally, the article does not conclude that Sweden, or a "growing number of countries," are deviating from providing the medical care in accordance with WPATH, or the Endocrine Society guidelines, protocols that Dr. Levine continues to generally adhere to in his own clinical practice.

**. Dr. Levine s Failure to Account for Contrary Scientific Literature and His Misrepresentation of E isting Data A out Gender Affirming Medical Care Renders His Related Opinions Unrelia le.**

At the outset it must be noted that Defendants mischaracterize Plaintiffs' arguments and misquote their opening brief in support of the instant motion.[6] Plaintiffs do not seek only to exclude Dr. Levine's opinions included in the non-exhaustive list of paragraphs from his report on page 15

[6] Defendants write that "Plaintiffs specifically cite to Paragraphs 23, 39, 51, 55 and 118 through 124 of Dr. Levine's Report…" Plaintiffs cite these as a non-exhaustive list of examples of Dr. Levine's unreliable opinions in this vein.

of their memorandum, but instead to exclude *all* of Dr. Levine's opinions that assert that gender affirming medical care is "experimental, risky and without lasting benefit." Nevertheless, Defendants again misunderstand the preponderance of evidence burden they bear in proving the admissibility of Dr. Levine's opinions in this case. Defendants suggest that the mere fact that Dr. Levine provides "support" for his opinions is sufficient to survive this Court's rigorous gatekeeping role under Rule 702. ECF No. 260 at 15. But "if the relevant scientific literature contains evidence tending to refute the expert's theory and the expert does not acknowledge or account for that evidence, the expert s opinion is unreliable." *yree*, 54 F. Supp. 3d at 520 (cleaned up). Such is the case here. As Plaintiffs discussed in their opening brief, Dr. Levine fails to acknowledge or account for "recent studies demonstrating that medical treatments for transgender adolescents and adults have favorable outcomes across many measures." ECF No. 255 at 11. Defendants make no attempt to explain or defend Dr. Levine's omissions in this regard. Defendants also notably offer no response to Plaintiffs' arguments about Dr. Levine's misrepresentation about two key studies showing positive long-term outcomes for transgender people who underwent gender reassignment via surgical interventions. ECF No. 255 at 11-12.

**. Defendants Attempts to Address the Methodological Fla s in Dr. Levine s Report y Re riting it Must Fail.**

Defendants attempt to rehabilitate another of Dr. Levine's unreliable opinions regarding "desistance" by ignoring Plaintiffs' arguments about specific methodological flaws and again attempting to introduce a source not found in Dr. Levine's report or deposition transcript. ECF No. 260 at 17. To begin, Defendants turn to their oft-repeated refrain that because Dr. Levine provides *any su ort* for his opinions whatsoever, regardless of whether the support is legitimate, that his opinions should be admitted in this case. Fortunately, that is not the standard by which expert testimony is evaluated and "proposed testimony must because supported by appropriate

validation i.e., good grounds' based on what is known." *yree*, 54 F. Supp. 3d at 526 (citing *Daubert v. Merrell Do Pharm.*, 509 U.S. 579, 590 (U.S. 1993)). Defendants fail to address Plaintiffs' arguments that Dr. Levine's sources to support this opinion are not "good grounds," nor based on what is known. Specifically, Defendants have *no ans er* for Dr. Levine's failure to rely on *any data or s ientifi literature* that studied transgender children or adolescents diagnosed under the current DSM V criteria for gender dysphoria other than to admit that "some of the literature cited to by Dr. Levine did analyze treatment outcomes using diagnostic criteria from the DSM-IV," which differed in significant ways from the current diagnostic criteria. ECF No. 260 at 17. Defendants go no further than this before attempting to distract the court with a key misrepresentation. Defendants state that "most of the literature cited to by Dr. Levine is from 2020 and 2021…Levine Report 90 (ECF 252-11)." While two of the three articles Dr. Levine relies on were published in 2020 and 2021, all three of articles use the same data collected from children whose gender non-conforming behavior was diagnosed between *and* , not 2020 or 2021. ECF No. 255 at 13. As Plaintiffs have already discussed in their opening brief, Dr. Levine points to no "recent available literature in the field" that analyzes data from children diagnosed with "Gender Dysphoria in Children" using the current and authoritative DSM-V which was released in 2013. ECF No. 255 at 17. Dr. Levine's citations to "papers that do not provide the support asserted" cannot be used to establish his opinion as reliable in this case.

Further, Defendants should not be permitted to submit in their reply to the instant motion a source that Dr. Levine did not include in his expert disclosure nor identify at deposition as a basis for this opinion. ECF No. 260 at 17 (citing De Vries, et al., *Reliability and Clini al tility of ender dentity Related Diagnoses Com arisons bet een the CD , CD , D M , and D M* , 8(2) LGBT HEALTH 133 (2021)). Even if the Court does consider this improperly cited

source, it does not stand for the proposition that Defendants allege, nor provide any additional support for Dr. Levine's challenged opinion. First, Defendants omit from their description that the study's purpose was to assess the "reliability and clinical utility" of the ICD-11, which has not yet been adopted in the United States, in comparison to other criteria. Defendants also omit the methods which involved sixty-four health care providers assessing videos of two children, two adolescents, and two adults for gender incongruence. This study notably did not purport to actually diagnose any of the six individuals, nor did it engage in long-term follow-up of the children and adolescents to see if they continued to experience gender incongruence or any other data points beyond "clinicians evaluating all four systems as convenient and easy to use." De Vries, et al., *Reliability and Clini al tility of ender dentity Related Diagnoses Com arisons bet een the CD , CD , D M , and D M* , 8(2) LGBT HEALTH 133 (2021). No matter how Defendants try to slice it, Dr. Levine's reliance on data collected under sweeping, outdated diagnostic criteria of the DSM III, III-R, IV and IV-R cannot pass muster to support this opinion and therefore it must be excluded.

**. Defendants Fail to Esta lish Dr. Levine s Unsupported Opinions A out Rapid Onset Gender Dysphoria and Detransition As Relia le or Supported y Scientific Evidence.**

In the service of attempting to salvage Dr. Levine's opinions from exclusion by this Court's gatekeeping obligations under Rule 702, Defendants misstate Plaintiffs' arguments, attempt to introduce a source that Dr. Levine did not include in his report or deposition testimony, and simply repeat Dr. Levine's unsupported opinions. Defendants' first sleight of hand to defend Dr. Levine's opinions about "rapid onset gender dysphoria" conflates an increase in the number of children and adolescents reporting to clinics for treatment of gender dysphoria with the scientifically unsupported hypothesis known as "rapid onset gender dysphoria." Dr. Levine Expert Disclosure

92, ECF No. 254-02.[7] Such a manipulation does not comport with the scientific method. "Rapid onset gender dysphoria" as a clinical term has not been "documented in the literature," contrary to Defendants' (and Dr. Levine's) assertions. This hypothesis was first posited in an article based on what parents, *not the adoles ents themselves*, described as their view that their adolescent experienced a "sudden onset of gender dysphoria." ECF No. 260 at 18. The researcher who introduced the term had to correct and republish the article, explicitly admitting that "rapid onset gender dysphoria is not a formal mental health diagnosis," and that "the report did not collect data from adolescents and young adults or clinicians and therefore *does not validate the henomenon*." Correction to Littman Article, ECF No. 254-18. Dr. Levine's report points to *no eviden e* to validate this hypothesis. Significantly, Dr. Levine did not cite in his report or discuss at deposition the one study to investigate the "rapid onset gender dysphoria hypothesis" that did use adolescent clinical data and which found no evidence to support the hypothesis. Bauer Article, ECF No. 254-19. " I f the relevant scientific literature contains evidence tending to refute the expert's theory and the expert does not acknowledge or account for that evidence, the expert's opinion is unreliable." *yree*, 54 F. Supp. 3d at 520 (cleaned up). Nor do Plaintiffs' experts support this hypothesis, and Defendants misrepresent their testimony by suggesting otherwise. ECF No. 260 at 18-19. Dr. Olson-Kennedy testified regarding a demographic shift seen at some gender clinics, but in no way suggested that it is accounted for by so-called "rapid onset gender dysphoria," and to the contrary suggested that other dynamics are likely the cause instead. Declaration of Carl S. Charles, Ex. U at 23:23-25:20; 55:6-56:10.

[7] Dr. Levine also attempts to use the WPATH SOC Version 8 draft's omission of "rapid onset gender dysphoria" and "detransition" as reasons to discredit the group and the forthcoming standards. For reasons discussed above, WPATH is under no obligation to include unscientific hypotheses and unverified reports from the internet in its internationally used Standards of Care.

Defendants repeat Dr. Levine's unsupported opinion that "a growing number of individuals are coming out publicly to discuss their own detransition." ECF No. 260 at 19. Dr. Levine conceded at deposition that he has no scientific evidence to support his opinion that the number of people "detransitioning" is growing, or that the number of people who report "detransition" is greater now that it has even been historically. Dr. Levine Fain Dep. Tr. at 158:8-159:2, 160:25-161:9; 163:9-24, ECF No. 254-3. Defendants offer no explanation for why any of Dr. Levine's scientifically unsupported opinions should be admitted under the Rules of Evidence or *Daubert* standards as applied to proposed testimony in this case. As such, these and others of Dr. Levine's opinions must stop at the gates of this Court.

**C. Defendants Cannot Tout Dr. Levine as a Qualified E pert Based on His E perience and Then Dismiss that E perience hen It Contradicts Their Arguments.**

Defendants take a "have their cake and eat it too" approach to the application of Dr. Levine's experience to the admissibility of his testimony in this case. They recite Dr. Levine's credentials at length and argue that has the requisite "education, training, experience, and knowledge" required by Rule 702 and *Daubert*, and highlight his "50 years of clinical practice." ECF No. 260 at 6-7. As a preliminary matter, credentials alone are "insufficient to support an expert's testimony." *el , n . v. Meyer Cor .,* U.S., 679 F.3d 146, 162 (4th Cir. 2012) (cleaned up). But when it comes time to reconcile the factual reality of Dr. Levine's years of clinical experience as described at his deposition in this and many other cases, Defendants suddenly deem that experience "irrelevant to the issues of this case." ECF No. 260 at 7. The undisputable reality of Dr. Levine's experience is that he has, for the entirety of his nearly 50-year clinical practice, written letters of approval for transgender patients in his care to access endocrine and surgical treatment and does not believe those treatments should be categorically denied. ECF No. 255 at 4-

5. This practice continues even to the present: in the last few months he approved surgical interventions for *several* incarcerated transgender people at Framingham Prison in Massachusetts, people who otherwise could not access this care and must rely on the State to provide them access to it. Dr. Levine Fain Dep. Tr. at 84:4-85:4, ECF No. 254-03. Similarly, Defendants concede, as they must, that Dr. Levine has rarely treated a pre-pubescent child in his 50-year practice. ECF No. 260 at 20. Despite this fatal blow to Dr. Levine's qualifications and the reliability of his testimony in this area, Defendants claim *e a tly the o osite*: that Dr. Levine has "education, training, experience and knowledge in the field of psychiatry and treating gender dysphoric children." *d*. Dr. Levine conceded otherwise. Dr. Levine Fain Dep. Tr. at 28:23-29:6; 62:6-14, ECF No. 254-03; Dr. Levine B.P.J. Dep. Tr. at 87:1-7, ECF No. 254-21. " A ny expert, including physicians, must have the specialized knowledge or skill in the specific area in which the testimony is proffered." *mith*, 278 F. Supp. 2d at 698 (emphasis added); *see also legant Massage, LLC v. tate arm Mut. Auto. ns. Co.*, 2022 WL 433006, at 9 (E.D. Va. Feb. 11, 2022) ("the Fourth Circuit has recognized that experience and expertise in one area does not automatically qualify someone as an expert in another similar area"); *Maldonado v. A le*, *n* ., 2021 WL 1947512, at 17 (N.D. Cal. May 14, 2021) (chemical engineer not qualified to opine about "reliability engineering," because "slapping the label engineering' on an expert or opinion is insufficient to show expertise across that expansive field"). As Plaintiffs have already demonstrated, Dr. Levine lacks both specialized skill or knowledge about the treatment and diagnosis of pre-pubescent children and he does not write, research or publish about them. ECF No. 255 at 18-20. Defendants' vague references to "his own published works and the works of others" do not address this failure. ECF No. 260 at 20. Defendants simply cannot have it both ways: either Dr. Levine is a qualified expert with experience that contradicts Defendants' arguments about the relevance and reliability

of his testimony in this case, or he is not. Either way, the Court must exclude his testimony.

In Defendant's efforts to diminish the fact that Dr. Levine's clinical practice supports the relief Plaintiffs seek, they obfuscate the meaning of "medical necessity" and fail to stretch Dr. Levine's testimony to cover the gap. ECF No. 260 at 7. Defendants suggest, without evidence or citation to the record, that Dr. Levine's provision of approval letters for surgery, a practice consistent with the WPATH SOC Version 7 is not "an admission of medical necessity." *d*. While this may be Defendants' opinion, it does not comport with the reality that Dr. Levine's letters (and those of other psychiatrists in this field) are used to support determinations of medical necessity for insurance coverage. Indeed, those determinations cannot be made without a provider's "letter of approval," as Defendants own internal documents confirm. Defs' InterQual Sheets, ECF No. 254-17. Additionally, nowhere in Dr. Levine's report does he demonstrate "experience, education, training or knowledge" about the concept of "medical necessity" beyond suggesting repeatedly that it should not be conflated with gender-affirming medical care. Dr. Levine Expert Disclosure 81, 82, 84, ECF No. 254-02. Instead, Dr. Levine alleges that establishing a basis for medical necessity for gender affirming medical care is "challenging" because science hasn't established a "causal mechanism" of gender dysphoria and because "the nature of the diagnosis is in flux." *d*. at 94. Yet again, this unsupported opinion fails the tests for relevance and reliability. Dr. Levine cites to *no s ientifi authority* for the idea that the cause of an illness or medical condition must be "scientifically established" for treatment to be medically necessary. If that dubious standard were used by West Virginia Medicaid to determine medical necessity then they would decline to treat a host of debilitating and widespread conditions with no "scientifically established" cause including

pediatric cancers[8], Type 1 Diabetes[9], and multiple sclerosis.[10] Plaintiffs already dispensed with Dr. Levine's unsupported and unreliable opinion that the diagnosis of gender dysphoria is in flux in their opening brief. ECF No. 254 at 14. At base, treatments for gender dysphoria under West Virginia Medicaid have already been established to be a medically necessary service, given the range of treatments Defendants already cover for gender dysphoria. ECF No. 261 at 1. Dr. Levine's scientifically unsupported personal beliefs about "medical necessity" are irrelevant and unreliable, and the Court should find them inadmissible under FRE 702 and *Daubert* and progeny.

## III. CONCLUSION

Accordingly, Plaintiffs respectfully request that this Court grant the instant motion and exclude Dr. Levine's purported expert testimony as inadmissible under *Daubert* and the Federal Rules of Evidence.

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[8] Risk Factors and Causes of Childhood Cancer, Am. Cancer Soc'y (Oct. 15, 2019), https://www.cancer.org/cancer/cancer-in-children/risk-factors-and-causes.html#: :text=But%20the%20causes%20of%20DNA,without%20having%20an%20outside%20cause.

[9] Diabetes, Mayo Clinic (Oct. 30, 2020), https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444#: :text=Causes%20of%20type%201%20diabetes,with%20little%20or%20no%20insulin.

[10] What Causes M.S.?, Nat'l Multiple Sclerosis Soc'y, https://www.nationalmssociety.org/What-is-MS/What-Causes-MS#: :text=The%20cause%20of%20MS%20is,of%20the%20body s%20immune%20system).

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

CHRISTOPHER FAIN, *et al.*, individually and on behalf of all others similarly situated,

*Plaintiffs*,

v.

WILLIAM CROUCH, *et al.*,

*Defendants.*

CIVIL ACTION NO. 3:20-cv-00740
HON. ROBERT C. CHAMBERS

**CERTIFICATE OF SERVICE**

I hereby certify that the foregoing document, and any attachments, were served electronically on June 21, 2022, on the following counsel for Defendants in this case:

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Dated: June 21, 2022

Respectfully submitted,

s/ Walt Auvil
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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.,<br><br>*Plaintiffs*,<br><br>v.<br><br>WILLIAM CROUCH, *et al.*,<br><br>*Defendants*. | CIVIL ACTION NO. 3:20-cv-00740<br>HON. ROBERT C. CHAMBERS |

**DECLARATION OF CARL S. CHARLES**

Pursuant to 28 U.S.C. § 1746, I, Carl S. Charles, do hereby declare as follows:

1. I am over 18 years of age.

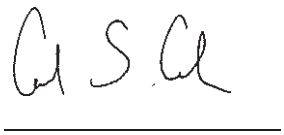
2. I am a Senior Attorney at Lambda Legal Defense and Education Fund, Inc. and serve as counsel of record for the plaintiffs in the above-captioned matter.

3. I have personal knowledge of the facts stated herein, except those stated upon information and belief, and if called upon, could and would testify competently to them.

4. I submit this declaration in support of Plaintiffs' Motion to Exclude Expert Testimony of Stephen B. Levine, M.D. ("Dr. Levine.").

5. Attached as **Exhibit U** is a true and correct copy of excerpts of the transcript of the deposition of Dr. Joanna Olson-Kennedy, taken on April 25, 2022, in relation to the above captioned matter.

I declare under the penalty of perjury that the foregoing is true and correct. Dated this 21st day of June 2022.



Carl S. Charles

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

CHRISTOPHER FAIN; ZACHARY MARTELL; BRIAN MCNEMAR, SHAWN ANDERSON a/k/a SHAUNTAE ANDERSON and LEANN JAMES, individually and on behalf of all others similarly situated,

Plaintiffs,

vs.

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; WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; JASON HAUGHT, in his official Capacity as Director of the West Virginia Public Employees Insurance Agency; and THE HEALTH PLAN OF WEST VIRGINIA, INC.,

Defendants.

Civil Action No.
3:20-cv-00740

REMOTE VIDEOTAPED DEPOSITION OF

JOHANNA OLSON-KENNEDY, M.D.

April 25, 2022

Reported By: Amy E. Simmons, CSR, RPR, CRR, CRC

REMOTE VIDEOTAPED DEPOSITION OF
JOHANNA OLSON-KENNEDY, M.D.

BE IT REMEMBERED that the remote videotaped deposition of JOHANNA OLSON-KENNEDY, M.D., was taken via videoconference by the Defendants before Veritext Legal Solutions, Amy E. Simmons, Court Reporter and Notary Public in and for the County of Ada, State of Idaho, on Monday, the 25th day of April, 2022, commencing at the hour of 8:39 a.m. Pacific Daylight Time in the above-entitled matter.

APPEARANCES (Remotely):

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Videographer: Jonathan Hernandez

Also Present: Michele Clanton-Lockhart

Plaintiffs.

THE WITNESS: My name is Johanna Olson-Kennedy. I am the expert witness here on behalf of the Plaintiffs.

THE VIDEOGRAPHER: Thank you. Now will the court reporter please administer the oath.

OHANNA OLSON-KENNEDY, M.D.,

a witness having been first duly sworn remotely to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:

MS. BORELLI: And before Mr. David begins his questions, we'd like to put a stipulation on the record.

The stipulation is that for purposes of this deposition, an objection to form will preserve all objections to form without needing to specifically state them.

Mr. David, is that agreeable to you?

MR. DAVID: That is agreeable to me.

MS. BORELLI: Thank you.

MR. DAVID: And, Tara, before I get going, do we want to note Walt's appearance? I just wanted to make sure.

MS. BORELLI: Sure. Walt, do you want to state your appearance?

MR. AUVIL: Walt Auvil for the Plaintiffs.

gender dysphoria in a patient, do you use the DSM-5 criteria for diagnosis?

MS. BORELLI: Objection; form.

THE WITNESS: Yes.

Q. (BY MR. DAVID) Are there any other criteria that you rely upon in making the diagnosis outside of the DSM-5?

MS. BORELLI: Objection; form.

THE WITNESS: I think that making the diagnosis in addition to what's in the DSM, I lean on my clinical experience, 16 years of doing this work, to facilitate that diagnosis.

Q. (BY MR. DAVID) Are there other diagnostic criteria other than what's listed in the DSM-5?

MS. BORELLI: Objection; form.

THE WITNESS: No. Those are the diagnostic criteria.

Q. (BY MR. DAVID) And I believe you just said that you have 16 years of clinical experience; is that correct?

A. That's correct.

Q. Over your 16 years of clinical experience, have you seen a shift in the patient population from primarily individuals who were

assigned male at birth to now individuals who were assigned female at birth?

MS. BORELLI: Objection; form.

THE WITNESS: We have seen a shift in that ratio.

Q. (BY MR. DAVID) Do you have an explanation for why that shift is occurring?

MS. BORELLI: Objection; form.

THE WITNESS: I have thoughts about it, yes.

Q. (BY MR. DAVID) Okay. And I'll ask you your thoughts in a second.

Are you aware of any literature that has looked into that specific shift and determined why that shift has occurred?

MS. BORELLI: Objection; form.

THE WITNESS: No.

Q. (BY MR. DAVID) And now can you tell me your thoughts on why that shift has occurred?

MS. BORELLI: Objection; form.

THE WITNESS: I think that there are many things that have to be considered. The first is, you know, I work in a youth clinic. So I see people that primarily are accessing services at around the age of 16. And their experiences are

of gender dysphoria -- their gender dysphoria is emerging around the time that they start puberty.

I think that it is critical to understand that the development of chest tissue is the first beginnings of puberty for people designated female at birth.

Because of that, it is likely that that change of puberty is the thing that is either exacerbating or creating the experience of gender dysphoria for them in a way that they can verbalize and talk about.

Q. (BY MR. DAVID) Okay. So would the rise in individuals who were assigned female at birth coming out as transgender in recent years compared to previously be more or less that that population has always existed, but now it's more acceptable from society's point of view to come out as transgender?

MS. BORELLI: Objection; form.

THE WITNESS: Yes, I believe so.

Q. (BY MR. DAVID) Okay. And so as a result of that, individuals who were assigned male at birth were, I guess, overrepresented in the ratio because those who were assigned female at birth were not comfortable coming out as transgender

been a shift in the ratio with more individuals presenting with -- who were assigned female at birth than previously were presenting --

MS. BORELLI: Objection; form.

I apologize, Caleb.

MR. DAVID: You're okay. I'm being a little clumsy with this, so I'll start over.

Q. (BY MR. DAVID) We previously talked at the beginning of your deposition about there is a shift in the ratio of your patient population from primarily those who were assigned male at birth to now a greater number who were assigned female at birth; is that right?

MS. BORELLI: Objection; form.

THE WITNESS: Well, let me clarify. There was not a time -- we -- there was not a time -- I'm going to go back because the historical context is important.

We've been providing services at our division of adolescent medicine since the '90s. But since we started tracking our new referrals, we -- in 2010 to 2015, there was an equal ratio.

And then in -- sorry, 2014-2015, we started getting a higher number of people designated female at birth new for consultation.

Q. (BY MR. DAVID) Okay. Has that population that you've seen starting to shift from 2014-2015, has it continued to today?

MS. BORELLI: Objection; form.

THE WITNESS: We still have -- it evened out a little bit -- at our center it evened out a little bit over the last year or two years, but we still have -- more than 50 percent of the people seeking services are designated female at birth, but it has evened out a little bit more.

Q. (BY MR. DAVID) Okay. Has that cohort of patients that has shifted that ratio been involved in studies regarding the efficacy of the services that you specifically provide, puberty blockers and hormone therapy? And we'll leave out the oral contraceptives.

But for puberty blockers and for the hormone therapy, has that cohort of patients been studied?

MS. BORELLI: Objection; form.

THE WITNESS: In -- are you talking about just broadly speaking, or in our program?

Q. (BY MR. DAVID) Well, let's start broadly speaking.

MS. BORELLI: Same objection.

REPORTER'S CERTIFICATE

STATE OF IDAHO )
) ss.
COUNTY OF ADA )

I, AMY E. SIMMONS, Certified Shorthand Reporter and Notary Public in and for the State of Idaho, do hereby certify:

That prior to being examined, the witness named in the foregoing deposition was by me duly sworn remotely to testify to the truth, the whole truth and nothing but the truth;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to typewriting under my direction, and that the foregoing transcript contains a full, true and verbatim record of said deposition.

I further certify that I have no interest in the event of the action.

WITNESS my hand and seal this 10th day of May, 2022.

AMY E. SIMMONS
CSR, RPR, CRR, CRC and Notary Public in and for the State of Idaho.

My Commission Expires: 06-13-2022

IN THE UNITED STATES DISTRICT COURT FOR THE

SOUTHERN DISTRICT OF WEST VIRGINIA, HUNTINGTON DIVISION

BEFORE THE HONORABLE ROBERT C. CHAMBERS, JUDGE

---o0o---

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

Plaintiffs,

vs. No. 3:20-CV-00740

WILLIAM CROUCH, et al.,

Defendants.

_____/

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REPORTER'S TRANSCRIPT OF PROCEEDINGS

CASE MANAGEMENT CONFERENCE

WEDNESDAY, JULY 13, 2022, 1:00 P.M.

---o0o---

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BY: WALT AUVIL

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BY: TARA L. BORELLI
and CARL SOLOMON CHARLES

(Appearances continued next page...)

Reported by: KATHY L. SWINHART, CSR
Official Court Reporter
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Proceedings reported by mechanical stenography, transcript produced by computer-aided transcription.

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BY: LOU ANN S. CYRUS
and CALEB B. DAVID
and KIMBERLY M. BANDY

Also Present:

CYNTHIA BEANE, Commissioner
West Virginia Bureau of Medical Services

HUNTINGTON, WEST VIRGINIA

WEDNESDAY, JULY 13, 2022, 1:01 P.M.

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THE COURT: Good afternoon.

MS. BORELLI: Good afternoon.

MX. SMITH-CARRINGTON: Good afternoon, Your Honor.

THE COURT: Before we start, I note that we have at least one individual who is participating by videoconference. I want to instruct you -- and I don't recall, I don't think any media requested to listen by phone. But in any event, anyone who is not here is prohibited from recording any part of this proceeding. Federal law prohibits the recording of any audio or video in federal courtrooms, and so I simply instruct you not to make any recording of this.

With that, we're here today primarily, or almost exclusively, I guess, to present arguments concerning the cross motions for summary judgment. What I'd like to do is start with plaintiffs' counsel. Each side will be given plenty of opportunity to respond and provide rebuttal or reply.

So, with that, are you ready to make a presentation?

MS. BORELLI: Yes, Your Honor.

Thank you.

THE COURT: All right.

MS. BORELLI: Good afternoon, Your Honor. Tara

Borelli with Lambda Legal on behalf of plaintiffs. And my pronouns are she and her.

With the Court's permission, I will argue all aspects of plaintiffs' summary judgment motion except the Medicaid Act claims, which will be handled by counsel Smith-Carrington, who uses they/them pronouns. And we, of course, wish to thank the Court for its accommodation to allow Ms. Prakash to argue the class cert motion virtually.

Regarding the equal protection claim, this case asks whether West Virginia Medicaid violates federal law's guarantee of freedom from sex and transgender status discrimination through its blanket ban on surgical care for transgender participants when cisgender participants face no such exclusion. The answer is, yes, this violates federal law.

With respect to equal protection, heightened scrutiny is required for multiple reasons. First, the exclusion is facial sex discrimination because it targets the fact of gender transition on its face by excluding, quote, transsexual surgery. The exclusion itself thus makes precisely clear who is targeted; that is, transgender people.

THE COURT: Let me interrupt you on this point. And I know there are implications for this in other parts of the argument, but one of the things that I tried to think through is that in this case, first, it does appear the Medicaid

program had a blanket exclusion for any gender transition treatment. It appears through the evidence that, in fact, one of the plaintiffs and other individuals have gotten some treatments, hormone treatments specifically, among other things. So I'm kind of puzzled at what the current state of the exclusion is and then might want to have a follow-up question about that.

So what's your view of the current state of the exclusion under West Virginia's Medicaid program?

MS. BORELLI: So our understanding, Your Honor, is that the exclusion is for surgery, but it is a blanket exclusion of surgery across the board. And that actually points to how arbitrary this exclusion is, because West Virginia Medicaid recognizes the diagnosis of gender dysphoria. They accept that a number of forms of care can be medically necessary for it. And so they cover, for example, hormone therapy, counseling, lab work and office visits.

But arbitrary --

THE COURT: Let me ask you about this, because I think it might have some bearing on the equal protection argument.

So I understand that in some of these cases, and for instance in the Grimm case, the leading Fourth Circuit case, that the exclusions were blanket exclusions. In Grimm, of course, it's a blanket exclusion over using the restroom. But in some of the other cases I've seen there were blanket

exclusions that precluded hormone treatment and so forth for people seeking to change their gender identity.

And so the question I've got is that if it's only aimed here at surgery and not at other treatment regimens for transgender people seeking to conform to their gender identity, does it really support an inference of discrimination?

MS. BORELLI: Yes, Your Honor. And Grimm is actually a perfect analogy because there was discrimination in that case based on restroom use and gender markers on records. But as the school argued in that case, there were other circumstances in which the school did not discriminate against Gavin Grimm, the transgender plaintiff, so the analysis is the same. No matter whether the discrimination is targeted to a particular benefit or is an across-the-board exclusion, that makes this case a lot like Fletcher, which was the challenge to the Alaska state employee health plan, where there the exclusion also was surgical, but it was a categorical exclusion of all surgery.

And part of what the courts have observed is how arbitrary it is to recognize the diagnosis and a variety of forms of care but to, without justification, draw the line at surgery and refuse that form of treat. The usual equal protection analysis applies even if the state has drawn the line right at surgery.

THE COURT: Okay. So here you argue that this is the type of facial discrimination that should be reviewed at an intermediate level of scrutiny. So would you address the defendant's arguments concerning determining who is similarly situated for plaintiffs? And then I'd like you to discuss some of the evidence in the record pertaining to the defendant's purported interests in supporting its exclusion.

MS. BORELLI: Thank you, Your Honor.

So on the subject of being similarly situated, we have testimony in the record from Dr. Schechter, who is the only surgical expert in the case. He performs hundreds and hundreds of these surgeries, and he has given unrebutted testimony that the surgical procedures here are similar or the same even down to the level of procedure codes.

So, for example, there is something called current procedural terminology, CPT codes, and those are the codes used to specify the procedure being performed. And as he testified, the CPT codes themselves illustrate that this is the same because, for example, if a cisgender woman required a vaginoplasty for a congenital absence of a vagina, the same CPT code might be used for her vaginoplasty and for a gender-confirming vaginoplasty for a transgender woman because the procedures are similar or the same.

On the subject of the government interests, Your Honor --

THE COURT: Before we get off of this argument, as I understand it, the defendant, and I guess plaintiffs don't dispute this, uses I think it's InterQual and then another utilization review company, Kepro, I think, or something like that.

MS. BORELLI: Yes, my -- yes.

THE COURT: Yeah. Can you explain what these entities do, and why it is that the defendant's wrong if they -- when they characterize these standards as being standards that reveal the differences between the same surgical procedure for gender confirmation versus other uses.

MS. BORELLI: Yes, Your Honor.

So our understanding is that Kepro is the vendor that West Virginia Medicaid uses, ah, to make determinations about medical necessity and coverage. And Kepro relies on standards produced by InterQual, which is a nationally accredited organization that produces these standards for determining medical necessity based on continuous review of the most current evidence-based research literature.

So what defendants have pointed to in the InterQual sheets is to say that the same procedures for cisgender people and transgender people, if you look at the titles of those policies, some titles refer to treatment for one diagnosis, some titles refer to treatment for gender dysphoria. That is not a relevant difference. All that really says is cisgender

people receive some of these procedures, and transgender people are denied access to the care that InterQual would be very willing to give them were it not for the exclusion.

THE COURT: So these standards contained in InterQual and Kepro don't reveal a significant difference in the nature of the surgical procedure itself, whether it's for gender confirmation or cancer treatment or something else?

MS. BORELLI: That's correct, Your Honor.

So defendants have also pointed in their briefs to the idea that a transgender woman, for example, who requires a vaginoplasty, she might also require procedures like a penectomy, for example. Those are also procedures covered through West Virginia Medicaid, and that is undisputed. So there is no relevant difference revealed in those InterQual sheets.

THE COURT: Do the standards -- so InterQual and Kepro also have standards for these procedures when used for gender confirmation?

MS. BORELLI: That's correct. And those sheets, which are in the record, Your Honor, what they reveal is that InterQual says that the procedures here can be medically necessary; that the sooner the diagnosis and treatment are provided, the more successful the care is; and delaying treatment is not a reasonable treatment option.

THE COURT: And do these reasonably track in a

parallel fashion the InterQual/Kepro standards for the same treatments for cisgender individuals?

MS. BORELLI: Yes, Your Honor.

As Dr. Schechter testified, the procedures do not differ. It is the reason a person might need them that may differ. But all that reason does is point to who is cisgender and who is transgender, and that is sex-based discrimination.

THE COURT: Do any of these things, whether it's the InterQual, Kepro or the billing standards, reveal whether or not the cost of these procedures is significantly different between care provided for cisgender or transgender people for a different diagnosis versus transgender for gender confirmation?

MS. BORELLI: So I'm not aware that the InterQual sheets contain any information pointing to differential cost. Dr. Schechter, however, did testify and said, because these procedures are the same, the cost is the same, right down to that CPT code.

THE COURT: And the billing code standard that you talked about doesn't provide information about relative cost, comparative cost?

MS. BORELLI: No. And Dr. Schechter's testimony is that it is the same.

So, in addition to that, Your Honor, I want to offer one more way to think about Kepro and InterQual, which is this

is the state system. They contract with this vendor. The vendor uses InterQual, and cisgender people receive coverage for care that InterQual would approve as medically necessary. They can get that as a matter of course if they qualify under the InterQual standards. Transgender people cannot. And the only reason is because of the exclusion for, quote, transsexual surgery. Were it not for that exclusion, and defendants admitted this in their briefing, plaintiffs would be able to submit claims and be covered if they met the InterQual criteria. So it is the exclusion that discriminates based on sex, which separates transgender people from the care they would otherwise receive.

THE COURT: How does -- how do these standards inform a decision about whether or not -- if it does, whether or not these surgical treatments for gender confirmation for transgender people is recognized within the standard of care as medically necessary?

MS. BORELLI: So, Your Honor, there are several sources the Court can actually look to on that point.

One is Grimm itself. So Grimm reviewed the standard of care, which is promulgated by the World Professional Association for Transgender Health, also known as WPATH. And Grimm says it's clear that these standards -- the standard of care is recognized as a matter of consensus among medical and mental health professionals --

THE COURT: But Grimm didn't involve the provision of medical care. As I recall, that was in the context of identifying gender dysphoria as a recognized medical condition, and that -- that wasn't really a discussion about the propriety -- the standard of care or the treatment, was it?

MS. BORELLI: Well, Your Honor, there were arguments raised in that case about the care that Gavin Grimm had received, and evidence of his care was presented to the court because it affected his secondary sex characteristics. And so there were arguments about the irrationality of requiring a transgender young man with facial hair and a deep voice, for example, to use the girls' restroom as defendant suggested would be appropriate.

And so Grimm undertakes this comprehensive look at the standard of care as part of setting the stage for its analysis, and it does say that the medical consensus has recognized that these are authoritative. And, second, I would point the Court to the InterQual sheets themselves. They rely on WPATH as an authoritative set of standards of care and the Endocrine Society, although hormone treatment is not at issue here.

But the care that plaintiffs' experts describe, standard of care, there's agreement on all of these fronts that this is the standard of care. And even defendants have

admitted -- and this was in response to request for admission No. 1, that gender-confirming care can be medically necessary. So I don't believe there's any material dispute of fact on this point, Your Honor.

THE COURT: Is it medically necessary only if there's a diagnosis of gender dysphoria?

MS. BORELLI: A diagnosis is a typical first step in --

THE COURT: Is it a necessary step?

MS. BORELLI: Typically a diagnosis code would be required for, ah, insurance coverage of, you know, a particular procedure. But, again, the Medicaid program here recognizes this diagnosis, and they cover a number of types of care on the basis of the diagnosis, and so I -- I don't believe there's any dispute about the validity of the diagnosis itself. There is, again, just this block interposed solely by that exclusion that prevents transgender people from getting the benefit of the InterQual standards that cisgender people receive.

THE COURT: Why do you think the State drew the line here with gender-confirming surgery where it appears to allow other gender-confirming treatment like hormones and so forth?

MS. BORELLI: I don't know, Your Honor. The testimony in the record is that there is no reason in medicine or science to draw that line.

There is -- there is no reason to take something widely recognized as sometimes urgently needed treatment for this care, and indeed InterQual itself recognizes that this kind of treatment should not be delayed, that that is not a reasonable treatment option.

THE COURT: Well, I know that in -- I will confess, I've looked a lot of the records. This is a huge record that you've presented me with. I haven't had time to look at literally every footnote cite to things in the record or read through everything completely.

Be that as it may, I do recall that you've argued that the defense has no substantive evidence to support its claim that the cost of covering gender-confirming surgery is such that they can reasonably draw the line for the fiscal integrity of the program.

Tell me what -- where the evidence is and the sources of the evidence that you -- that the defendant has relied upon in making that claim as best you understand it.

MS. BORELLI: Your Honor, that's the key. They have not relied on anything. The admissions of their witnesses were that there's been no research, no analysis performed of cost or any other matter related to this exclusion. Those are admissions of their organizational representatives.

We also have a stipulation on the docket with the Court, and that stipulation says that the defendants are not

aware of a single document considered by anybody responsible for adopting or maintaining the exclusion, let alone any analysis of cost.

On the other hand, the evidence that plaintiffs have introduced related to cost is the testimony of Dr. Schechter and Dr. Karasic, who testified that this care is cost effective, and indeed providing this medically necessary care is more effective than treating the effects of denying the care, including depression, anxiety, suicidality and others.

THE COURT: I remember in looking through some of the exhibits, and I can picture this better than I can identify it in the record -- I think when it was used in deposition, it was Exhibit 33 or something to that effect. As I recall, plaintiffs cited this, and it's a different number under the docket system than 33, but said, well, here's what the defendant's representatives -- and I assume these are like 30(b)(6) representatives -- here's what they said they took into consideration in deciding not to extend coverage for surgery for gender confirmation.

And it consisted of three or four, as I recall, journal articles, one which was a survey that was done of all the states examining the Medicaid policy with respect to each state when it comes to similar exclusions. And so can you -- do you know what I'm talking about, first of all? Can you tell me where that fits in the evidence that the Court ought

to be considering?

MS. BORELLI: Yes, Your Honor. And we regret the confusion caused here, but the background to help the Court understand how we arrived at what is the operative stipulation on the docket now is that, in response to discovery requests, defendants identified a series of documents that may have been considered by decisionmakers. Ah, in the course of a subsequent 30(b)(6) representative -- there were several in this case. In the course of one of the depositions of those representatives, the parties reached a stipulation about exactly what had been considered by the decisionmakers. An incorrect version of that stipulation was uploaded on the docket. To their credit, defendants caught the error, notified us, and we then filed a superseding stipulation, which says it supersedes the prior one.

And that stipulation clarifies that there are no documents of which they are aware that any decisionmaker or person who has decided to maintain the exclusion has considered.

THE COURT: All right. So you don't at this point have evidence that any of these decisionmakers considered, for instance, the particular journal article survey that I was --

MS. BORELLI: That's correct. And, in fact, the stipulation is that they have not considered those documents.

THE COURT: All right. But it's your position that

they stipulated that they have no sort of documents or studies relied upon to estimate the cost of this -- of covering this type of service?

MS. BORELLI: That's correct, Your Honor. And that's why we think it could be reasonably characterized as post-hoc. We don't think that the evidence currently meets their burden to show that it actually motivated a decisionmaker.

THE COURT: I know they also cited, and there may be testimony from some of their representatives about this, about the CMS study that was done I think in 2016 or so, maybe '17, where CMS reported that at that point, it didn't have sufficient peer-reviewed information to be able to say that this type of surgical treatment for gender conformity had long-term benefits and was otherwise within the standard of care.

Can you tell me, did the defendants rely in part on that study?

MS. BORELLI: So, ah, they stipulated that they did not, but I do want to address the substance of it. Because this -- these documents from HHS actually support plaintiffs, and not defendants. And if the Court wants to go back and refer to a portion of the record in writing with a lengthy explanation, Dr. Schechter's rebuttal report does so.

So here's the answer, Your Honor. They point to a second decision of HHS, and they ignore the first one. And

the first one is what is relevant and matches this case.

In that first decision of HHS, it was asked to consider the blanket ban on surgical care for Medicare participants. And HHS reviewed it and said, this is unsupportable and struck that ban, and so Medicare no longer has a blanket ban on surgical care. That is exactly the relief plaintiffs seek here.

The subsequent decision to which they point involved a request for Medicare to issue a national coverage determination. Many, many services under Medicare do not have NCDs. What that would involve is --

THE COURT: Meaning they're not mandated as part of the --

MS. BORELLI: Correct.

That's because, as Dr. Schechter explains, a national coverage determination means that a service would be available without limitation. And in a population that involves people who are older, where age may be a risk for surgery, ah, it doesn't make sense to have it be available without any limitation.

But that is consistent with a variety of care that is available under Medicare.

THE COURT: Well, then to be clear about it, there are other coverages within the West Virginia Medicaid program for services that would be characterized as optional by CMS.

MS. BORELLI: Yes, that's right, Your Honor.

THE COURT: And so the State can't claim that we don't provide this service because we are restricting our available services to that which is mandated and nothing more.

MS. BORELLI: Right.

So, yes, Your Honor, on that point about CMS and this argument that they're simply following the advice of CMS, ah, we don't believe there's any substance to this argument, Your Honor, because CMS is not the ultimate arbiter of any state's obligations to comply with the Constitution or with federal law. States do have an obligation to follow their statutory and constitutional obligations regardless of whether a federal agency has explicitly told them that they must do so. And so we think that disposes of the argument that they're simply -- they're doing what CMS might say is or isn't required. Their obligation is to the Constitution and the Affordable Care Act, not to what this federal agency has or hasn't told them.

THE COURT: All right. I think we've kind of been diverted to talking about some of the evidence in the record concerning the State's interest and so forth. Let's come back to this equal protection claim, then.

So you've kind of, through this discussion of the record, I think maybe answered my questions about what the State asserted as its interest that should be balanced by the Court even under intermediate scrutiny.

The defendant argues persistently that this -- this surgery exclusion should not be considered as targeting a group or a class but, rather, targeting a particular treatment or condition. And while there is certainly more elaborate discussion, and I'm going to let them articulate that, one of the cases they cite or argue about a fair amount is the pregnancy case decided by the Supreme Court several years ago.

And we've all struggled with how you pronounce that, because other than the extent to which I've read about in this case, I didn't recall it even.

So tell me how you distinguish that case from this one.

MS. BORELLI: Yes, Your Honor.

We think it's Geduldig, but --

THE COURT: Sounds pretty --

MS. BORELLI: -- I shouldn't be quoted on that.

So we would point the Court for a particularly cogent discussion of how Geduldig does, and more importantly does not, apply to an exclusion like this to a recent summary judgment decision by the Middle District of North Carolina in a case called Kadel.

THE COURT: I've read it a bunch of times, so I'm pretty familiar with it.

MS. BORELLI: Yes.

THE COURT: And I will say that, as is true with some

of the other cases that I've read here, you kind of get hopefully deeper levels of understanding when you spend more time with it. But it still does trouble me that in Geduldig, if that is close -- first, what's your understanding of the level of scrutiny that the court was applying there?

MS. BORELLI: So the court was applying heightened scrutiny.

THE COURT: I didn't see them say that anywhere. It almost seemed to me it was more like a rational basis test, but I don't feel confident making that judgment.

In any event, what the -- even at a -- well, at a heightened scrutiny, then you would think it would require much more justification, and yet they certainly found that the exclusion for pregnancy disability was constitutional.

So how does it differ, then?

MS. BORELLI: Your Honor, I apologize. In my last answer, I may have misunderstood the Court's question.

Were you referring to the level of scrutiny in Kadel?

THE COURT: No, I was still talking about --

MS. BORELLI: I see. I apologize.

THE COURT: Okay.

MS. BORELLI: So, yes, in Geduldig, I don't actually recall the level of analysis the court applied. It may have been rational basis. I don't know that it was entirely clear.

THE COURT: Honestly I don't see that they gave it a

label, which is just kind of unusual when you read all these other cases how --

MS. BORELLI: Yes, Your Honor.

THE COURT: -- the court is to identify a level of scrutiny.

MS. BORELLI: That said, I -- I happen to be partial to the Kadel analysis, and it's not just because we're counsel in that case as well.

So what the Kadel court said is if you look at Geduldig's statement about pregnancy -- so the court there says: Pregnancy is an objectively identifiable condition. And what the court meant by that is you can reference it and describe it without reference to sex.

And the Kadel court says there is no -- no way to talk about the exclusion at issue in this case without referencing sex, gender or transgender status, and that is what distinguishes Geduldig --

THE COURT: Honestly it does seem odd to say that you can describe pregnancy without referencing sex because only females can get pregnant. And so, you know, that seemed to me to be a little bit of a simplistic explanation that I kind of struggled with accepting.

MS. BORELLI: Right. Now, that language comes from Geduldig itself.

THE COURT: Uh-huh.

MS. BORELLI: And so the Kadel court says, accepting that analysis for what it is, ah, it simply is not the same as the exclusion here, which references sex explicitly on its face, and that's equally true of the exclusion here. The exclusion is for transsexual surgery. It references sex explicitly. It references transgender people explicitly. It is a world apart from the exclusion considered in Geduldig.

THE COURT: Okay.

MS. BORELLI: If the Court has no further questions, Your Honor.

THE COURT: Well, not on equal protection.

MS. BORELLI: Okay. Does the Court have any questions about the Affordable Care Act? I can address it briefly.

THE COURT: Yes, please.

MS. BORELLI: So the Affordable Care Act, we believe it raises pure questions of law. West Virginia Medicaid admitted in its answer to the complaint that it is a health program or activity that receives federal financial assistance, ah, and that makes it a covered entity under the Affordable Care Act. We don't understand there to be any dispute between the parties about that key element of the claim.

And then the analysis of sex discrimination in the Affordable Care Act comes directly from Title IX because the ACA borrows its anti-discrimination standard from Title IX.

That makes Grimm and Bostock directly controlling for this statutory claim. Grimm, of course, was ruling on a Title IX claim, and Grimm relied interchangeably on Title VII and equal protection principles, ah, to determine what constitutes sex discrimination.

And we think that means that the answer has to be this is sex --

THE COURT: What about the district judge's forbearance of that issue in Kadel?

MS. BORELLI: So, Your Honor, what I would say about that is, we think that the statutory language is clear, and there are slightly distinct positions of the parties here. So there is -- there is no question here that this defendant is a covered entity. They've admitted it. The defendant in Kadel has sought to contest that, and so the court said it was interested in rulemaking around that issue.

But here --

THE COURT: Whether or not the coverage extends to an insurance claim.

MS. BORELLI: Right. Yes. So there is a state health plan that is its own independent entity there providing state employee health coverage.

Here there is just no contest --

THE COURT: The West Virginia health plan is no longer a party here.

MS. BORELLI: The state employee -- correct, Your Honor, the state employee health plan is no longer a party here. So we think that there is simply no contest based on defendant's own binding admissions, and that would -- that would make the Kadel treatment of that claim, that aspect of that claim irrelevant.

THE COURT: All right. Thank you.

MS. BORELLI: Thank you, Your Honor.

THE COURT: Someone else, then, is going to argue about the Medicaid Act?

MS. BORELLI: Yes, Your Honor.

THE COURT: All right.

MS. BORELLI: Thank you so much.

MX. SMITH-CARRINGTON: Good afternoon. May it please the Court. My name is Avatara Smith-Carrington, I use the they/them pronouns, and I represent Christopher Fain and Shauntae Anderson.

Participation in the Medicaid program is optional. However, once a state has chosen to take part in the program, they must comply with all federal statutory and regulatory requirements. West Virginia has participated in the Medicaid program since its inception and does so to service its most vulnerable citizens, which also includes transgender West Virginians.

Defendant's exclusion of coverage for

gender-confirming surgical care violates two provisions of the Medicaid Act.

First, the exclusion violates the comparability requirement because it discriminates on the basis of diagnosis. Second, it violates the availability requirement, because it excludes gender-confirming surgical care regardless of medical necessity.

In Flack versus Wisconsin Department of Health Services, the district court considered an exclusion similar to the one that is at issue here. In Flack, the district court found that the exclusion violated the comparability requirement because the same medical treatments were covered when used to treat other medical conditions that were not due to dysphoria.

Recognizing that the availability requirement mandates that states make covered treatments available in sufficient amount, duration and scope in order to reasonably achieve its purpose, the district court also found that the exclusion violated the availability requirement because Wisconsin Medicaid failed to make covered treatments available in sufficient amount, duration and scope.

Simply put, once Wisconsin Medicaid offered to cover a form of care, they were required to cover that form of care for everyone so long as it was medically necessary. Because the exclusion failed to make available medically necessary

covered treatments, Wisconsin Medicaid violated the availability requirement.

The same is true here. Although defendants admit they provide coverage for the relevant procedures, chest surgery, hysterectomy, vaginoplasty, penectomy, defendants arbitrarily draw a line at providing coverage for gender-confirming surgical care regardless of medical necessity, which violates the availability requirement.

And defendants violate the comparability requirement by denying coverage for gender-confirming surgical care when indicated for gender dysphoria, but covering the same surgical procedures when necessary for other medical conditions. Ultimately defendants violate both the availability and comparability requirement.

Your Honor, at this time, I would be happy to answer any questions that you might have on these two claims.

THE COURT: In addition to discussing medical necessity as one of the factors, I see some of the case law -- this might be based upon the statute where there is a mention of utilization controls or utilization review.

What does that mean, and why does that not provide the defendant discretion to draw the line here about the surgical procedures?

MX. SMITH-CARRINGTON: Understood.

So in Bontrager versus Indiana Family and Social

Services Administration, the Seventh Circuit in that case found that when a state uses financial obligations as a reason to shirk its obligations to cover medically necessary care, that is not an appropriate use of what would be considered a utilization control procedure.

So in Bontrager, the Seventh Circuit found that Indiana's thousand dollar budgetary cap on medically necessary dental services, that didn't constitute a proper utilization control procedure. So even though here defendants assert that, you know, a budgetary issue is a reason for -- or even though defendants here assert that the budget is a utilization control procedure, that would not be proper when you're looking at the availability requirement.

THE COURT: Has any court or any relevant agency explained what utilization control means, then?

MX. SMITH-CARRINGTON: So the definition of a utilization control procedure remains somewhat up in the air in terms of, like, how other courts interpret it. But what is clear is that when it usually is used, it's around numerical limitations on other services.

So, for example, in the Fourth Circuit there's another case of Charleston Memorial Hospital where it's talking about inpatient and outpatient hospital days, so hospital stays. And in that case, the Fourth Circuit found that that was proper because the services were still provided ultimately,

and essentially the services were still made available.

And so other courts look at utilization control procedures not with regard to what, ah, defendants are doing here with regard to the budget, but more so in terms of, like, limitation on services that are already made available.

THE COURT: So, for instance, being able to discharge someone from an assisted living facility back home at a reduced cost by still providing access to the same services.

MX. SMITH-CARRINGTON: Correct, Your Honor.

THE COURT: All right. Are there any particular district court or circuit opinions other than the one you mentioned that you think are real helpful to the Court in deciding this?

Many of the cases that I've read -- and I'm certainly not going to claim that I've read all of what both sides have cited, but a number of them which discuss equal protection and the ACA don't get into the Medicaid Act. So are there any particular cases you think are helpful for the analysis?

And one I remember, and I'm going to say I think it's the Cruz case out of New York, was a pretty elaborate detailed discussion of how that judge applied availability and comparability. And I'm not sure how -- how much I see of an explanation here to mirror what that judge analyzed.

MX. SMITH-CARRINGTON: I understand.

So I would first say that I would first point the

Court to Flack v. Wisconsin. You can also look at Cruz --

THE COURT: Was that --

MX. SMITH-CARRINGTON: Oh, sorry.

THE COURT: What stuck in my mind about Flack is that was at a preliminary injunction stage.

MX. SMITH-CARRINGTON: Yeah, so -- well, they ruled at the preliminary injunction stage for plaintiffs there, and then they permanently enjoined the exclusion from being enforced as well. So Flack versus Wisconsin would be a good case to look at. Also, Cruz versus Zucker is also a good one.

But even if you're looking at the two requirements or if you're looking at the availability requirement or you're looking at the comparability requirement, there are a couple of great cases. So, for example, if you're looking at the availability requirement, I would definitely point the Court to Bontrager versus Indiana Family and Social Services Administration. And for the comparability requirement, which prohibits discrimination on the basis of diagnosis, I would point the Court to White versus Beal or Davis versus Shah, which perfectly handle the analysis there.

THE COURT: And those cites are in your --

MX. SMITH-CARRINGTON: Yes.

THE COURT: All right. Thank you.

MX. SMITH-CARRINGTON: Okay. Thank you.

THE COURT: All right. For the defense?

MS. CYRUS: Thank you, Your Honor.

May it please the Court, opposing counsel. My name is Lou Ann Cyrus, and I represent the defendants to this case, the West Virginia Department of Health and Human Services, Bureau for Medicaid -- and I'll call that either DHHR or Medicaid if that is okay.

THE COURT: Sure.

MS. CYRUS: As well as the cabinet secretary, who is Bill Crouch, and as well as the commissioner for the Bureau for Medical Services, who is Cynthia Beane, who actually is here today in person, Your Honor.

One thing I would say at the outset, and the Court has seized on this, and the Court is exactly right, there is a huge, huge distinction here between all the other cases that have been discussed in that -- and when this case was initially filed, the plaintiffs alleged in both the complaint and the amended complaint, and the Court alluded to this earlier, that there was a categorical exclusion of all services, gender-confirming services that transgender folks need. Well, that is not a correct statement, and we demonstrated -- and the Court asked, you know, has that been changed, corrected? No, it's remained the same throughout this case from the outset.

We did -- we covered all those things except the transsexual surgery, and that is a huge difference because

all -- and we can go through these. The cases that the Court has mentioned and been discussed, Flack specifically, talk -- there was an exclusion for all transgender services.

THE COURT: Let me try to clarify this.

MS. CYRUS: Yes.

THE COURT: This is probably something I can and will understand more clearly from this going over the briefing in more detail after the arguments today, but it does seem to me that it has been part of a written policy that gender-confirming services were excluded. But now, as I understand it, the fact is that some of the gender-confirming treatment, for instance, hormone treatment, has nonetheless been provided.

But is it true that you still have the literal language as part of the policy that excludes these things?

MS. CYRUS: The Medicaid manual is what contains the language, and it excludes -- it has non-covered -- exclusion is somewhat of a misnomer, but it's non-covered services --

THE COURT: It's the broad language --

MS. CYRUS: -- of transsexual -- transsexual surgery is what is not covered, Your Honor.

THE COURT: Only transsexual surgery.

MS. CYRUS: That's correct. And the whole gamut of everything else is -- they cover the hormones, the therapy, psychiatric, psychological evaluations, the lab work that has

to be done, doctors' visits. And it's only the surgery.

THE COURT: So how does that make it different in your mind?

MS. CYRUS: Well, because it's not a -- it's not discrimination based upon sex. If you take the plaintiffs' argument, because these folks are transgender, and that transgender is based on sex, it's discrimination based on sex. No, actually it's not.

That would be the case if we were like these other states where they provide no services to transgender individuals for their -- their trans -- gender-affirming care. In this instance, we only exclude -- don't cover the diagnosis of gender dysphoria for gender-confirming surgery. And it's not even limitation on the diagnosis because the hormones that are provided are also for the diagnosis of gender dysphoria as is pretty much everything else that is covered.

So it's limited to a particular procedure or procedures. It's a category of procedures, which are the surgical procedures, and those -- that's not based on sex. That is based on the procedures.

So this would be a different case, Your Honor, if it were what the plaintiffs alleged in the complaint, the amended complaint, that we provide no coverage, and we exclude all services for transgender individuals. Because transgender individuals have the exact same services as cisgender

individuals, and that's what's significant here.

If we have two buckets, we have this bucket is everything that Medicaid provides as coverage, the other bucket is for everyone, over here is what they provide for cisgender -- I'm sorry -- transgender individuals, these two buckets are exactly the same. What the plaintiffs are trying to do is add more to the transgender bucket to add in the transgender gender-affirming surgery.

THE COURT: In Grimm, the Fourth Circuit determined that a quasi suspect class can be identified as transgender individuals. So how do you get around applying that same determination in this case?

MS. CYRUS: Well, here, again, this -- Grimm is distinguishable, as is Bostock, because Grimm dealt with a policy that affected all transgender students, all of them. It was based on their sex of being transgender, and that's not the case here.

Again, this -- we are not -- we don't have a policy that applies to all transgender people. Even the plaintiffs' expert has testified what we're talking about is a subgroup of a subgroup of a subgroup, Your Honor. It is -- it would be transgender individuals who are diagnosed with gender dysphoria, who then seek gender-confirming surgery, and then who are then cleared and available to have surgery.

So -- because their expert, Dr. Schechter, has

admitted and testified, number one, not all transgender people are diagnosed with gender dysphoria; number two, not everyone who has gender dysphoria seeks gender-confirming surgery; and, number three, of those who would seek gender-confirming surgery, not all of them will be approved.

For example, Mr. Fain is a perfect example. He would like to have surgery, he says, but he has a smoking habit, and he is not ready to proceed with surgery until he stops smoking because he understands the risks that have been explained to him.

THE COURT: But isn't this just kind of parallel to the University of Virginia case where the court observed that it's still discrimination if you create bars that keep women out or make it more difficult for them to get in, even though it is certainly true not all women would want to go there?

MS. CYRUS: Well, but in that instance, again, you're -- it's applying to a whole sex. In that case, it was female.

THE COURT: And treating them as a class.

MS. CYRUS: Right, and we're -- and that's not what West Virginia Medicaid does here, Your Honor. They aren't doing anything that applies to all transgender individuals.

And, remember, transgender is the protected class that has been -- that is recognized based on sex if you adopt that from Grimm, but I don't know that it necessarily applies here

at all.

THE COURT: Well, I don't know that this language came from Grimm, it's probably post-hoc, but part of the test that the court laid out concerning whether there was a suspect class was in the case of sex, and transgender status, was whether you could explain the policy without using any reference or making any reference to any of these words that are relevant to sex or -- or transgender.

It seems to me that you can't describe the State's policy here not covering this surgery without explaining that it's not covered because these people are transgender or seeking to confirm a sexual identity -- gender identity that is not the same as their birth identity.

So how do I -- how do I avoid applying that test?

MS. CYRUS: Yes, Your Honor. Well, because, as we talked about, this isn't necessarily on the basis of being transgender. If there were a policy that applied to all transgender people, obviously that would be on the basis of being transgender.

This is simply --

THE COURT: But isn't that just like saying that we don't have a prohibition against hiring black people because we do hire some, but we don't hire all, we don't have to hire all, not all will apply?

I don't quite understand how I treat this as not being

discriminatory just by saying, well, it only applies to the people who are transgender who want the surgery and who could otherwise meet the criteria.

MS. CYRUS: Well, again, black people would be a whole protected class. That is -- that is the distinguishable characteristic, is the whole class here is not being implicated. It is a subgroup of a subgroup of a subgroup.

THE COURT: Well, I guess kind of what I mean, I'm confused by this because it's a -- only a portion of the transgender population would seek or otherwise qualify for this surgery, but how does that allow for them to be treated differently as a class?

I mean, yeah, it's a subclass of all transgender people, but it is still a class that is based upon sex and transgender status, which the circuit and the United States Supreme Court have recognized are suspect classifications. And if they're suspect classifications, even if it only affects a small portion of them, the Court still has to apply either heightened or rational basis test to it.

MS. CYRUS: Well, first of all, I mean, Grimm -- there is -- this is a case of first impression. There is no case in this district or in the Fourth Circuit that addresses Medicaid benefits. Grimm dealt with -- it's a bathroom policy, and, you know, Bostock dealt with employment practices.

These are Medicaid benefits that are health benefits,

and there are -- there are cases where it's been recognized that the agency -- because Medicaid has constraints, it has limitations, and it cannot provide everything for everyone, and so it has -- based upon utilization procedures and so forth, it doesn't cover -- it can't possibly cover everything. And -- but this is not excluding people -- everyone who is transgender. This is simply saying they are not paying for the procedure -- ah, for surgical procedures for transgender individuals who have gender dysphoria. That -- and that is all it is saying.

And the other -- the significance here in terms of the analysis -- and the analysis, Your Honor, is really very much the same in all of these causes of action. Whether it be equal protection or the Medicaid Act, you can't treat one group differently than the other. And in this case, as I've indicated, every single thing that the cisgender people are entitled to under Medicaid in West Virginia the transgender folks are entitled to. No one who is cisgender is -- has services available to them that the transgender folks do not have available.

You know, as -- Mr. Fain, for example, had a hysterectomy. If a transgender person has breast cancer, they will get a mastectomy. And so all of the services that are available to cisgender individuals are available to transgender individuals. That is -- that's the focus here.

There is no discrimination because they're being treated the same, Your Honor.

And I will point out that Dr. Schechter --

THE COURT: Well, but is it the same if they can't get treatment that is determined to be medically necessary?

MS. CYRUS: Well, but it -- the test is, is it the same? They have to be in all relevant respects --

THE COURT: Isn't that the same, two people who want the same treatment, different diagnoses, but in each case medically necessary treatment?

MS. CYRUS: Well, I -- I'm not sure if the Court is asking is it -- and making, just for sake of argument, an assumption that the treatment is the same, but it's actually not the same.

The surgery -- and Dr. Schechter admits this -- that would be done for someone who is a biological male, ah, to get a vaginoplasty is totally different than the procedure for a biological female. And there actually is a district court case that talked about that, which -- with an inmate who wanted -- who was complaining because he could not obtain --

THE COURT: Give me the name of that case so I don't forget to look at it.

MS. CYRUS: Okay.

THE COURT: Is it Williams from Louisiana maybe?

MS. CYRUS: Well, I had marked here.

It's Williams versus Kelly, Your Honor --

THE COURT: Yes.

MS. CYRUS: -- where the inmate was claiming she had gender dysphoria and denying the sexual reassignment surgery violated her equal protection right.

And the court -- the court actually said, and this is an argument we've made, this debate does not fit within an equal protection analysis. It doesn't fit because the procedures aren't the same. And the court actually said -- this is the same argument that we're making.

The plaintiff wasn't claiming that she was being treated differently than other inmates with gender dysphoria. She was saying she was being treated differently than cisgender females, and those are not similarly situated.

And so what I thought was a really good point, they talk about it in that case, is the fact that there are biological differences that make it impossible to say that a surgery on a male is the same on a female in the same area of the body because -- and it even says, a biological female has a vagina, a biological male does not. And on the other hand, of course, a biological male has a penis, and a biological female does not.

Lord help me, my grandmother would turn over in her grave hearing me talking about this. I apologize.

However, there are biological differences. These are

not the same surgeries.

THE COURT: Well, I'm curious, did you have -- I know you have a couple of experts. I've only started looking at Dr. Levine. But do you have evidence in your part of the record that explains what is really different about these surgeries based upon the diagnosis difference here?

MS. CYRUS: Well, the ex -- we did not have an expert who testified on that, but, you know what, we ended up we didn't need one because the plaintiffs' expert, Dr. Schechter, talked about that. And he actually said that the differences, for example, for a mastectomy, how it's performed would be different, ah, from someone having a tumor removed versus a mastectomy for transgender persons.

THE COURT: This is one of the things I think that's important for me to dig deeper in the record than I've been able to, so I'm curious.

It's easy to say, well, they're different because you start off with different anatomy. But what I'm expecting you to be able to demonstrate when you make this argument is that it's -- that it's a fundamentally different procedure such that surgeons who do this work would say this is really different from treating -- providing the same surgery for someone who is cisgender or transgender with a different diagnosis.

So just to say that they're different sounds to me

honestly just a bit superficial, at least more superficial than I think I should accept. And so what I'm wondering is, does anybody, their doctor or do you have any other evidence you can point me to where it explains how these things are different so that I can get a better grasp of it?

Because here's what I've seen and some of the record shows, first, that it doesn't seem that those procedures are more costly when it's a treatment, a surgical treatment done for gender conformity versus cancer treatment or prophylactic treatment of some kind. If they're not really different in cost, then I start to think, well, they must not be that much different for the surgeon to do because I can't imagine that it wouldn't be reflected in the cost.

Quite honestly, I think most people, average citizens have kind of assumed that surgery for gender conformity is a much more elaborate and expensive type surgery that frankly makes people skeptical of whether it should be done or whether it should be covered. And so what I'm wondering is, what evidence is there from your perspective in this record that would support me saying, yes, this really is fundamentally or significantly different surgery when it's done for gender conformity versus a different diagnosis, but it's labeled the same procedure.

MS. CYRUS: Well, Dr. Schechter, who is the plaintiffs' expert, did say that what is involved for a

gender-affirming surgery is different; that the procedure for making a male anatomy below the belt, for lack of a better term, into female anatomy is not a comparable procedure or service that a cisgender individual would receive. And he also said there's not one mastectomy procedure for all purposes. There would be different ways to perform the mastectomy.

And, I mean, by definition, someone who is getting a gender-affirming surgery is -- is getting a different procedure than a cisgender individual. Those are -- those are different procedures, and they are for different medical needs as well.

But on the equal protection issue, it's not just enough to show that they've been treated differently from others for whom they are similarly situated. There also has to be a showing of intentional or purposeful discrimination in the Morrison versus Garraghty case, which is a Fourth Circuit opinion.

There is no showing that there was any intentional conduct here, any intent to discriminate. Secretary Bill Crouch testified he didn't even know this was not covered until this lawsuit was filed, and he's been in office since 2017. Commissioner Beane, likewise, said she had never looked into it, and no one's in fact challenged it. This is the first time it's been challenged. So there's not been any

purposeful discrimination here.

And I'll go back to something the Court asked earlier. They -- we don't know when it was first adopted. We were able to -- the farthest they were able to go back was 2004 and see that it was -- transsexual surgery was listed as a non-covered service, back to 2004. But no one who is at the agency knows, you know, why -- why it was there. We just -- they just know it's there, it's never been reviewed, it's never been challenged. And they have very limited resources.

And importantly -- this is a really important point to this. I know that plaintiffs' counsel said, well, it doesn't matter that CMS reviewed it and that CMS -- that doesn't give us license to discriminate or words to that effect. Well, CMS is the agency. They -- the federal government currently provides the State of West Virginia 80 percent of its Medicaid dollars, and it's -- and more than it normally is at the moment due to COVID, but 80 percent of its funds are coming from the federal government. CMS approves Medicaid's plan as well as any other amendments.

And there is a case cited by plaintiffs, the Davis case, Davis v. Shah, which is a Second Circuit case, which -- it dealt with the Medicaid Act comparability provision that actually said there is a presumption, if there has been a review by the federal government, that all laws, applicable laws are complied with.

And here the question -- I wish I knew the answer. If it's not -- if there's a problem with the plan, why hasn't CMS told us that? Why not, number one. Number two, why did they tell Medicare they did not have to cover it? Why did -- why? Why wouldn't they -- if the plaintiffs are right, why did -- why didn't CMS tell -- HHS, I'm sorry, tell Medicare you must cover this or it's unconstitutional?

And so the reason for that is because it's not. As I said, this is a matter of first impression in this district, in the Fourth Circuit, and certainly the U.S. Supreme Court has not addressed it.

THE COURT: If I -- I understand. So if I agree with you and say that this is not an exclusion or non-coverage that targets a suspect class and that, therefore, there is not discrimination based upon that, then you really don't have to have a justification for it.

MS. CYRUS: Well, it would be a rational basis. I think there's a rational basis, which is a very low standard.

The State --

THE COURT: Well, okay. Then if I'm going to apply a rational basis, what is your proffered explanation, justification of what state interest is advanced here? Because it sounds like you stipulated away much of it. You've apparently stipulated that you don't have any cost status, so you can't say, well, we're not covering this surgery because

it's expensive or going to cost the program more.

You've indicated that you -- well, you tell me. What are your state interests if I apply a rational basis and --

MS. CYRUS: Well, there were two state interests that were given as the reasons that -- for the -- we believe for this to -- to exist. One is that obviously CMS has not told us that we are required to have it. Because I will say, during the pendency of this lawsuit, CMS has sent letters to Commissioner Beane's office saying you must covered these COVID-related procedures, mandating coverage for certain things, and they've never done that with this.

But, number two, Your Honor, West Virginia Medicaid is projecting a budget deficit in 2024 of over $128 million. If -- unless the Legislature decides, which there is no indication at this time they're going to give more money, they are going to have to -- the testimony is they're going to have to cut services somehow.

In fact, there was a bill this past legislative session, 2022, to provide blood pressure cuffs for individuals who needed them in the homes in West Virginia. That was going to cost $500,000. The Legislature said, no, we're not paying that.

There also was a bill seeking an employee at a cost of $75,000, and the Legislature said, no, we're not -- we're not providing those funds.

So -- and that's a huge distinction from Flack versus Wisconsin, Your Honor. West Virginia is not Wisconsin. Wisconsin has a $9 billion Medicaid budget. West Virginia is a fraction of that. There was no indication and in none of these cases is there a discussion like we have in West Virginia where we are going to be in a deficit.

THE COURT: You mentioned CMS obviously implicitly approved this, and so I guess it's fair to characterize this non-coverage of gender-confirming surgery as being optional. They don't -- CMS doesn't disallow it, doesn't prohibit it, but it doesn't mandate it.

But, in fact, Medicaid -- West Virginia Medicaid provides a number of services that are not mandated. Isn't that the case?

MS. CYRUS: It does provide some services that are optional. But the U.S. Supreme Court in Alexander versus Choate actually said Medicaid programs don't guarantee that each -- each recipient is going to get the level of health care precisely tailored to his or her particular needs. The states get substantial discretion to choose the proper mix of amount, scope and duration, limitations of coverage as long as the services and care provided is in the best interest of the recipients.

So --

THE COURT: Let me -- hold on. I'm familiar with that

language.

If I'm applying a rational basis test, and you're telling me that the legitimate state interest that supports this decision by the State is that CMS didn't mandate this service, how can I agree with that when the State provides a number of services that aren't mandated by CMS? How is that -- how does that sustain your position that this is a legitimate government interest and not a pretext?

MS. CYRUS: Well, first of all, I want to make clear to the Court, we believe equal protection does not apply here, so the Court's not applying a standard at all. But if it were to apply, it would apply the least restrictive standard --

THE COURT: Rational basis.

MS. CYRUS: -- which is why I said rational basis.

But we believe there is ample evidence that, as the Williams court said, this -- these facts don't fit into the box of equal protection. So the Court, in our view, doesn't even get to apply the stand -- get to that point.

THE COURT: I understand.

MS. CYRUS: Yes.

THE COURT: Yeah, so what I was trying to do is have you articulate -- if I disagree with you and find that there's at least a rational basis test that applies to this, I'm trying to discern exactly what state interests you believe support this exclusion, and what the evidence is in the record

to support the basis for that interest.

So the first one you said was, well, CMS doesn't mandate it, and, in fact, they've approved us not having that coverage. And my response was to say, well, okay, but there are other coverages that the state Medicaid program provides that aren't mandated by CMS, so I don't see how that's very strong evidence in support of that state interest.

I assume that another state interest is the cost. But the plaintiffs have pointed out that the record is devoid of information that the State can point to that it relied upon in deciding that covering this kind of surgery would be expensive and make it difficult for the Medicaid program. It sounds like you even stipulated that you don't really have data or evidence to support that.

MS. CYRUS: Well, the evidence -- the data and the evidence would be the budget that we produced that shows a shortfall of over $128 million in 2024.

THE COURT: This is a multi-billion-dollar program, and so honestly, you know, the plaintiffs point out that there are a very small number of people that would likely be considered for this type of gender-confirming surgery if Medicaid did cover it, and that it would actually be perhaps less expensive than not covering it because these people end up accessing the medical system for treatment of the results of their gender dysphoria, and that the procedures aren't

really fundamentally different whether it's for gender conformity or cancer treatment or something else.

And so none of that would support the State concluding that this is too expensive to add to the coverage, so I'm trying to give you a chance to tell me where in the record you think there's evidence to support the State's position, if that's what it is, that none of this would be a significant cost addition to the program.

MS. CYRUS: Well, we're not arguing necessarily that it is a significant cost. We obviously don't know what that is right now because we don't -- so --

THE COURT: Has the State done anything to try to figure that out that you know of?

MS. CYRUS: The State has not because no one had ever challenged it. It had never been a topic of discussion. And these folks who are there now, during their tenure, know they haven't looked into that.

But the U.S. Supreme Court said in Beal versus Doe -- that was a case where they wanted Medicaid to fund non-therapeutic abortions. Nothing in the Medicaid Act suggests states are required to fund every medical procedure that falls within the delineated categories of medical care, and it gives states broad discretion to determine the extent of medical services that are reasonable.

This is -- this is an issue that is best left to the

states, ah, to decide.

THE COURT: Well, I mean, it sounds to me like you're saying that there is never an availability or comparability requirement, and I don't think you really mean that because there obviously is. Here we're talking about -- I have not looked at the abortion decision, but I will, but it does strike me that that is probably not analogous.

Here we're talking about medically necessary treatment that is being denied to a suspect class. Even if I'm applying a rational basis test for it, I'm not hearing evidence that the State has got cost information that would support its decision to maintain this exclusion or this non-coverage. And we're talking here about treatment that you do provide to other people, the types of treatment, the types of surgeries. I understand your argument that it's fundamentally different, but it also may be the type of surgical treatment that is provided for other diagnoses.

MS. CYRUS: Yes, and we do dispute that. We dispute that it's the same procedure, but also this -- the State is going to have a deficit. I'm not sure how they could add anything to the -- they are going to be in a position, the testimony is they are going to be in a position of having to cut existing services in order to maintain the budget.

THE COURT: Well, I don't minimize the challenge that the State faces. I've been there, I've been to the

Legislature myself, so I certainly appreciate the long-term and annual difficulties in coming up with a budget. In this state, it's been particularly challenging. But we're talking about a multi-billion-dollar program. And the plaintiffs' evidence is that the costs to Medicaid would essentially be negligible and not drive some huge deficit in the Medicaid program, and that the State has to and the department has to balance this every year.

I'm sure with rising costs and other challenges, every year requires an adjustment in the payments that will be made to providers and in the coverage and utilization review and those things, so you don't, you know, dig a deeper hole. I guess I'm just saying I have trouble believing, with the absence of specific information, that the State can say, well, if we extend this coverage for gender confirmation surgery, we're going to significantly widen this projected gap down the road. I don't see where in the record that there is evidence to support it.

MS. CYRUS: The evidence is that the State is going to be in a deficit where they're not able to take on any new services. And so -- and under the Medicaid Act, there is a decision, Casillas versus Dains, ah, that talks about a state is not required to fund a benefit it currently provides to no one. And it's our position that these transsexual surgeries are not being provided to anyone, so it doesn't discriminate.

It could apply -- it complies with the Medicaid Act, it complies with equal protection, as well as the Affordable Care Act.

THE COURT: All right. Do you want to make a response to the argument about the Medicaid availability and comparability argument?

MS. CYRUS: Well, yes.

So I think we sort of touched on that because one of the cases actually says that, at least in terms of the availability and the comparability, both of those sort of rise and fall together. They're very similar, and it's a very similar argument to equal protection because it's basically the State can't provide services to one group, we can't provide services to the medically needy that -- and not provide it to the categorically needy.

The difference being, the Court probably knows this, categorically needy are those who just -- they have a need overall, versus the medically needy, who they can take care of their basic needs, but they have huge medical needs. And so it's the same analysis.

You could see based on the briefs from both sides there's not a whole lot added on those arguments because it follows the equal protection that there -- that they have to be different for there to be -- you know, for there to be some action.

So they -- the State provides the same thing to all the groups. You know, the only thing different is they don't provide transsexual surgery coverage to anyone, to anyone. That is, they don't prohibit anyone from that. So there is -- no one is being treated differently.

THE COURT: All right. Thank you.

MS. CYRUS: So -- thank you.

THE COURT: All right. I'll give each of you a chance for rebuttal, and then we'll hear a reply.

MS. BORELLI: Thank you, Your Honor.

Unless the Court has initial questions, I'll just proceed to respond.

THE COURT: Go ahead.

MS. BORELLI: So I think one of the first points that my colleague raised was an argument that there is a big distinction between this case and the others because only surgery is excluded. The case law is replete with cases involving challenges to one specific benefit. There is no requirement in the law that there must be discrimination across the board or else there is no claim, and that is the position they're asking this Court to take.

And so a perfect example of this is the Fletcher case which involved a surgery-only bar, and the court there examined the benefit in question and applied precisely the same analysis as happens routinely in other cases where there

is discrimination with respect to a particular benefit or aspect of government treatment or employment.

Number two, responding to the argument that my colleague made saying that this is, quote, adding more to the trans bucket to get gender-affirming surgery, that is not an accurate characterization of what this claim asks. This claim asks for equal treatment, not special treatment.

So other cisgender people can get the same procedures where they're medically necessary. Transgender people are simply asking for the same rule to apply, lift the blanket exclusion so that they can get the benefit of the InterQual criteria that everyone else does.

THE COURT: In response to my questions, counsel for the defendant pointed to your expert's deposition testimony where, according to the defense, the expert conceded that there are very significant differences between these types -- these different surgical procedures when it's a transgender gender confirmation procedure versus something else.

Can you respond to that?

MS. BORELLI: So the expert opinion that Dr. Schechter offered is that the procedures are the same or similar. That is his opinion. It's a surprising misrepresentation in my view to point to his deposition testimony -- and it's recounted in the briefs, and so the Court will see the quote in the briefs.

What Dr. Schechter is saying in the very first sentence of that quote is, there are a variety of surgical techniques used for any surgery, and that is equally true, as he says explicitly, for transgender people and cisgender people. And those techniques are generally the same. But what he said is a surgeon might pick one technique based on a particular individual's circumstance. That's just the nature of surgery. That does not differ between transgender people and cisgender people.

We think his testimony is clear on its face.

THE COURT: All right. So you believe his testimony would fall more in line with the -- for instance, the surgeon testifying about the difference between performing a particular procedure on a 45-year-old male versus perhaps a -- who has other health conditions versus a 25-year-old male who has got excellent health conditions or something --

MS. BORELLI: We think that is clear in that very first sentence of the quote that they rely on, yes, Your Honor.

THE COURT: And does he also provide testimony based on his experience and knowledge and profession as to the relative costs for these various procedures, whether it's for gender confirmation or some other diagnosis?

MS. BORELLI: Yes. He addresses the topic.

He doesn't provide specific numbers, of course,

because --

THE COURT: Right

MS. BORELLI: -- that might vary depending on locality.

But because his testimony is that the procedures are the same, he says, you know, safety and efficacy is the same. Cost is the same.

And so to use an example that my colleague just pointed to about vaginoplasty in an effort to argue that these are different -- I think Ms. Cyrus said that a cisgender woman has a vagina, and a transgender woman does not. One of his examples is that a surgeon performing this care would view it in the following way. There are cisgender women who get vaginoplasty because they have a congenital absence of a vagina, and that is like a transgender woman. And the very same CPT codes may be used, and that generally means that there's no divergence in billing because it's the same procedure being billed.

So, Your Honor, there is also an argument that has been made that this doesn't apply to all transgender people. Ah, the policy itself does indeed, including by its own terms. It literally says it bars transsexual surgery. It doesn't make distinctions among transgender people. The fact that not everyone will require a surgery at any given time, ah, doesn't change the fact that it's a discriminatory barrier that on its

face applies to all trans people.

This is, and I believe the Court referenced this, just like the U.S. versus VMI case. Not every woman will want to subject herself to the adversative educational method at the Virginia Military Institute, but it is discrimination to deny the opportunity to those who do. Phillips versus Martin Marietta would be another example. Not every woman is a mother of a preschool-age child, but an employer who refuses to hire those women discriminates based on sex. The same logic applies here.

There was discussion with respect to Mr. Fain and I think his standing, and I just want to point to the aspects of the record that we think make very clear he's testified that he is ready for the surgery. He has the required letters for the surgery. Dr. Karasic evaluated him, confirmed that it's medically necessary. This exclusion is the barrier that prevents him from being able to qualify for that surgery. He has standing to challenge it.

Number five, there was an argument that Grimm shouldn't apply because it's not about Medicaid and a suggestion that this Court should view this case as asking purely questions of first impression, but that is not how the law works.

So, for example, Grimm's statement that discrimination based on transgender status receives heightened scrutiny in

and of itself, separate from sex discrimination, that pronouncement applies in every context. There isn't a separate rule, for example, for race or sex discrimination that's context dependent. Generally speaking, the standard of review that the government makes a classification based on that characteristic, generally that standard of review applies across contexts. Grimm -- Grimm does apply here even though this applies in the specific context of health services.

I think we've addressed Dr. Schechter's testimony and how to properly view it.

The Williams versus Kelly case that was discussed as part of that conversation, I think it's telling, Your Honor, that defendants want to continually point the Court to cases outside of this circuit in a very different legal landscape like a decision at a preliminary screening stage, which is Williams versus Kelly, by a pro se person incarcerated, in the Fifth Circuit which has a dramatically different legal landscape and nothing like Grimm that guides the Court's analysis.

When the Court looks at the cases decided in this circuit, by courts that are bound by Grimm and follow that guidance, we believe the analysis should look similar to Kadel, for example, and that that's a more analogous case to review.

In terms of the same care, ah, I just want to

reemphasize again, there are a series of admissions from the defendants about whether the same procedures are covered for cisgender people. That is undisputed, and the briefs and the record do point to these admissions.

Hysterectomy, oophorectomy, penectomy, phalloplasty, vaginoplasty, chest surgeries. Feminizing chest surgeries for cisgender women are covered. Masculizing chest surgeries for men and boys who have gynecomastia are covered. There is just no dispute that the same procedures are available to cisgender people who qualify under the InterQual standards.

On the topic of Secretary Crouch and Commissioner Beane and whether there's intent, there is no requirement in the law that a specific office holder be the one to have written the exclusion themselves with their own pen or have taken specific steps that are personal to them beyond the actual enforcement. What we do have under the tenure of these officials -- I don't think there's any dispute of which I'm aware that they were appropriate officials to enjoin, and that that's the relevant question.

It simply isn't the case that if back in 2004, under different leadership, an exclusion was adopted, and then that office holder left, that there can never be a claim then, that that just immunizes the discrimination no matter how much subsequent officials continue to enforce it. That's what we have here. It remains in the policy manual, and that

exclusion is written every single year into each contract with every managed care organization with which the program contracts. And so the exclusion is actively enforced, and these are appropriate people to enjoin should the Court find that that is appropriate.

And then on the subject of HHS, I would just reiterate again, the decision of HHS that they ignore is this case. That's the decision of HHS that says a blanket exclusion is inappropriate, and it cannot be supported. The medical literature does not support it. That is what HHS ruled. That is this case. That's all the plaintiffs are asking for is enjoining enforcement of the exclusion.

And finally on the topic of limited resources, I will just point out, all public entities have limited resources. The point -- and the law is we think very, very clear on this. The point under the equal protection clause is that that burden is a shared burden. It cannot be -- public fisk cannot be protected on the backs of a vulnerable minority group. Whatever the burden of those limited resources is, it must be borne equally by all.

If the Court has no further questions --

THE COURT: No. Thank you.

MS. BORELLI: -- I'll turn it over to my colleague. Thank you.

THE COURT: All right.

MX. SMITH-CARRINGTON: Hello. So I just wanted to address two different points that were raised by our colleague.

So first with regard to whether or not the availability requirement and comparability requirement rise and fall together, it is our position that the availability requirement and comparability requirement, while they are complimentary, these two different claims are very distinct.

So, again, with regard to the availability requirement, it mandates that once a state has chosen to cover a form of care, they must cover that form of care for all Medicaid participants so long as it is medically necessary. Whereas the comparability requirement prohibits discrimination on the basis of diagnosis. So I just wanted to address that.

And then the other point that I wanted to address was the reference to, I believe -- and hopefully I say this name correctly -- Casillas v. Daines, which is a district court decision, and it had to do with New York Medicaid. And specifically in Casillas v. Daines, the reference there was to another case, specifically Rodriguez v. City of New York. And in Rodriguez v. City of New York, that case is factually distinguishable from what is happening here.

So in Rodriguez, the Medicaid participants there were asking the state to cover a benefit that it didn't provide to anyone else. So essentially, again, the Medicaid participants

were asking for the state to fund a benefit that no other Medicaid participant received. Here, that's not the case.

Defendants have already admitted that they provide coverage for the relevant procedures. So, again, hysterectomy, chest surgery, penectomy, phalloplasty, vaginoplasty, these are all procedures that are already covered. And then with regard to, again, specifically the comparability requirement, these procedures are simply denied, our plaintiffs are refused coverage on the basis of diagnosis.

So, again, with regard to Casillas v. Daines, which is pointing to Rodriguez v. City of New York, that is a factually distinguishable case because here plaintiffs are not asking for the Medicaid program to provide a benefit that it doesn't provide to anyone else. They're asking for simply the coverage to be extended to them because these benefits are already provided.

THE COURT: All right. Thank you.

All right. Ms. Cyrus?

MS. CYRUS: Your Honor, I just wanted initially to read -- this is from our motion -- Dr. Schechter's explanation of what is involved in a vaginoplasty for gender-affirming surgery.

(As read:) The typical procedure involves formation of a vulva --

THE COURT: Read slowly.

MS. CYRUS: Sorry.

(As read:) The typical procedure involves formation of a vulva and associated structures, meaning the clitoris and labia, removal of the penis and testicles, most often construction of a vaginal canal. In such surgeries, tissue from the penis is used to construct the vaginal canal, labia and clitoris.

So that is a different procedure because it involves parts of the body that aren't present in a biological female.

Also, with regard to what -- I am not sure the basis of saying we cover these procedures. Gynecomastia surgery is only covered if the patient has actual physical pain. It's not covered for some -- for emotional or mental symptoms.

And also, hypomastia, that is a procedure plaintiffs' expert, the rebuttal expert said that would be comparable to a mastectomy. We don't cover the hypomastia. What that -- hypomastia is when a female, a biological female has small breasts that don't develop. So the hypomastia is what plaintiffs' rebuttal expert said would be comparable to the mastectomy or chest reconstruction. Medicaid does not cover that procedure.

THE COURT: Does Medicaid consider that cosmetic?

MS. CYRUS: No, Your Honor -- yes, it's my understanding it is.

And by the argument plaintiffs are making, that would

be based upon sex, and we ought to be covering that. I mean, that is also not covered.

So -- but also I wanted to go back to, under the rational basis test, we're not required to show that we actually required on the bases.

And also with regard to the optional coverages, the testimony has been things that are optional, there have been -- a number of them have been the subject of legislative appropriations just for those items, and that's how those have been covered. We -- Medicaid provides service up to the budget, and the budget, we're up to the limit at this point.

So -- also, there is no blanket exclusion. I've heard blanket exclusion since the day practically this came in the door. That's because I assume there are other states that do have a blanket exclusion. That's not West Virginia. We -- Medicaid covers everything for these folks except their surgical procedures. That is not discrimination based upon their sex, i.e. being transgender. That is based upon a procedure. They're not -- they're not singling them out for being transgender. Those are -- that is a category based upon a diagnosis.

THE COURT: All right.

MS. CYRUS: Thank you, Your Honor.

THE COURT: Thank you.

All right. That concludes the argument on the summary

judgment. We're going to take a brief recess, and then we'll deal with the class certification motion when we resume.

All right? Take about a 10-minute recess.

THE COURT SECURITY OFFICER: All rise. This Court is now in recess.

(Recess taken from 2:35 to 2:46 p.m.)

THE COURT: All right. We'll now turn to the motion for class certification.

Plaintiffs' counsel may proceed.

MS. PRAKASH: Thank you, Your Honor. My name is Anna Prakash. My pronouns are she/her. I'm with the law firm of Nichols Kaster in Minneapolis, and I'm one of plaintiffs' counsel. Thank you for accommodating me over video.

So there are two primary points I want to emphasize for the Court with respect to class certification. The first is what plaintiffs are not asking for in this case, and the second is the importance of the class action mechanism even though the named plaintiffs are seeking an injunction.

So as to the first point, plaintiffs are not asking this Court to decide that any one class member has gender dysphoria; that any one class member is eligible for surgery; that any one class member meets medically necessary criteria; that any one class member should be approved for surgery; or that any one class member should submit a claim for insurance coverage, because those are individualized issues. But you

don't get to any of those issues, the defendants, the class members, their doctors, they don't have to grapple with those issues in the context of insurance coverage until and unless the exclusion is struck down. Here that means being held unlawful and having an injunction issue.

All we're asking for is the opportunity to get to that everything else. That everything else, medical necessity for each person, eligibility and the like, those are outside the scope of this case because that claims process, those decisions as to whether or not to have surgery can only occur in this context if the exclusion comes down.

So there is one particular case, and I think Your Honor is familiar with it, that I would like to point you to, and that's the Baxley case that Your Honor decided a couple years ago. There are a couple lines in that opinion that I think apply quite directly here.

This was, as you recall, a jail class of people who were challenging the healthcare there. And the opinion says: Plaintiffs need not show that every class member will use the healthcare system at the regional jail. Instead, they simply need to show that the entire class is subject to the same policies.

And then the opinion goes on to say that the claimed injury is the exposure to policies and practices that place both the named and unnamed class members at substantial risk

of harm. And that is what we have here.

Everyone -- and I think this was covered in Your Honor's questions during the summary judgment portion of today's hearing -- everyone is subject to this risk of not being allowed to have their certain kinds of healthcare, here surgery, covered because of the exclusion.

And so, you know, when the defendants point to Dukes, as they do in their brief over and over again, and they highlight the question that the Supreme Court asks, why was I disfavored, the answer for every single class member is because you're seeking what defendants call transsexual surgery. If you are seeking that, you are being discriminated on the basis of sex and being transgender. That question can be answered for every single person.

The second point I want to make is that the class action mechanism in this case remains important. I think, you know, at first blush one can say if the named plaintiffs prevail, then an injunction will issue, end of story, the exclusion is gone. But class certification in this case matters for three reasons.

One is that each class member will have, if this case is certified, an independent enforceable right. And that matters in the context of them eventually making claims or seeking surgery because they wouldn't have to go through any kind of res judicata analysis in the event that they meet with

resistance.

The second reason is that, if for some reason the named plaintiffs after judgment were able to obtain the surgery, if that happens during the pendency of an appeal, for example, if the class is certified, it is a legal entity, and it survives any kind of mootness challenge that may occur down the road.

And the last is that this is the type of case, and we say it in our brief, that Rule 23(b)(2) was made for. It is made for the instance in which a defendant or a party acts or fails to act on grounds generally applicable to the class. And here the class is defined as all transgender West Virginia Medicaid participants who are seeking or will seek care banned by the exclusion.

So those are the main points I'd like to make. If Your Honor has any specific questions, I'm happy to answer those.

THE COURT: What did you determine from your review of the defendant's response that defendant contested other than this commonality sort of question?

MS. PRAKASH: Right. So other than the commonality question, the defendant contested numerosity as well as adequacy.

With respect to numerosity, it is undisputed that there are at least 686 West Virginia Medicaid participants who

have a diagnosis of gender dysphoria. If just 5 percent, just over 5 percent of those people were to seek surgery, that would bring the number of people seeking surgery to 40.

The other thing that I think is important in the context of numerosity is that we're talking about the impracticability of joinder. You know, this is a statewide program. We're not going to go find every single person, nor do we need to, for the purpose of certifying a (b)(2) class. It is sufficient that we know, with respect to the sensitivity of the issues and the way that people may or may not come forward, that they will become known to defendants if and when they apply for such surgery.

The other point under numerosity, and then I'll turn to adequacy, is that InterQual guidelines themselves -- and I think there's been a lot of discussion of those. I would like to point the Court to plaintiffs' summary judgment Exhibit 26, which is docket 250-30. And in that first set of guidelines, I think it's on, like, page 3 or something, InterQual starts going through various steps that -- that support the method of determining whether somebody should have a certain surgery.

In those comments, they cite to WPATH, which is the association that my colleague Ms. Borelli referred to. They also talk about estimating the number of gender-affirming surgeries nationwide. And so I think in just 2017 alone, there were something like 8300 which they point to. So I

think applying that in this case and considering impracticability of joinder, the numerosity issue is satisfied.

With respect to adequacy, it is notable that defendants do not challenge the adequacy of counsel, and they do not challenge the adequacy of the plaintiffs with respect to anything related to, you know, truthfulness or the ability to see through a litigation or look out for the class's best interests. Those are things that a defendant typically brings up in opposition to certification. Instead, the only thing they point to is this mention of puberty-delaying treatment.

So obviously our plaintiffs, the class representatives here are adults. They are not seeking puberty-delaying treatment. But puberty-delaying treatment is just another form of gender-confirming treatment. And plaintiffs and the class representatives and the class do not have to be precisely identical in order for them to have the same type of claim based on the same type of things that warrant certification.

But, as you heard Ms. Cyrus say, this is potentially not an issue at all because it sounds like, according to Ms. Cyrus, everything is covered except surgery, and so the -- you know, the ink spilled on puberty-delaying treatment in the context of certification was probably for nothing if it is in fact a covered service.

THE COURT: All right. And so with regard to puberty-delaying treatment, the effect of including or not removing it from the class would simply be that, to the extent Medicaid provides puberty-affirming or delaying treatment to cisgender or other diagnoses, they'd have to -- they couldn't have a blanket of non-coverage for gender-conforming treatment here?

MS. PRAKASH: I think that is correct. You know, I am not familiar with all of the other ways in which puberty-delaying treatment is indicated for cisgender people, but Your Honor's explanation or summary of it is in the analysis, right. Like, this is a form of gender-confirming care. And to the extent they are not providing this medically necessary care, when they are providing medically necessary care for cisgender folks, that is a violation of the law.

And, again, going into whether it should be provided to one class member or the other is outside the scope of this case because all we're asking for is that exclusion to be struck down.

THE COURT: All right. Thank you.

For the defense?

MR. DAVID: Thank you, Your Honor. Caleb David on behalf of the defendants.

And I'd like to start with something that opposing counsel said, was that number two is the importance of the

class form in this case. And as the Court recognizes, if the Court finds that the exclusion, as plaintiffs are calling it -- we call it just simply it's a non-covered service along with dozens others.

But if the Court finds that the non-covered service violates the equal protection clause, violates the ACA, is discriminatory, that applies to everyone. It does not simply apply to Christopher Fain and Shauntae Anderson. It applies to everyone.

After the Obergefell decision, same-sex couples did not have to litigate to go and have -- and be able to get married. That is something that applied to everyone regardless of the fact that there was not a class form in that case.

So specifically for the plaintiffs' first two claims, the claims under the equal protection clause and under Section 1557 of the Affordable Care Act, there is no benefit, there is no judicial economy, there is nothing that would benefit the parties or -- or the proposed class members from the class form.

And the other aspect is that, in terms of numerosity, commonality, typicality and adequacy of representation, plaintiffs have not met their burden. It is their burden, and plaintiffs are the ones that have to show that they have met those requirements, the first requirement being numerosity.

And as plaintiffs have alleged, there are 686 individuals that have been identified as having some gender-related diagnosis. Those diagnostic codes do not say gender dysphoria. They say things such as gender identity disorder unspecified or transsexual -- there are different diagnostic codes. None of them are specific to gender dysphoria, but they are related.

However, as plaintiffs conceded and plaintiffs' experts have conceded, within that subset of 686 is the subset of individuals who will seek gender-confirming care. At this stage, there are two people that we know of in West Virginia who are seeking gender-confirming surgery. That is Christopher Fain and Shauntae Anderson. There is no one else who has made a claim, who has come forward to say that they are seeking surgeries. So at this point in time, the only number that we know of that fits into plaintiffs' class is two.

Plaintiffs' class definition is all transgender people who are or will be enrolled in West Virginia Medicaid and who are seeking or will seek gender-confirming care barred by the exclusions. So the 686 number might fit that first part, all transgender people who are or will be enrolled in West Virginia Medicaid, and we'll grant that there may be additional ones in the future. However, that does not cover the second part of the definition, and that is who are seeking

or will seek gender-confirming care barred by the exclusions.

So all we know at this point, and all that the plaintiffs have proven, is that there are two individuals who fit the full class definition. Both of those individuals have been joined in this action, and, therefore, joinder is not impracticable.

THE COURT: When you have a non-coverage or an exclusion, however you want to characterize it, it does seem to me that that can be presumed to discourage people from seeking the benefit at issue because the policy is pretty clear. So while I am not going to quarrel with your numbers, but shouldn't we reasonably conclude that that probably underestimates the number of people who might seek the benefit of this class?

MR. DAVID: And, Your Honor, and to your point, there does not have to be a 100 percent certainty as to what the numbers are.

THE COURT: Sure.

MR. DAVID: However, we know that the number is somewhere between two and 686 right now. We don't know what it is, if it's above that 40, the magic number of 40 threshold. We don't know -- there has not been testimony from an expert that says of individuals who seek gender-confirming care that is non-surgical care at this point, this percentage of individuals goes on to seek surgical care. That doesn't

exist.

THE COURT: I thought one of the plaintiffs' experts did have sort of a projection that -- they used some, I guess, national percentage.

MR. DAVID: So Dr. Schechter's testimony was that one in 200 individuals in America are transgender. Of those .5 percent of individuals who are transgender, one in -- I believe it was one in 500 are -- or excuse me -- one in five seek gender-confirming care. There was not something that was specific to gender-confirming surgery, and so all we know is that one in 1,000 individuals in America will seek gender-confirming care at some point based on Dr. Schechter's testimony, but it was not specific to the surgery.

And that is what we're dealing with in the class definition now, now that the evidence has shown that the hormone therapy and psychiatric and psychological therapies are covered. So we're -- looking specifically at surgeries, we know somewhere between two and 686. The only proven number at this point is two, and essentially we would be guessing at anything in between those two numbers.

THE COURT: All right.

MR. DAVID: Now, the commonality and typicality are obviously somewhat interrelated. And in terms of the claims for Affordable Care Act and under the equal protection clause, in terms of commonality there is no doubt, as I just conceded,

that if it applies to one, it's going to apply to all. There is no doubt about that. But in terms of the Medicaid Act, it is slightly different.

And the Medicaid Act's comparability requirements state that you cannot provide some category -- you cannot provide care to medically needy individuals that you do not provide to categorically needy individuals. So off the bat, of those 686 individuals that potentially could be there, but somewhere in between two and 686, there has to be some analysis whether those individuals are medically needy or categorically needy. There also has to be an analysis of medical necessity for those particular claims under the Medicaid Act.

Plaintiffs' counsel has stated in here that we only have to provide medically necessary care under the Medicaid Act. That is, I believe, undisputed. And medical necessity requires -- as plaintiffs' experts have testified to and our expert has testified to, requires a review of the patient's history, physical exam, mental health examinations, patient's goals, desires, expectations, and conversations with primary care providers and mental health professionals. All of that, of course, is within those InterQual guidelines that plaintiffs' counsel has referred to, and so all of that is a highly individualized, ah, assessment.

Plaintiffs have stated in their arguments here today

that they are not asking for the Court to find that anyone has gender dysphoria, meets medical necessity criteria or meets insurance criteria, but also stated that one of the reasons that the class form is necessary is so that there is a legally protected and enforceable right, and it bars against res judicata in the future.

Well, in terms of the Medicaid Act claims, res judicata could not possibly apply just simply by saying that the -- the policy is exclusionary and discriminatory and unconstitutional. There has to be an analysis of each individual's circumstances, and so there -- there isn't going to be res judicata even if they are members of the class, and the only question is whether the Medicaid Act requires -- excuse me. The only question -- if the only question is that the policy and its language that this is a non-covered service is unlawful under the Medicaid Act, that analysis does not entitle anyone to any actual surgery or any actual services. All -- what plaintiffs' counsel is saying is that they would be entitled to a -- an enforceable right that is subject to res judicata.

It would be a completely different issue that would be litigated in terms of whether they are entitled to the actual services.

THE COURT: Well, isn't that true under equal protection or the ACA?

MR. DAVID: Absolutely, Your Honor, and that -- but the elements of proof that are required for equal protection analysis and for Section 1557 of the Affordable Care Act end at whether or not this is discriminatory or violates equal protection principles. It ends there.

In terms of the Medicaid Act, it doesn't end at whether this is discriminatory between categorically and medically needy individuals. It ends when there is a determination of medical necessity. The regulations that accompany the Medicaid Act specifically provide for the ability for services to be denied based on medical necessity and utilization management.

THE COURT: All right. I understand your position.

MR. DAVID: So -- and, Your Honor, on the last two points.

Typicality, our argument on that is simply that Christopher Fain and Shauntae Anderson are not typical of the rest of these individuals who could potentially be in this class because, again, we don't know what services those individuals are going to be looking for. And we also at this point, even two years into litigation, do not know exactly which gender-confirming surgeries are -- the plaintiffs are seeking to have covered.

So we understand that Christopher Fain is seeking a double mastectomy. Shauntae Anderson is seeking breast

augmentation and a vaginoplasty. We know that those are surgeries that these two individuals are seeking. However, there has been testimony in this case from plaintiffs' experts that surgeries such as facial feminization, vocal shave, electrolysis, hair implants, other body contouring can all be medically necessary surgeries for gender-confirming surgery. We don't know if -- at this point whether the plaintiffs' claims in this case, the named plaintiffs' claims are typical of the class members, whether the class members are going to seek the same types of surgeries, as there's been a dispute here today that there are types of mastectomies and mastectomies that are covered for certain purposes.

Electrolysis is not covered for any purpose. Vocal shave is not covered for any purpose. And so there has to be some analysis under the Medicaid Act to say, well, you -- you cover this service for cisgender people. If the Court accepts the plaintiffs' argument that covering mastectomy for one reason for cisgender individuals means that it has to be covered for all other reasons, it's a different analysis for something like vocal shave, which is not covered for any cisgender people, nor is it covered for transgender people. So there are comparability issues in that instance.

So the typicality is -- is precluded in this instance because of the specific issues that need to be proven under the Medicaid Act.

And finally on adequacy of representation, we do not dispute that plaintiffs' counsel appears to be qualified and capable of handling this. And in terms of keeping in contact with their counsel, the plaintiffs do also appear to be adequate in terms of that.

The only issues that we have raised really with adequacy of representation are, again, the typicality type issues, such as plaintiffs also asserted in their class certification motion -- or excuse me -- in their motion for summary judgment that there may be questions about puberty blockers. That's something that neither Mr. Fain nor Ms. Anderson are seeking. Their claims would not be typical of children or adolescents even though the class definition would include both children and adolescents who also are subject to different diagnostic criteria for gender dysphoria.

So, Your Honor, for all of those reasons, we believe that the class form is entirely unnecessary for the Affordable Care Act and equal protection claims, and that it is improper for the Medicaid Act claims. Thank you.

THE COURT: All right. Thank you.

Ms. Prakash, I'll allow you to reply.

MS. PRAKASH: Thank you, Your Honor.

So let me start with numerosity. Opposing counsel just talked about not needing to have a hundred percent certainty on numerosity, and I would submit to the Court that

the vast majority of circuits that have considered the standard at class certification have settled on preponderance of the evidence, more likely than not, like, what gets you just that much over the 50 percent mark. And courts in this circuit -- although the Fourth Circuit has not weighed in on this, courts in this circuit have applied the preponderance standard.

So if you take that we have 686 people, if you take that we know that the two named plaintiffs here are seeking or will seek this surgery, and we know, as Your Honor pointed out, that there is a chilling effect when you know that the thing that you want is not covered by insurance, if we take all of that combined with that 8300 number from the InterQual guidelines, I think we get to the more likely than not in terms of people who will seek or are seeking this surgery, not to mention the impracticability of joinder, which doesn't depend on a certain number.

There is an analogy that I do want to draw with respect to numerosity before I move on, and that is in the context of wage cases, specifically wage and hour cases, where you have an opt-in mechanism under the Fair Labor Standards Act, and you might have a state law Rule 23 class that is an opt-out mechanism. And courts have taken the view that the low opt-in rate is supportive of the superiority of the class action device because it doesn't require somebody to take that

affirmative step to challenge their employer, their insurer, their healthcare coverage, to out themselves in any way. You're just automatically included, and that is the beauty of a class action.

Moving on from numerosity, with respect to commonality I think we heard defense counsel there concede that, and typicality as to the equal protection claim and the Affordable Act claim -- the Affordable Care Act claim.

With respect to the Medicaid claims, what I heard was a complaint that all of the potential surgeries that could qualify as gender-confirming surgeries have not been listed or provided in this case. I think that is untrue as a factual matter because we have all of the InterQual guidelines, and defendant produced those in response to document requests that asked for specific comparators.

The other reason that I think -- the other reason that I think that that argument doesn't really fly is that the defendants themselves -- the defendants don't look into those individual issues on what type of surgery. Instead, they just say if you are seeking transsexual surgery or sex transformation surgery or sex change surgery, it's not covered. And what we are asking for is the InterQual guidelines for gender-affirming surgery to be applied in the same way that the defendant applies all of their other InterQual guidelines.

And, again, I would point the Court to that docket 250-30. It's a checklist. It's does the patient have X, Y and Z? If so, move to No. 2. Does the patient have X, Y and Z? If so, move to No. 3 and so on and so forth.

We are just asking that those guidelines with respect to gender-affirming surgery actually be used such that coverage decisions can be made on an individualized basis. But that can't happen with the exclusion as written and as enforced by defendant.

I don't have anything else for the Court unless you have questions for me.

THE COURT: Well, what about his argument on the Medicaid Act and the -- what's the effect of a class that just broadly states that the exclusion or the non-coverage is prohibited? Does that implicate the issues he raised about the Medicaid Act being -- specifically requiring, for instance, medical necessity for various treatments?

MS. PRAKASH: I don't think so, because I think the analysis is the same.

If you look at it, as Ms. Borelli had pointed out, as having those InterQual guidelines apply to cis people, but not having them apply to transgender folks, you do the side by side of medically necessary care is being provided on this side to cisgender folks and medically necessary care is not being provided on this side to transgender folks.

And we are not asking, class certification doesn't ask for the Court to make a decision on ultimately whether for any one person, surgery would be medically indicated. But as the class as a whole, because of their sex, because of their transgender status, and the fact, as the class is defined, are seeking or will seek -- and these are defendant's words -- what defendant calls transsexual surgery, in other words, care barred by the exclusion, that brings everyone under the same category of being denied services because of diagnosis or diagnoses leading to these types of procedures, and because defendant has chosen to cover surgical procedures for cisgender folks, but not in the -- in this instance for transgender folks.

THE COURT: You mentioned that if I certify this class the way you've tendered it, that the Court would effectively prohibit the defendant from applying the so-called exclusion or the non-coverage. And you referred to, I guess, it's assertion of fact that in that event, the state Medicaid program would be obligated to follow the InterQual criteria for surgery for gender confirmation diagnoses; is that right?

MS. PRAKASH: They would be obligated to provide equal care. And right now, the way that they determine how care is provided is by using their vendor, Kepro, which then utilizes the InterQual guidelines. So if they change to some other set of guidelines, if they go through a different process, it just

needs to be provided on the same basis to transgender folks as it is to cisgender folks.

THE COURT: Okay. And by the operation of that fact, the Medicaid program would be applying essentially the InterQual standards for a given treatment or a given type of surgery whether it's for gender confirmation or whether it's for some other diagnosis?

MS. PRAKASH: Yes, provided that -- there is this medical necessity part, right -- provided that it is medically necessary. But that's what the guidelines help determine.

THE COURT: All right. Anything else?

MS. PRAKASH: No, Your Honor.

THE COURT: Thank you very much. I appreciate your participation. Thank all of you.

Well, this has been very helpful to help sort of crystallize and focus the issues. I have been working on this, I expect to work on it fairly intensely for the next couple of weeks. I don't think I'm going to have a decision out for at least two weeks or more. And, you know, when you hear a judge say that, you probably automatically add a little time to it.

I know this is important. I know that at this point really the case -- we don't even have a scheduling order in place to go beyond this, so I'm very cognizant of that. And for that and the obvious reasons, I'll try to get a ruling on

this as quickly as I can, but it is going to take me a few weeks at least.

With that, I thank all of you for your presentations, both in writing and orally. You're outstanding lawyers, you obviously know the case quite well, and you articulated your clients' positions very clearly. So thank you.

Is there anything else we need to take up at this time?

MS. CYRUS: No, Your Honor.

THE COURT: If not, thank you all. We stand adjourned.

THE COURT SECURITY OFFICER: All rise.

THE COURT: We're adjourned.

THE COURT SECURITY OFFICER: Court is adjourned.

(Proceedings were concluded at 3:21 p.m.)

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CERTIFICATION:

I, Kathy L. Swinhart, CSR, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter as reported on July 13, 2022.

July 27, 2022
DATE

/s/ Kathy L. Swinhart
KATHY L. SWINHART, CSR

**IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA**

**HUNTINGTON DIVISION**

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

Plaintiffs,

v. CIVIL ACTION NO. 3:20-0740

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;
WEST VIRGINIA DEPARTMENTOF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

Defendants.

**MEMORANDUM OPINION AND ORDER**

Pending before the Court is Plaintiffs' Motion for Class Certification Pursuant to Federal Rule of Civil Procedure 23. ECF No. 248. Plaintiffs ask this Court to certify the proposed class of "all transgender people who are or will be enrolled in west Virginia Medicaid and who are seeking or will seek gender-confirming care barred by the Exclusion." It is clear to this Court that Plaintiffs meet the requirements of Rule 23 to justify the certification of this class. Accordingly, the Court **GRANTS** Plaintiffs' Motion. ECF No. 248.

**BACKGROUND**

The Plaintiffs in this case are transgender West Virginian Medicaid participants. Plaintiff Christopher Fain is a 46-year-old transgender man enrolled in West Virginia Medicaid and is seeking surgical treatment for his gender dysphoria diagnosis. *Fain Tr.*, ECF No. 252-5, at 22, 23.

Plaintiff Shauntae Anderson is a 45-year-old transgender woman enrolled in West Virginia Medicaid and is also seeking the surgical treatment for her gender dysphoria. *Anderson Dep.*, ECF No. 250-11, at 11–12. The proposed class in this class exceeds 600 people annually, as 686 participants in the West Virginia Medicaid Program submitted at least one claim with a diagnosis for gender dysphoria or gender incongruence in 2021. *Defs.' Resp. to Pls.' Second Set of Interrogs.*, ECF No. 250-6, at 5.

The West Virginia Medicaid Program provides a blanket exclusion for "transsexual surgery," stating that such a service is not covered "regardless of medical necessity." *Ex. 23*, ECF No. 250-27, at 5–6. Thus, any transgender Medicaid participant in West Virginia who may be diagnosed with gender dysphoria is barred from coverage for the surgical treatment of this diagnosis.

**STANDARD OF REVIEW**

Rule 23(a) of the Federal Rules of Civil Procedure establishes four class certification requirements: (1) a class so numerous that joinder of all members is impracticable; (2) questions of law or fact common to the class; (3) a representative party whose claims and defenses are typical of the class's claims and defenses; and (4) a representative party that will fairly and adequately protect the class's interests. Fed. R. Civ. P. 23(a); *Monroe v. City of Charlottesville*, 579 F.3d 380, 384 (4th Cir. 2009). In addition to these four requirements, a plaintiff must also demonstrate that the proposed class action fits into one of three forms permitted by Rule 23(b). *See Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 163 (1974).

"Rule 23 does not set forth a mere pleading standard." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011). The plaintiffs seeking certification "must affirmatively demonstrate [their] compliance with the Rule—that is, [they] must be prepared to prove that there are in fact

sufficiently numerous parties, common questions of law or fact, etc." *Id.*; *EQT Prod. Co. v. Adair*, 764 F.3d 347, 358 (4th Cir. 2014) (noting that the plaintiff bears the burden of proving it has complied with Rule 23). Nevertheless, "the district court has an independent obligation to perform a 'rigorous analysis' to ensure that all of the prerequisites have been satisfied." *EQT*, 764 F.3d at 358 (quoting *Wal-Mart*, 564 U.S. at 350–51). This "rigorous analysis" may "entail some overlap with the merits of the plaintiff's underlying claim," *Wal-Mart*, 564 U.S. at 351, but courts have been cautioned not to "engage in free-ranging merits inquiries at the certification stage," *Amgen Inc. v. Conn. Ret. Plans & Tr. Funds*, 568 U.S. 455, 466 (2013).

**DISCUSSION**

As a threshold matter, this Circuit requires that, in addition to the explicit requirements of Rule 23, proposed classes must be "readily identifiable." *EQT Prod. Co. v. Adair*, 764 F.3d 347, 358 (4th Cir. 2014) (quoting *Hammond v. Powell*, 462 F.2d 1053, 1055 (4th Cir. 1972)). This means that "[a] class cannot be certified unless a court can readily identify the class members in reference to objective criteria." *Id.* The goal of this requirement is to avoid "mini-trials" to determine who is or is not a class member. *Id.* (quoting *Marcus v. BMW of N. Am., LLC*, 687 F.3d 583, 593 (3d Cir. 2012)).

While all potential class members have yet to be identified, it does not mean that such class members are not identifiable. *Id*. at 358 ("The plaintiffs need not be able to identify every class member at the time of certification."). Here, the criteria Plaintiffs present are clear. The class is comprised of all transgender people who are or will be enrolled in west Virginia Medicaid and who are seeking or will seek gender-confirming care. Such factors are well documented and easily ascertainable. Thus, while not all class members have been identified, such members can be easily identified.

1. Numerosity

Plaintiffs assert that the size of the class exceeds the numerosity requirement and that joinder of all class members is impracticable. *See* Fed. R. Civ. P. 23(a)(1) (noting that the first requirement for a class action is that "the class is so numerous that joinder of all members is impracticable"). There is no "mechanical test" or minimum class size requirement, but courts have generally found numerosity present when a class has 40 or more members. *Baxley v. Jividen*, 338 F.R.D. 80, 86 (S.D.W. Va. 2020) (citing *Holsey v. Armour & Co.*, 734 F.2d 199, 217 (4th Cir. 1984)). Plaintiffs argue they easily satisfy the numerosity requirement, as their proposed class includes at least 686 Medicaid participants (which filed claims related to gender dysphoria or gender incongruence between January 1 and September 30, 2021). This Court agrees. The joinder of this many plaintiffs would be impracticable, given that all potential plaintiffs are not yet known and reside all over the state of West Virginia. *See Flack v. Wisconsin Dep't of Health Servs.*, 331 F.R.D. 361, 368 (W.D. Wis. 2019) (noting that, in a motion to certify a class challenging the exclusion of gender confirming surgeries in a state Medicaid program, "the proposed class may be too numerous to join in a single lawsuit, especially since some members of the class are not capable of being identified until sometime in the future).

Defendants argue that the characterization of the 686 Medicaid members is not accurate, explaining that, while 686 participants made claims related to a number of gender identity disorders, the number does not necessarily mean that those claims were all related to that particular gender identity diagnosis. Further, not all of those participants necessarily made claims related to gender-confirming care. But Defendants misunderstand the boundaries of the proposed class. Plaintiffs seek to ensure that all transgender Medicaid participants who may experience gender

dysphoria are not precluded from surgical treatment by the current Medicaid exclusion. While all 686 transgender Medicaid participants are not currently seeking surgical care for gender dysphoria, it is only transgender participants that have the potential to receive this diagnosis. The boundaries of this class include all transgender Medicaid participants who may experience gender dysphoria and who may require the surgical treatment of such diagnosis; this includes all 686 identified Medicaid participants and any individual who meets these criteria in the future.

Defendants also argue that the proposed class is unworkable, as it is broadly made up of transgender individuals who seek gender-confirming care, while the determination of whether such individuals would be eligible for this care must be assessed on a case-by-case basis. However, this position mischaracterizes the issue. The exclusion precludes the surgical care categorically—it is a barrier to surgical care altogether. A doctor providing someone an individualized assessment determining whether surgical treatment would be appropriate would not be meaningful when surgical care to treat gender dysphoria is not available to any transgender Medicaid participants. The exclusion precluding coverage for surgical care must be eliminated before such determinations can be made, giving transgender Medicaid participants with gender dysphoria this treatment option.

Thus, the Court finds that Plaintiffs have met the numerosity requirement.

2. Commonality

Plaintiffs argue that commonality is met because each member has suffered the same injury due to exclusion that categorically denies transgender participants coverage for gender-confirming surgical care. Commonality requires that there be "questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). Although "[a] single common question will suffice, . . . it must be of such a nature that its determination 'will resolve an issue that is central to the validity of each one of the

claims in one stroke." *EQT*, 764 F.3d at 360 (quoting *Wal-Mart*, 564 U.S. at 350).

The exclusion precludes coverage to all transgender Medicaid participants with gender dysphoria from receiving surgical treatment for that diagnosis. This exclusion applies to every member of the class without exception; it is a barrier for all transgender participants who seek or who may seek this treatment. Defendants argue that the proposed class do not present common questions of law, rather, that the question as to whether a class member may be approved or denied coverage for a surgical treatment of gender dysphoria cannot be answered by this Court in the resolution of this case. But again, Defendants' position misunderstands the nature of the issue. Plaintiffs do not ask this Court to make a determination about whether the individual transgender Medicaid participants with gender dysphoria diagnoses may get surgical treatment. Like Defendants point out, the determination of whether surgical treatment is appropriate is a case-by-case analysis done by a health professional. Plaintiffs merely ask this Court to 1) determine whether the exclusion violates the Constitution, the ACA, and the Medicaid Act, and 2) enjoin Defendants from enforcing the exclusion. *See Baxley*, 338 F.R.D. at 87 (finding that plaintiffs challenged defendants' policies and practices and that such claims were "consistent with common questions presented" by other similar certified jail classes); *see Flack*, 331 F.R.D. at *369 (finding that the lawfulness of the exclusion for gender-confirming surgery was a question common to all members of the proposed class). Only once these issues have been resolved can the individualized determinations regarding the appropriateness of the surgical treatment be take place. These issues are common to all members of the proposed class; thus, the Court finds Plaintiffs have meet the commonality requirement.

3. Typicality of proposed class representatives

Federal Rule 23 requires that "the claims… of the representative parties are typical of the claims… of the class." Fed. R. Civ. P. 23(a)(3). To meet the typicality requirement, the proposed class representatives must show that "the claims or defenses of the class and class representatives arise from the same event or pattern or practice and are based on the same legal theory." *In re Serzone Prods. Liab. Litig.*, 231 F.R.D. 221, 238 (S.D.W. Va. 2005) (quotations omitted).

Plaintiffs argue that the proposed class representatives have claims identical to the those of the class they seek to represent, as, like all transgender Medicaid participants, they are denied without exception access to surgical care for gender dysphoria on the basis of sex and transgender status. This Court agrees. The exclusion invidiously discriminates against Plaintiffs as much as it would other members of the class (transgender Medicaid participants who are seeking or may seek surgical treatment for gender dysphoria). The relief sought is identical to other class members—the declaration of the exclusion's unlawfulness and an injunction precluding the enforcement of it. *See Flack*, 331 F.R.D. at 369 (finding that the plaintiffs' claims were identical to those of the other class members, as they arose from the enforcement of the challenged exclusion).

Defendants argue that the claims of each proposed class member are unique and thus are not common. To Defendants, the claims of each proposed class members are actually individualized assessments of whether the participants experience gender dysphoria and whether surgical care is appropriate to treat this diagnosis—a case-by-case determination. Due to the individualized nature of this determination, Defendants also assert that, as a matter of law, they are entitled to assert any individual affirmative defenses. As previously discussed, this mischaracterizes the issue before the Court. The determination of whether surgical care is appropriate for a participant is still individualized. Defendants may still assert affirmative defenses

to demonstrate that a participant was denied care for a lawful reason. Plaintiffs merely ask the Court to preclude Defendants from asserting the exclusion as a reason to deny coverage.

Thus, Plaintiffs have met the typicality requirement.

4. Plaintiffs as representatives

The class representatives must "fairly and adequately protect the interest of the class." Fed. R. Civ. P. 23(a)(4). The counsel representing the class must also be capable of "fairly and adequately" representing the interest of the class. Fed. R. Civ. P. 23(g). This analysis takes into consideration "(1) whether there is conflict between the representatives and class members, and (2) whether the representatives will vigorously prosecute the matter on behalf of the class." *Baxley*, 338 F.R.D. at *89 (internal quotations omitted).

Plaintiffs here are adequate representatives. There are no conflicts of interest between Plaintiffs and the proposed class. Plaintiffs also share a common interest with the proposed class in seeking a declaration that the exclusion is unlawful and seeking an injunction precluding Defendants from enforcing the exclusion. While Defendants argue that Plaintiffs are inadequate because they have not presented any facts that an exclusion for puberty-delaying treatment exists nor have they sought such treatments, this argument again misses the mark. Plaintiffs seek to represent all transgender people who are or will be enrolled in west Virginia Medicaid and who are seeking or will seek gender-confirming care barred by the exclusion. If puberty-confirming care is barred by the exclusion, then Plaintiffs' representation—seeking the declaration of the exclusion's unlawfulness and an injunction against its enforcement—is adequate. If this care is not barred from the exclusion, then such care is not the subject of this matter and the proposed class and Plaintiffs would have equal access to it, as it would not be excluded on the basis of sex and transgender status.

Further, Plaintiffs' proposed class counsel can fairly and adequately represent the proposed class. Plaintiffs have provided ample background on their counsel, Nichols Kaster, Lambda Legal Defense and Education Fund, Inc., and the Employment Law Center. Lambda Legal has extensive experience with civil right and class action litigation, specifically with LGBT issues. *See generally Aff. of Smith-Carrington*, ECF No. 248-4. Nichols Kaster is a top plaintiffs' litigation firm representing many class litigation matters. *See generally Aff. of Schladt*, ECF No. 248-2; *see Ex. A. to Aff. of Schladt*, ECF No 248-3. Walt Auvil, as the sole member of the Employment Law Center, has served as lead counsel on many discrimination cases in state and federal court in West Virginia and has also been lead counsel on class action matters. *See generally Aff. of Walt Auvil*, ECF No. 248-1.

5. The proposed class satisfies the requirements of Rule 23(b)(2)

Rule 23(b)(2) provides that "[a] class action may be maintained if Rule 23(a) is satisfied and if…the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). "As the Supreme Court has instructed, '[t]he key to the (b)(2) class is the indivisible nature of the…remedy warranted.'" *EQT Prod. Co.*, 764 F.3d at 357 (citing *Wal-Mart Stores, Inc.*, 564 U.S. at 360). Class certification is appropriate "only when a single injunction or declaratory judgment would provide relief to each member of the class." *Wal-Mart Stores, Inc.*, 564 U.S. at 360.

Here, certification of the class seems appropriate given that the exclusion applies broadly to all members of the proposed class. A declaratory judgment finding that the exclusion is unlawful and an injunction enjoining Defendants from enforcing the exclusion would be appropriate to the class as a whole. Upon Plaintiffs' successful motion for summary judgment, the

declaratory judgment and injunction sought would provide "meaningful, valuable" and "indivisible" relief to each class member. *Berry v. Schulman*, 807 F.3d 600, 609 (4th Cir. 2015).

The Court finds that certification here is warranted, as the exclusion affects all proposed class members, and the declaratory and injunctive relief sought would benefit all class members. *See Flack*, 331 F.R.D at *370 ("[C]ertification of the Proposed Class is warranted under Rule 23(b)(2) because the categorical coverage ban on gender-confirming care under the Challenged Exclusion is generally applicable to the class, making a final injunction and corresponding declaratory judgment appropriate to the full class." (internal citations omitted)).

**CONCLUSION**

For the foregoing reasons, the Court finds that certification of the proposed class is appropriate. Accordingly, the Court **GRANTS** Plaintiffs' Motion for Class Certification. ECF No. 248.

The Court **DIRECTS** the Clerk to send a copy of this Order to counsel of record and any unrepresented parties.

ENTER: August 2, 2022

ROBERT C. CHAMBERS
UNITED STATES DISTRICT JUDGE

**IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA**

**HUNTINGTON DIVISION**

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

Plaintiffs,

v. CIVIL ACTION NO. 3:20-0740

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;
WEST VIRGINIA DEPARTMENTOF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,

Defendants.

**MEMORANDUM OPINION AND ORDER**

Pending before the Court are cross motions for summary judgment filed by Plaintiffs (transgender individuals who receive healthcare through the West Virginia Medicaid Program) and Defendants (the State actors and agencies responsible for administering the Medicaid Program). ECF Nos. 250, 252. This case challenges the constitutionality of the West Virginia Medicaid Program's exclusion of the surgical treatment of gender dysphoria.

As it currently stands, the West Virginia State Medicaid Program does not afford coverage for gender-conforming surgical care as treatment for gender dysphoria. Ultimately, the exclusion in the healthcare plan precludes coverage for these surgical treatments when a person is diagnosed with gender dysphoria. However, the same or similar surgical treatments are available to persons when the diagnosis requiring that treatment is not gender dysphoria. It is undisputed that the criteria

determining whether or not such treatment is covered under the Medicaid Program hinges on a diagnosis—but when treatment is precluded for a diagnosis based on one's gender identity, such exclusion invidiously discriminates on the basis of sex and transgender status. Thus, the Court **GRANTS** Plaintiffs' Motion for Summary Judgment (ECF No. 250) and **DENIES** Defendants' Motion for Summary Judgment (ECF No. 252).

## BACKGROUND

The Plaintiffs in this case are transgender West Virginian Medicaid participants. Plaintiff Christopher Fain is a 46-year-old transgender man enrolled in West Virginia Medicaid. He receives hormone therapy for his gender dysphoria diagnosis. Because of this diagnosis, he seeks a bilateral mastectomy. Two physician letters recommend this treatment. *Fain Tr.*, ECF No. 252-5, at 22. However, he has not formally sought coverage for this surgical procedure or received a denial letter. *Id.* at 23. He felt such an exercise would be futile, knowing that the surgery is excluded under his insurance policy. *Id.*

Plaintiff Shauntae Anderson is a 45-year-old transgender woman enrolled in West Virginia Medicaid. She also receives hormone therapy for her gender dysphoria diagnosis. She seeks vaginoplasty and breast reconstruction surgery to relieve her gender dysphoria. *Anderson Tr.*, ECF No. 250-11, at 11–12. Plaintiff Anderson noted that she has not spoken with a doctor about these procedures because it is known such surgeries are not covered and speaking about the unavailable treatment would cause her distress. *Anderson Tr.*, ECF No. 252-4, at 43.

Medicaid is a federal-state program providing health insurance for eligible persons. 42 U.S.C. § 1396–1396w-5. West Virginia has participated in the Medicaid program since its inception in 1965. The purpose of the program is to "furnish [] medical assistance" to individuals "whose income and resources are insufficient to meet the cost of necessary medical services." 42

U.S.C. § 1396-1. Medicaid for West Virginia has an annual budget of between $4.5 and $5.1 billion. *Manning Tr.*, ECF No. 250-16, at 13. CMS subsidizes 74% to 81% of the state's program. *Beane Tr.*, Ex. 250-13, at 31, 40.

Mountain Health Trust is West Virginia's Medicaid Program. Eligible Medicaid participants may choose a primary health provider and select one of three managed care organizations (MCOs). Each plan provides participants with Medicaid-covered health services. While 85% of Medicaid participants receive coverage through Mountain Health Trust, the remaining 15% receive care through a fee for service model where Medicaid pays providers directly.

Defendants maintain a comprehensive state plan for medical assistance which is detailed in a Medicaid Policy Manual. *Beane Tr.*, ECF No. 250-13, at 28. The Policy Manual provides a blanket exclusion for "transsexual surgery," stating that such a service is not covered "regardless of medical necessity." *Ex. 23*, ECF No. 250-27, at 5–6. Additionally, BMS's contract with each of the three MCOs has an explicit exclusion of coverage for "transsexual surgery." *See Aetna Contract*, ECF No. 250-33; *see UniCare Contract*, ECF No. 250-34; *see The Health Plan Contract*, ECF No. 250-35. The exclusion for "transsexual surgery" was adopted around 2004 and has been maintained since without review. *See Becker Tr.*, ECF No. 250-14, at 11–12; *Beane Tr.*, ECF No. 250-13, at 43–44.

Defendant West Virginia Department of Health and Human Resources, Bureau for Medical Services (BMS) is a bureau of the West Virginia Department of Health and Human Resources (DHHR) and is the agency responsible for administering the Medicaid program in West Virginia. BMS receives funding from the U.S. Department of Health and Human Services—federal funds. Defendant Bill Crouch is the Cabinet Secretary of DHHR and is responsible for ensuring that BMS

meets the federal requirements. He is also responsible for developing a managed care system to monitor the services provided by the Medicaid program. *See* W. Va. Code § 9-2-9(a)(1). Defendant Cynthia Beane is the Commissioner of BMS. She is responsible for administering the state Medicaid plan and ensuring that it complies with the Affordable Care Act (ACA) and Medicaid Act.

**STANDARD OF REVIEW**

To obtain summary judgment, the moving party must show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a). In considering a motion for summary judgment, the Court will not "weigh the evidence and determine the truth of the matter[.]" *Anderson v. Liberty Lobby, Inc*., 477 U.S. 242, 249 (1986). Instead, the Court will draw any permissible inference from the underlying facts in the light most favorable to the nonmoving party. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587-88 (1986).

Although the Court will view all underlying facts and inferences in the light most favorable to the nonmoving party, the nonmoving party nonetheless must offer some "concrete evidence from which a reasonable juror could return a verdict in his [or her] favor[.]" *Anderson*, 477 U.S. at 256. Summary judgment is appropriate when the nonmoving party has the burden of proof on an essential element of his or her case and does not make, after adequate time for discovery, a showing sufficient to establish that element. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). The nonmoving party must satisfy this burden of proof by offering more than a mere "scintilla of evidence" in support of his or her position. *Anderson*, 477 U.S. at 252.

**DISCUSSION**

Plaintiffs bring the following claims against Defendants:

1. Denial of Equal Protection under the Fourteenth Amendment
2. Violation of the Affordable Care Act
3. Violation of the Comparability Requirement of the Medicaid Act
4. Violation of the Availability Requirement of the Medicaid Act

The Court will address each claim.

1. Equal Protection under the Fourteenth Amendment

Plaintiffs assert that the exclusion for the surgical treatment of gender dysphoria violates their rights under the Equal Protection clause of the Fourteenth Amendment. The Equal Protection Clause provides that "[n]o State shall… deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1. This "keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). A claim for an equal protection violation requires a plaintiff to show that they have "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). Once this demonstration is made, next the court must "determine whether the disparity in treatment can be justified under the requisite level of scrutiny." *Id.*; *City of Cleburne v. Cleburne Living Ctr., Inc.*, 43 U.S. 432, 440 (1985).

a. Resolution of facts related to Equal Protection analysis

Important to the Court's review of the Equal Protection claim are some key factual findings.

*i. Policy exclusion and covered services*

The exclusion at issue here is the exclusion for "transsexual surgery," stating that such a service is not covered "regardless of medical necessity." *Ex. 23*, ECF No. 250-27, at 5–6.

Nonetheless, the policy does cover other treatments related to transgender healthcare. The policy covers psychiatric diagnosis evaluation, psychotherapy, psychological evaluation, counseling, office visits, hormones, and lab work when medically necessary even if the treatments are related to gender-confirming care. *Tr. of Proceedings*, ECF No. 269, at 32–33; *see Beane Tr.*, ECF No. 250-13, at 5, 50. Transgender individuals are covered for the same care as cisgender individuals when such treatment is not the surgical treatment for gender dysphoria.

The West Virginia Medicaid Program uses a utilization management vendor called Kepro to determine whether a service is covered. *See Sarah Young Dep.*, ECF No. 250-18, at 23. Kepro is a screening tool that determines the medical necessity of a treatment, and this system uses nationally accredited criteria established by InterQual. *Id.* at 24. The criteria are derived from a systematic and continuous review of current, evidence-based literature, and also include input from an independent panel of clinical experts. *Id.* at 26. InterQual relies on guidelines promulgated by the World Professional Association of Transgender Health (WPATH) and the Endocrine Society that provide guidance on transgender health treatments. *See generally InterQual Composite*, ECF No. 250-30. Due to the exclusion, Medicaid does not follow the InterQual/Kepro guidance for surgical care to treat gender dysphoria.

*ii. Material differences between surgery for gender-confirming and surgeries for non-gender-confirming treatments*

Defendants assert that the surgical procedures provided to treat gender dysphoria are distinct from those provided to cisgender and transgender patients for non-gender-confirming purposes. To support this position, Defendants point to the InterQual guidelines for gender-affirming care, which are utilized by Kepro. Defendants argue that, because InterQual has guidelines that are specific to gender-affirming surgical services, they are distinct from the

guidelines that relate to the surgeries covered by Medicaid. To Defendants, the fact that there are these separate and distinct InterQual guidelines relating to gender-affirming surgical services proves that the procedures are different. But this argument lacks merit. InterQual's guidelines to determine the medical necessity of surgery to treat gender dysphoria are based on the diagnosis of gender dysphoria; thus, the criteria to determine the medical necessity of surgery to treat a different diagnosis would be based on that different diagnosis. That does not make the actual surgical treatments materially different.

In fact, Defendants' assertion that the surgical services provided for gender dysphoria are fundamentally different from those provided for cisgender and transgender patients is unsupported by the expert and other evidence in the record. In his expert report, Dr. Loren Schechter explains that the same surgical treatments can be performed to address several different diagnoses. *Dr. Schechter Expert Report*, ECF No. 250-23, at 17–18. For example, a vaginoplasty can be performed for a transgender patient to treat gender dysphoria or for a non-transgender woman as a treatment for congenital absence of the vagina. *Id.* at 18. When documenting and billing for these surgical treatments, health care providers utilize Current Procedural Terminology (CPT) codes developed and maintained by the American Medical Association. *Id.* at 17–18. The same CPT codes are used to document and bill the same surgical treatment when performed for a transgender patient with gender dysphoria and for any patient for a different diagnosis.

Defendants also assert that the techniques used to perform gender-affirming surgeries and those used to perform non-gender-confirming surgeries are different, supporting their argument that the procedures are distinct. But, to support this claim, Defendants offer no evidence themselves and instead mischaracterize Plaintiffs' expert testimony. It is true that there are many techniques used for the same kind of surgeries, and the specific technique used by a surgeon will

"depend upon the specific situation" or would depend on "the clinical conditions" of the individual patient *Dr. Schechter Dep.*, ECF No. 252-15, at 40–41. For example, there "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 [cancer.]" *Id.* at 40. However, the "technical act of a mastectomy" can be performed to treat both a non-gender dysphoria related diagnosis and a gender dysphoria related diagnosis. *Id.* Based on the expert opinion of Dr. Schechter, this Court finds that a surgery, such as a mastectomy, for a gender dysphoria diagnosis and the same surgery for a non-gender dysphoria diagnosis, are not materially different

*iii. Costs associated with the surgeries*

In their memoranda, Defendants put forth cost considerations as a legitimate governmental interest to support the exclusion. Defendants assert that Medicaid is projecting a budget deficit within two years. *Beane Dep.*, ECF No. 252-3, at 46. Thus, their argument goes, if the program were to include coverage for surgical care for gender dysphoria, the program would have to "cut existing services or receive additional appropriations from the [L]egislature." *Id.* Defendants also note the Legislature's hesitancy to increase the Medicaid budget. *Id.*

But Defendant's cost-related argument is unsupported by the record. First, the Court notes that, puzzlingly, Defendants stipulated to the fact that there are "no documents of which they are aware that were considered in adopting and/or maintaining the Exclusion" in the Medicaid Program.[1] *Corrected Stipulation of Pls. and Defs.*, ECF No. 258. It is curious as to how, in the face of this stipulation, Defendants can assert that the exclusion was adopted with cost

[1] Defendants admit that there is no known reason as to why this Exclusion was ever adopted in the first place. *See Beane Dep.*, ECF No. 250-13, at 42–43.

considerations in mind. Cost information could have been ascertained by Defendants, but it appears that there has been no direct cost analysis regarding surgical care to treat gender dysphoria at all.[2]

Beyond Defendants' failure to rely on any cost-related documents in consideration of the exclusion, the information in the record that does pertain to costs shows that the cost of providing this coverage is not burdensome. There are a relatively small number of people affected by the exclusion. *See Dr. Karasic's Dep.*, ECF No. 252-8, at 4–5 (noting that around one person in 200 identifies as transgender, while around one in 1,000 is in clinical care for gender dysphoria); *Grimm v. Gloucester Cty. School Bd.*, 972 F.3d 586, 594 (4th Cir. 2020) (noting that only "approximately 0.6% of the United States adult population" identifies as transgender). In fact, Defendants provided that, through September of 2021, there were 686 West Virginia Medicaid participants who have submitted one or more claims with a diagnosis code for gender dysphoria or gender incongruence. *Defs.' Resp. to Pls.' Second Set of Interrogs.*, ECF No. 250-6, at 5. Further, there is no evidence in the record to show that surgeries to treat gender dysphoria are any more or less costly than those similar surgeries to treat other diagnoses. *See Dr. Karasic's Expert Report*, ECF No. 252-8, at 65–66 ("[W]hen a form of treatment is covered for cisgender people under an insurance plan, it is generally not disproportionately costly to cover the same treatment for transgender people simply because it is provided to treat gender dysphoria."). As discussed above, such surgeries are in all relevant aspects the same, so it logically flows that a surgery to treat gender dysphoria will not be significantly more expensive than one for a different diagnosis. Given the fact that very few individuals will seek such treatment, the Court is unpersuaded that

[2] Information about how other states apply policies regarding the coverage of surgical treatment for gender dysphoria could have been ascertained. *See Becker Tr.*, ECF No. 250-14, at 18 (discussing documents reviewed by Becker).

providing coverage for this treatment would be too burdensome of a cost.

Further, this assertion flies in the face of unrefuted expert testimony. Dr. Schechter's expert report discusses research of the cost-effectiveness of gender confirmation surgeries. *Dr. Schechter Expert Report*, ECF No. 250-23, at 17–18. Citing to research done at the John Hopkins Bloomberg School of Public Health, the Commonwealth of Massachusetts Group Insurance Commission, and the University of Colorado, Dr. Schechter opines that gender confirmation surgeries typically result in a "significant reduction of gender dysphoria," while those suffering from gender dysphoria without access to these surgeries tend to "have higher rates of negative health outcomes such as depression, HIV, drug abuse, and suicidality." *Id.* at 18. The research shows that "the one-time costs of gender confirmation surgeries coupled with standard post-operative care, primary and maintenance care, were overall less expensive at 5- and 10-year marks as compared to the long-term treatment of the negative health outcomes associated with the lack of insurance and resulting healthcare access." *Id.* at 18–19. Thus, overall, Dr. Schechter notes that these surgeries are both affordable and a "nominal percentage of the care offered through group health plans." *Id.* at 19.

Defendants can point to no evidence in the record to support the assertion that providing coverage for surgical treatment of gender dysphoria is too costly. In fact, Defendants concede that they have not conducted or ever obtained any cost analysis information to rebut Plaintiffs' claims. The only evidence in the record points to the contrary—that the surgical treatment of gender dysphoria is ultimately cost-effective and comparable to surgery for other diagnoses.

b. <u>The exclusion discriminates based on transgender status</u>

"In determining what level of scrutiny applies to a plaintiff's equal protection claim, we look to the basis of the distinction between the classes of persons." *Grimm*, 972 F.3d at 607 (citing

*United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4, (1938)). The classifications in most state policies are generally held to be valid when those classifications drawn are "rationally related to a legitimate state interest." *Cleburne*, 473 U.S. at 440. However, "[t]his general rule 'gives way'… when the policy discriminates based on membership in certain suspect classes." *Kadel v. Folwell*, 1:19-cv-272, 2022 WL 2106270, *18 (M.D.N.C. June 10, 2022) (citing *Cleburne*, 473 U.S. at 440). The Fourth Circuit has determined that policies that discriminate on sex or transgender status are reviewed under a heightened scrutiny. *Grimm*, 972 F.3d at 608–10.[3,4] Policies that classify based on a quasi-suspect classification are found to be unconstitutional unless they are "substantially related to a sufficiently important governmental interest." *Cleburne*, 473 U.S. at 441.

Plaintiffs' Equal Protection claim is grounded in the assertion that transgender West

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[3] When considering whether a certain group constitutes a quasi-suspect class, the Fourth Circuit analyzed four factors:

- Whether the class historically has been subject to discrimination
- Whether the class has a defining characteristic that bears a relation to its ability to perform or contribute to society
- Whether the class may be defined as a discrete group by obvious, immutable, or distinguishing characteristics
- Whether the class lacks political power.

*Grimm v. Gloucester Cty. School Bd.*, 972 F.3d 586, 607–08 (4th Cir. 2020) (internal citations omitted).[3] The *Grimm* court discussed the history of discrimination of transgender peoples in education, employment, housing, healthcare access, and military service, in addition to the history of violence and harassment of transgender peoples. The court then opined that one's transgender status "bears no… relation" to one's ability to "perform or contribute to society." *Id.* at 612 (internal quotation omitted). Moving on, the court discussed that a person's gender identity is "as natural and immutable as being cisgender," and that transgender people constitute a minority lacking political power, as only 0.6% of the United States population identify as transgender.

Many courts have held that discrimination against transgender persons is sex-based discrimination for Equal Protection purposes because such policies punish transgender persons for gender non-conformity, thus relying on sex stereotypes. *Id.* at 608. Thus, this Court follows *Grimm* and finds that the Plaintiffs in this case fall within a quasi-suspect class, necessitating the application of heightened scrutiny.

[4] At the outset, the Court notes that Defendants have argued that *Grimm* should not apply to this analysis. Defendants argue that the matter before this Court is a case of first impression, entirely novel from the *Grimm* case, where the Fourth Circuit considered a challenge to a policy requiring students to use bathrooms based on their biological, or birth-assigned, sex. Here, in contrast, the Court is grappling with a Medicaid benefits case. But the context of the cases is immaterial to the application of the applicable level of scrutiny. Regardless of the specific set of facts under which each case arises, the Court must use the appropriate level of scrutiny to analyze each of the policies. The four-factor test enumerated in *Grimm* aids this Court's determination of whether a suspect class exists here.

Virginia Medicaid participants are denied the medically necessary surgeries that participants receiving those same surgeries for non-gender dysphoria related treatments are allowed—thus, the classification is based on transgender status. Defendants refute this assertion, claiming that the exclusion does not take into consideration gender status, but instead is based on diagnosis, i.e., surgeries are excluded for the diagnosis of "gender dysphoria," not excluded for transgender people. Further, Defendants say that transgender Medicaid participants are not denied any coverage that similarly situated persons have. According to Defendants, the persons affected by the exclusion, transgender people suffering from gender dysphoria seeking surgery, are similarly situated only to other transgender people suffering from gender dysphoria seeking surgery—thus, there is no disparate treatment, as surgery for gender dysphoria is not covered for anyone. Defendants assert that Plaintiffs cannot seek comparison with cisgender persons who seek surgeries for reasons for other than gender-confirmation, because those procedures sought by cisgender persons are not gender-confirmation procedures, making the groups not "in all relevant aspects alike." Defendants further assert that, because other gender-confirming treatments are made available under the West Virginia Medicaid Program, and that only a subgroup of transgender people will ever seek surgery, Defendants are not discriminating against transgender people.

The Court is not persuaded by Defendant's arguments. First, inherent in a gender dysphoria diagnosis is a person's identity as transgender. In other words, a person cannot suffer from gender dysphoria without identifying as transgender. *See Kadel*, 2022 WL 2106270, at *20 ("even if the Court credited Defendant's characterization of the Plan as applying only to diagnoses of gender dysphoria, it would still receive intermediate scrutiny. Discrimination against individuals suffering from gender dysphoria is also discrimination based on sex and transgender status. As with the

Plan's exclusions, one cannot explain gender dysphoria 'without referencing sex' or a synonym." (quoting *Grimm*, 972 F.3d at 608)). Transgender people have access to the same surgeries for other diagnosis—the exclusion is aimed specifically at a gender change procedure. Thus, the exclusion targets transgender people because they are transgender.

Second, the Court turns to the argument that transgender individuals with gender dysphoria seeking gender-confirmation surgery are not similarly situated to individuals seeking the same surgeries for reasons other than gender-confirmation. Defendant supports this position by relying on a report and recommendation out of the Eastern District of Louisiana, where a pro se prisoner filed a § 1983 action alleging that defendants were deliberately indifferent to her need for medical treatment for gender dysphoria and violated her right to equal protection. *Williams v. Kelly*, No. 17-12993, 2018 WL 4403381, at *1 (E.D. La. Aug. 27, 2018). The report found that plaintiff was not similarly situated to cisgender patients seeking vaginal surgeries, so her Equal Protection claim failed. *Id.* at *12. This Court is neither bound nor persuaded by this report. The *Williams* court was not bound by *Grimm*'s sex discrimination analysis and decided that case before *Bostock*'s guidance for analyzing sex discrimination against transgender people. *See Bostock v. Clayton Cnty., Georgia*, 140 S. Ct. 1731 (2020). Further, the majority of cases support this Court's analysis.[5]

The Court disagrees with Defendants' position. The exclusion at issue here denies coverage to transgender people with a gender dysphoria diagnosis seeking medically necessary surgeries. "Similarly situated persons in all relevant aspects alike" cannot refer only to people from the same exact group—the legal standard simply asks the Court to look to persons "in all *relevant* respects alike." *Morrison*, 239 F.3d at 654 (emphasis added). The *Grimm* court agreed, rejecting a similar argument where the school board contended that the plaintiff, a transgender boy, was not similarly

[5] *See Grimm*, 972 F.3d at 609–10; *see Kadel v. Folwell*, 1:19-cv-272, 2022 WL 2106270, *21 (M.D.N.C. June 10, 2022); *see Fletcher v. Alaska*, 443 F. Supp. 3d 1024, 1030 (D. Alaska 2020).

situation to cisgender boys, but only to biological girls. *Grimm*, 972 F.3d at 609–10. The Fourth Circuit opined that embedded in this argument is the bias that gender identity is a choice, and that adopting this framing of the issue would give in to stereotyping. *Id.* at 610.

The relevant comparison here is to persons who seek the same, medically necessary surgeries for non-gender dysphoria related treatments. The West Virginia Medicaid Program provides, for example, medically necessary mastectomies for non-gender dysphoria related diagnoses. The only difference between this scenario and the Plaintiffs' circumstances is that Plaintiffs seek these surgeries to treat gender dysphoria—thus, a distinction hinging on their transgender identity. There are InterQual standards, which are evidence-based standards, that determine the medical necessity of a procedure—these standards exist for both gender dysphoria treatment surgeries and non-gender-affirming surgeries, providing objective basis for determining when such treatments will be covered. Additionally, the surgeries for both gender-affirming and non-gender-affirming reasons utilize the same CPT codes in documenting and billing. The only difference, which results in the preclusion of coverage for Plaintiffs, is that their diagnosis is for gender dysphoria, arising from their identity as transgender.

Lastly, the Court disagrees with Defendants' assertion that, because West Virginia Medicaid provides coverage for some treatments of gender dysphoria, excluding coverage for surgical treatments for gender dysphoria is not discriminatory, as only a subset of transgender individuals will seek this treatment. Defendant relies on *Toomey v. Arizona*, a report and recommendation that found that a policy exclusion which "discriminates against some natal females but not all...is not, on its face, discrimination on the basis of sex." No. CV-19-0035-TUC-RM, 2020 WL 8459367, *4 (D. Ariz. Nov. 30, 2020).[6] This is an out-of-district case and is non-

[6] The Court notes that this report and recommendation was denied in part by the District Court. *Toomey v. Arizona*, 19-cv-00035, 2021 WL 753721 (D. Ariz. Feb 26, 2021).

binding on this Court. The District Judge in this matter did not discuss the magistrate's report and recommendation regarding this analysis in detail, but rather, found that 1) plaintiffs had not met the heightened standard for such relief and 2) the preliminary injunctive relief sought by plaintiffs was the same as the ultimate relief sought in the case, and without a showing of extraordinary circumstances, such relief could not be granted at the preliminary injunction phase. *Toomey v. Arizona*, 19-cv-00035, 2021 WL 753721 *5–*6 (D. Ariz. Feb 26, 2021). The report was adopted only to the extent that it recommended denying the Motion for Preliminary Injunction on the grounds that Plaintiff had not met the heightened standard. *Id.* at *6. The rest of the report was rejected by the District Court. *Id.* Thus, this report and recommendation is not persuasive to this Court's analysis.

Further, the Supreme Court has made clear that it "does [not] matter if an employer discriminates against only a subset of men or women." *Bostock*, 140 S. Ct. at 1775; *see also Phillips v. Martin Marietta Corp.*, 400 U.S. 542, 544 (1971) (finding that, even though only some women will become pregnant or have children, the refusal to hire women with preschool-aged children was facial sex discrimination). The exclusion here denies surgical care to all transgender people who may seek surgery to treat gender dysphoria—that subset of transgender people is equally protected against discrimination. Further, the narrow question addressed by this Court is the exclusion of surgical care. Simply because the West Virginia Medicaid Program does not discriminate in all aspects does not permit it to discriminate narrowly against transgender surgical care.

c. The exclusion discriminates on its face

Generally, a plaintiff must show that a policy based on sex or transgender status had discriminatory intent. But such a showing is unnecessary when the policy tends to discriminate on

its face. *Kadel*, 2022 WL 2106270, at *18 (citing *Shaw v. Reno*, 509 U.S. 630, 642 (1993)). The Court looks to the language of the policy to determine whether it is facially neutral or whether it explicitly references gendered or sex-related terms. *See Washington v. Seattle Sch. Dist. No. 1*, 458 U.S. 457, 485 (1982).

In *Grimm*, the Fourth Circuit found that a bathroom policy that required students to use bathrooms according to their "biological genders" discriminated on the basis of sex. *Grimm*, 972 F.3d at 608–10. The court reasoned that the policy "necessarily rests on a sex classification" and "cannot be stated without referencing sex." *Id.* at 608. Further, the court found that the bathroom policy propagated sex stereotyping, as the transgender plaintiff was viewed as "failing to conform" to sex stereotypes. *Id.* The *Grimm* court also found that the policy further discriminated on the plaintiff's status as a transgender boy, noting that "[m]any courts…have held that various forms of discrimination against transgender people constitute sex-based discrimination for purposes of the Equal Protection Clause because such policies punish transgender persons for gender non-conformity, thereby relying on sex stereotypes." *Id.*

Looking to the language of the exclusion, it is clear that the exclusion discriminates on its face. The exclusion denies coverage for "transsexual surgery." This language refers explicitly to sex—one seeking a "transsexual surgery" seeks to change from their sex assigned at birth to the sex that more accurately reflects their gender identify. Only individuals who identify as transgender would seek "transsexual surgery," and as the Supreme Court reasoned in *Bostock v. Clayton County, Georgia*, one cannot consider the term "transgender" without considering sex. *Bostock*, 140 S. Ct. at 1746 ("[T]ry writing out instructions for who should check the [transgender] box [on a job application] without using the words man, woman, or sex (or some synonym). It can't be done."). Following this reasoning, the Court finds that the exclusion references sex on its

face. *See Kadel*, 2022 WL 2106270, at *19 (finding that the health plan's exclusions for sex changes or modifications and related care facially discriminate); *see also Fletcher v. Alaska*, 443 F. Supp. 3d 1024, 1030 (D. Alaska 2020) ("In sum, defendant's policy of excluding coverage for medically necessary surgery such as vaginoplasty and mammoplasty for employees, such a[s] plaintiff, whose natal sex is male while providing coverage for such medically necessary surgery for employees whose natal sex is female is discriminatory on its face and is direct evidence of sex discrimination.").

Defendants point to *Geduldig v. Aiello* to support their argument that the exclusion is facially neutral. 417 U.S. 484 (1974). In *Geduldig*, the Court found that a disability insurance program which exempted from coverage any work loss resulting from pregnancy did not discriminate based on sex. *Id.* at 494. The Court reasoned that pregnancy was a physical condition divorced from gender, and while only women can get pregnant, the group of members who were not pregnant included both men and women. *Id.* at 496. Here, the nonsuspect class—those not seeking surgical treatment for gender dysphoria—are treated more favorably, as their materially same surgeries are covered. This is unlike *Geduldig*, where men were not treated more favorably under the challenged policy. And, as the *Kadel* court found, the exclusion precludes a specific treatment that is connected to a person's sex and gender identity—not just a single "objectively identifiable physical condition with unique characteristics." *Kadel*, 2022 WL 2106270, at *21.

Thus, it is the opinion of the Court that the exclusion at issue here facially discriminates on the basis of sex and transgender status. Thus, there is no need for Plaintiffs to show discriminatory intent or purpose.

d. Heightened Scrutiny Analysis

Finding that the exclusion does discriminate on the basis of sex and transgender status, the

Court must determine whether the exclusion survives heightened scrutiny. It does not.

Classifications based on sex and transgender status "fail[ ] unless [they are] substantially related to a sufficiently important governmental interest." *Grimm*, 972 F.3d at 608 (citing *Cleburne*, 473 U.S. at 441). The governmental interests that Defendants put forward to support the exclusion are unsupported by the evidence in the record.

*1. Cost*

Defendants assert cost considerations as a reason to justify the exclusion. However, as previously discussed, Defendant has not supported with any evidence in the record its concern about the costs of providing coverage for surgical treatments of gender dysphoria. In fact, Defendant stipulated to having not considered any documents, let alone any documents considering costs, in adopting this exclusion. *See* ECF No. 258. Further, all the evidence in the record point to the long-term cost-efficiency of providing this coverage, contradicting Defendants' assertion. Thus, cost considerations have not been established as an important governmental purpose that justifies the discrimination.

*2. Consistency with CMS policy*

Next, Defendants claim that providing coverage consistent with what is required by the Centers for Medicare and Medicaid Services (CMS) is an important governmental purpose for the exclusion. CMS oversees Medicaid by maintaining the Medicaid regulations and approving state plans and state plan amendments. *See Sarah Young Dep.*, ECF No 252-1, at 42–43. The Medicaid Program bases "all of [its] policies and procedures within the confines of the federal regulation, the state code, state laws, and [it] ensure[s] that the covered services are available to members." *Id.* at 20. CMS communicates with the Medicaid Program to dictate changes to the program or clarify a policy. *Id.* at 21. Further, CMS generally has an active role in reviewing and approving

of changes to Medicaid coverage. *Id.* at 17. CMS neither mandates nor prohibits coverage for the surgical care of gender dysphoria—this decision is left up to the individual states. *See id.* at 42.

Defendants assert that Secretary Crouch and Commissioner Beane have relied on guidance from CMS and the Department of Human Health Services (HHS) to determine required coverages. Since surgical treatment of gender dysphoria is not a mandated coverage dictated by CMS, Defendants assert that excluding this coverage is simply following CMS guidance and is an important governmental interest. Further, Defendants note that CMS has never notified the West Virginia Medicaid program that excluding this coverage is in violation of any law, thus, they argue, the Exclusion is not unlawful. *Id.* at 37.

Importantly, the lack of a mandate by CMS does not permit Defendants to ignore their obligations under the Constitution. CMS's lack of guidance on the matter does not give a green light for the states to enact discriminatory policies. Defendants' purported governmental interest in providing coverage consistent with what is required by CMS rings hollow in light of the fact that the West Virginia Medicaid Program covers other services which would be characterized as optional by CMS. *Tr. of Proceedings*, ECF No. 269, at 45.

Defendants also point to a 2016 study by HHS, discussed by Dr. Stephen Levine, where HHS refused to mandate coverage for transgender surgeries, leaving such decisions up to the individual states due to the lack of evidence regarding the long-term benefits of such surgeries. *Dr. Stephen Levine's Expert Report*, ECF No. 252-11, at 14. But this assertion regarding the long-term benefits is inconsistent with the body of literature on this topic. As Dr. Karasic points out in his rebuttal report, gender confirming surgery "has been studied extensively, with much evidence of the effectiveness of such treatment." *Dr. Karasic's Rebuttal Report*, ECF No. 250-21, at 16; *see also id.* at 14 (citing to a Cornell University study which found a "robust international consensus

in the peer-reviewed literature that gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals.).[7] Further, the underlying HHS study to which Dr. Levine references followed the agency's decision to eliminate a categorical ban on gender-affirming surgery, like the ban found in the West Virginia Medicaid Program. *See Dr. Loren Schechter's Rebuttal Report*, ECF No. 250-24, at 5.

Thus, the Court does not find that the adherence to the required services as mandated by CMS to be a sincere or compelling governmental interest.

*3. Question of medical necessity*

Lastly, Defendants question the medical necessity of the surgical treatment of gender dysphoria. This assertion is without support in the record. Dr. Schechter directly addresses the medical necessity of surgical care to treat gender dysphoria. *See Dr. Schechter's Expert Report*, ECF No 250-23, at 12–13; *see Dr. Schechter's Rebuttal Report*, ECF No. 250-24, at 13. As Dr. Schechter points out, these procedures are "clinically indicated to treat the underlying medical condition of gender dysphoria." *Dr. Schechter's Expert Report*, ECF No. 250-23, at 13. Dr. Schechter discusses that the "prevailing consensus of the medical community recognizes "that procedures used to treat gender dysphoria are reconstructive, not experimental, and are medically necessary." *see Dr. Schechter's Rebuttal Report*, ECF No. 250-24, at 13. The techniques used to perform these surgeries are well-established and used to perform many different surgeries, not just gender confirming surgeries. *Id.* Gender confirming surgeries have been performed "for decades" and have demonstrated benefits. *Id.*

There are Standards of Care promulgated by the World Professional Association of

[7] Dr. Karasic also points out the potential bias in Dr. Levine's testimony, as recognized by the Judge Jon Tigard in the Northern District of California. *See Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1188 (N.D. Cal. 2015) (where the court gave Dr. Levine's opinion very little weight due to his misrepresentations of the Standards of Care and illogical inferences).

Transgender Health (WPATH) that provide clinical criteria for the medical interventions to treat gender dysphoria. *Dr. Karasic's Expert Report*, ECF No. 250-20, at 8. These Standards of Care are recognized by a number of leading medical professional entities, including the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association, the Endocrine Society, the Pediatric Endocrine Society, the American College of Obstetrics and Gynecology, the American College of Physicians, and the World Medical Association, among others. *Id*. Similarly, the Endocrine Society has published a clinical practice guideline providing protocols for the medically necessary treatment of gender dysphoria. Further, many of the major medical organizations have opposed the blanket denial of this medically necessary care. *Id.* at 10. The medical treatments for gender dysphoria have been studied extensively, and have been shown to improve "quality of life and measures of mental health" for patients. *Id.* at 11–12 (citing to the Cornell University study that supported gender affirming "hormone and surgical treatment improved the well-being of transgender individuals").

Further, InterQual has developed clinical standards of care to determine the medical necessity of surgical treatment for gender dysphoria. For example, the InterQual standards created for vaginoplasty for gender affirmation surgery note that "[d]elaying treatment for those with gender dysphoria is not a reasonable treatment option." *InterQual Composite*, ECF No. 250-30, at 36. These standards note that this procedure can be performed for medically necessary purposes and that the criteria found therein is intended to determine the medical appropriateness of the procedure. *Id.* at 38. The InterQual standards for the surgical care of gender dysphoria would be utilized by West Virginia Medicaid Program's Kepro system if the exclusion at issue here did not prohibit coverage of this treatment.

The argument that surgical treatment of gender dysphoria is not medically necessary is

wholly unsupported by the record, and importantly, is refuted by the majority of the medical community. Thus, the Court finds that concern for the medical necessity of this treatment is not a sufficiently important governmental interest.

e. The exclusion does not survive heightened scrutiny, thus, violating Equal Protection

The Court has discussed Defendants' purported governmental interests that are upheld by the exclusion. None survive heightened scrutiny. Without a sufficiently important governmental interest, this exclusion must fail. Thus, the Court finds that the exclusion violates the Equal Protection Clause of the Fourteenth Amendment.

2. Violation of the Affordable Care Act

The Affordable Care Act (ACA) "aims to increase the number of Americans covered by health insurance" through the creation of "a comprehensive national plan to provide universal health insurance coverage." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538, 583 (2012). An important component of the ACA is the anti-discrimination mandate in section 1557. *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, 485 F. Sup. 3d 1, 11 (D.D.C. 2020). This section provides that "[e]xcept as otherwise provided… an individual shall not, on the ground prohibited under title VI of the Civil Rights Act…[and] title IX…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…". 42 U.S.C. § 18116. Because the ACA explicitly incorporates Title VI and Title IX, and the Fourth circuit looks to Title VII to guide the evaluation of claims under Title IX, the test announced in *Bostock* is the appropriate test to determine whether a policy discriminates in violation of the ACA. *Kadel*, 2022 WL 2106270, at *29.

To prevail on a section 1557 claim, a plaintiff most show that:

1. Defendant is a health program or activity that receives federal funds, and
2. Plaintiff was subjected to discrimination in healthcare services on the basis of sex.

*See id.*

BMS has already admitted that it is a "health program or activity" for purposes of Section 1557 analysis. *See Defs.' Answer to Am. Compl.*, ECF No 151, ¶ 15 ("These Defendants further admit that West Virginia Medicaid is jointly funded by the State of West Virginia and the federal government. These Defendants admit that BMS is a recipient of federal funds from the U.S. Department of Health and Human Services, including Medicaid funding."). Thus, the first element of the 1557 claim is met.

Pursuant to the Equal Protection analysis above, this Court has found that Plaintiffs were subjected to discrimination in healthcare services on the basis of sex. The exclusion precludes individuals who are seeking surgical treatment of gender dysphoria from coverage. As already noted by this Court, a transgender identity is inherent in an individual who suffers from gender dysphoria. Transgender status, and thus, this exclusion, cannot be understood without a reference to sex. *See Bostock*, 140 S. Ct. at 1746. Plaintiffs are subjected to discrimination on the basis of sex.

Defendants make the argument that, historically, the term "sex" has referred to the binary sexes of male and female. Gender identity, Defendants assert, is something entirely distinct from the sexes, and thus, for the purposes of the ACA, Defendants cannot be guilty of discrimination because transgender status does not implicate this binary categorization—*Bostock* rejects this limitation on the scope of discrimination.

Defendants also to *Hennessy-Waller v. Snyder* out of the District of Arizona to support their position. 529 F. Supp. 3d 1031 (D. Ariz. 2021). At the outset, the *Hennessy-Waller* court was deciding a motion for preliminary injunction, which requires a different standard than this Court deciding motions for summary judgment. In that case, the plaintiffs were transgender minors enrolled in the state Medicaid who were diagnosed with gender dysphoria. The Medicaid program covered other treatments for gender dysphoria but excluded coverage for gender reassignment surgeries. With respect to the plaintiffs' ACA claim, the court reasoned that the exclusion only precluded coverage for surgical treatment; other treatment was covered, so plaintiffs could not show that there was discrimination. *Id.* at 1045. Further, the District of Arizona also questioned the safety of these procedures for adolescents. *Id.* Defendants here made similar arguments. But as already discussed, this Court fundamentally disagrees with these positions. First, Defendants are not permitted to discriminate on one aspect of healthcare just because they do not discriminate across the board for all treatments. The issue here is narrow regarding the discrimination with respect to surgical care, and this Court found that the exclusion does discriminate. Second, the safety, effectiveness, and medical necessity have been clearly demonstrated by the expert evidence in the record and is confirmed by the many major health organizations supporting the safety and effectiveness of this treatment. The *Hennessy-Waller* court did not have the robust medical evidence in the record that this Court has before it; this case is unpersuasive here.

Thus, because this Court finds that Defendants are a "health program or activity" under the ACA, and that Plaintiffs have been subjected to discrimination on the basis of sex, Defendants have violated ACA section 1557.

3. Violation of Medicaid

Plaintiffs assert that the Exclusion violates the Availability and Comparability requirements of the Medicaid Act, because coverage for medically necessary treatments for gender dysphoria are excluded from coverage while the same treatments are covered for other medically necessary reasons.

The Medicaid Program is established in Title XIX of the Social Securities Act. 42 U.S.C. §§ 1396 *et seq*. The purpose of this act is to enable "each State, as far as practicable under the conditions in such state, to furnish… medical assistance [to individuals] whose income and resources are insufficient to meet the costs of necessary medical services." *Id.* § 1396-1. Participation in Medicaid is optional—however, once a state elects to participate in the Medicaid program, it is subject to federal laws and regulations. *See Antrican v. Odom*, 290 F.3d 178, 183 n.2 (4th Cir. 2002); *Flack v. Wisconsin Dep't of Health and Servs.*, 395 F. Supp. 3d 1001, 1015 (W.D. Wisc. 2019) (noting that a state Medicaid Program "must comply with all federal statutory and regulatory requirements").

Plaintiffs allege violations of both Medicaid's Availability and Comparability requirements. The Court will address each.

*a. Violation of Medicaid's availability requirement*

A state Medicaid Program "must… provide… for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), (28), (29), and (30) of section 1905(a)." 42 U.S.C. § 1396a(a)(10)(A). A state must provide coverage for mandatory categories of treatment and must cover services when they (1) fall within a category of mandatory medical services or optional medical services that the state has elected to provide; and (2) are "medically necessary" for a particular participant. *See Beal v. Doe*, 432 U.S. 438 (1977). The state "may place appropriate limits on a service based on such criteria as medical necessity or

on utilization control procedures." 42 C.F.R. § 440.230. "These limits must be 'reasonable' and 'consistent with the objectives of the [Medicaid] Act." *Flack*, 395 F. Supp. 3d at 1015 (quoting *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980)).

Plaintiffs here assert that BMS has either mandated or chosen to cover the same surgical procedures for non-gender-dysphoria related treatment and that the unrebutted evidence in the record demonstrates the medical necessity of surgical care. This Court agrees. The surgical care precluded by the exclusion is made available and covered by Medicaid when the surgical care is to treat diagnoses other than gender dysphoria. Indeed, the same CPT codes are used to document the surgeries, whether performed for gender dysphoria treatment or for treatment of another diagnosis. And, there is ample evidence in the record to support the medical necessity of the treatments. *See Alvarez v. Betlach*, 572 F. App'x 519, 521 (9th Cir. 2014) (discussing that states are prohibited "from denying coverage of 'medically necessary' services that fall under a category covered in their Medicaid plans." (quoting *Beal v. Doe*, 432 U.S. 438, 444 (1977)); *see Bontrager v. Ind. Fam. Soc. Servs. Admin.*, 697 F.3d 604, 608 (7th Cir. 2012) ("[T]he State is required to provide Medicaid coverage for medically necessary in those service areas that the State opts to provide such coverage."); *see Beal*, 432 U.S. at 444 ("[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage…").

Defendants point to *Casillas v. Daines* to support the contention that regulations permit a Medicaid Program to place limits on services, even when those services are required to be covered. 580 F. Supp. 2d 235, 245–46 (S.D.N.Y. 2008). Notably, *Casillas* is nonbinding on this Court, and was not even followed within the Southern District of New York. *See Cruz v. Zucker*, 116 F. Supp. 3d 334 (S.D.N.Y. 2015). And, while states are granted "discretion to choose the proper mix of amount, scope, and duration limitations on coverage," such choices must ensure that the "care and

services are provided in 'the best interests of the recipients.'" *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (quoting 42 U.S.C. § 1396a(a)(19)). The limitations must also be consistent with the Medicaid Act. *Id.* at 303 n.23. When a state Medicaid Program does choose to limit services, it cannot limit a service it has elected to cover based on diagnosis—this Court finds that such a limitation would not be "appropriate." *See e.g. Bontrager*, 697 F.3d at 609 (finding that a budgetary cap on coverage for medically necessary procedures was not a proper utilization control procedure). The exclusion violates the availability requirement.

*b. Violation of Medicaid's comparability requirement*

The State Medicaid Program provides coverage for both the "categorically needy" and "medically needy" participants. "Categorically needy" individuals receive some form of public assistance, *see* 42 U.S.C. § 1396a(a)(10)(A), while "medically needy" individuals are those "whose incomes are too large to qualify as categorically needy," yet "lack the funds to pay for medical expenses." *Benjamin H. v. Ohl*, No. Civ. A. 3:99-0338, 1999 WL 34783552, *3 (S.D.W. Va. July 15, 1999) (citing *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981)).

The Medicaid statute provides 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). Further, the regulations promulgated pursuant to the Medicaid Act provide that:

> (a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; 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 recipients within the group:

a. The categorically needy
b. A covered medically needy group

42 C.F.R. § 440.240. The regulations also provide that "[t]he agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 U.S.C. § 440.230.

Plaintiffs assert that Defendants violate the comparability requirement of the Medicaid Act by providing particular services to some Medicaid participants but not others based solely on diagnosis. This Court has found that the surgeries, such as mastectomies, which are covered to treat non-gender dysphoria diagnoses are materially the same as the surgeries provided to treat gender dysphoria. Thus, the difference in treatment clearly violates the comparability requirement, which requires that all persons within a specific category be treated equally. *See White v. Beal*, 555 F.2d 1146, 1151 (3d Cir. 1977) ("We find nothing in the federal statute that permits discrimination based upon etiology rather than need for the services.").

Defendants rely on *Rodriguez v. City of New York* to support their argument that, since surgical treatment for gender dysphoria is not covered for any Medicaid participant, there is no violation of the comparability requirement. 197 F.3d 611 (2d Cir. 1999). But their reliance on *Rodriguez* is misplaced. In *Rodriguez*, plaintiffs challenged the failure of New York City to provide personal-care services to Medicaid recipients. A key distinction in *Rodriguez* is that the benefit sought by Plaintiffs was provided to no one. *Id.* at 616. Here, the surgeries sought by Plaintiffs are materially the same to covered procedures that treat other diagnoses. The exclusion essentially denies services to some categorically needy persons while the same services are provided for other persons with similar needs. *See Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016) (discussing that an analysis under the comparability requirement must "entail some independent

judicial assessment of whether a state has made its services available to all categorically needy individuals with equivalent medical needs").

The exclusion "fails to make covered treatments available in sufficient amount, duration and scope" and discriminates on the basis of diagnosis. *Flack*, 395 F. Supp. 3d at 1019 (internal quotation omitted). Thus, it violates the comparability requirement of the Medicaid Act.

4. Standing

Lastly, Defendants argue that Plaintiffs lack the standing to bring this case because neither has suffered an injury in fact. 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) is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *South Carolina v. United States*, 912 F.3d 720, 726 (4th Cir. 2019) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 180–81 (2000)). Defendants argue that, because Plaintiffs have not submitted a claim for and been denied gender-affirming care by Medicaid, they cannot show injury in fact, and thus, lack standing.

However, Defendants enacted a clear policy excluding coverage for surgical care of gender dysphoria with no exceptions. This caused an actual, concrete injury to Plaintiffs by essentially constructing a discriminatory barrier between them and health insurance coverage. This is not a hypothetical injury. Plaintiffs requesting coverage would have been futile due to the exceptionless exclusion, and the law does not require Plaintiffs to take such futile acts. *Townes v. Jarvis*, 577 F.3d 543, 547 n.1 (4th Cir. 2009). "In the context of applications for government benefits… [the] threshold requirement… may be excused… where a plaintiff makes a substantial showing that the application for the benefit… would have been futile." *Safari Club Int'l v. Jewell*, 842 F.3d 1280,

1286 (D.C. Cir. 2016) (internal quotations omitted). Defendants' policy was clear—a request for coverage would have been denied under the exclusion. Thus, Plaintiffs have standing.

**CONCLUSION**

The West Virginia Medicaid Program exclusion denying coverage for the surgical care for gender dysphoria invidiously discriminates on the basis of sex and transgender status. Such exclusion violates the Equal Protection clause of the Fourteenth Amendment, the Affordable Care Act, and the Medicaid Act. Defendants are enjoined from enforcing or applying the exclusion.

Thus, the Court **GRANTS** Plaintiffs' Motion for Summary Judgment (ECF No. 250) and **DENIES** Defendants' Motion for Summary Judgment (ECF No. 252).

The Court also **DENIES as MOOT** the Motion to Exclude Expert Testimony of Stephen B. Levine, M.D. ECF No. 254. Resolving the Motion for Summary Judgment in favor of Plaintiffs moots this Motion.

The Court **DIRECTS** the Clerk to send a copy of this Memorandum Opinion and Order to counsel of record and any unrepresented parties.

ENTER: August 2, 2022

ROBERT C. CHAMBERS
UNITED STATES DISTRICT JUDGE

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*,

v.

WILLIAM CROUCH, *et al.*,

*Defendants.*

CIVIL ACTION NO. 3:20-cv-00740
HON. ROBERT C. CHAMBERS

**JUDGMENT ORDER**

IT IS ORDER AND ADJUDGED that judgment is entered in favor of plaintiffs Christopher Fain, Shauntae Anderson, and the certified Rule 23 Class against defendants William Crouch, Cynthia Beane, and the West Virginia Department of Health and Human Resources, Bureau for Medical Services (the State actors and agencies responsible for administering the Medicaid Program in West Virginia) declaring that the West Virginia State Medicaid Program's exclusion of gender-confirming surgical treatment for transgender West Virginia Medicaid participants violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution; Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116; the Medicaid Act's Availability Requirement, 42 U.S.C. § 1396a(a)(10)(A); and the Medicaid Act's Comparability Requirement, 42 U.S.C. § 1396a(a)(10)(B).

IT IS FURTHER ORDERED AND ADJUDGED that defendants William Crouch, Cynthia Beane, and the West Virginia Department of Health and Human Resources, Bureau for Medical Services are PERMANENTLY ENJOINED from enforcing or applying the exclusion.

IT IS FURTHER ORDERED AND ADJUDGED that plaintiffs shall have up to and including 45 days after the date of entry of this judgment to file a bill of costs, and a motion for attorney's fees and costs.

IT IS FURTHER ORDERED AND ADJUDGED that the court retains jurisdiction to enforce the judgment.

Approved as to this 17th day of August, 2022.

Honorable Robert C. Chambers
U.S. District Court Judge

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

**CHRISTOPHER FAIN,**
**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; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

**Defendants.**

## NOTICE OF APPEAL

Defendants William Crouch, Cynthia Beane, and West Virginia Department of Health and Human Resources, Bureau for Medical Services appeal to the United States Court of Appeals for the Fourth Circuit from the certification of a class and final judgment as set forth in two Memorandum Opinion and Orders entered on August 2, 2022, [ECF Nos. 270, 271] and the Judgment Order entered on August 17, 2022 [ECF No. 273].

**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,**
**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; **WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES,**

**Defendants.**

## CERTIFICATE OF SERVICE

Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources, by counsel, hereby certify that on the 31st day of August, 2022, a true and exact copy of their ***Notice of Appeal*** was served on counsel via electronic means as follows:

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