STATE OF MINNESOTA

COUNTY OF RAMSEY

DISTRICT COURT

SECOND JUDICIAL DISTRICT

CASE TYPE: Other Civil

OutFront Minnesota, OutFront Minnesota Community Services, and Evan Tysilio Thomas,

Plaintiffs,

vs.

Emily Johnson Piper, in her official capacity as Commissioner of the Minnesota Department of Human Services

Defendant.

Court File No.: 62-CV-15-7501
Judge William H. Leary III

ORDER

This matter came before the undersigned Judge of the District Court on August 15, 2016, on both parties' motions for summary judgment.

F. Matthew Ralph, Esq.; JoLynn M. Markison, Esq.; and Erin E. Conti, Esq., appeared on behalf of Plaintiffs. Jacob D. Campion, Esq., and Alethea Huyser, Esq., appeared on behalf of the Defendants.

This court, having in mind the arguments of counsel, the applicable law, and all files and records herein, issues the following order.

IT IS ORDERED:

1. That the declaration of this court is that Minn. Stat. § 256B.0625, subd. 3a, (a) violates the equal protection clause of Minnesota Constitution Article 1, section 2, and (b) violates

the right to privacy as protected by the Minnesota Constitution and, therefore, is void and unenforceable.

2. That Defendant Commissioner of Human Services, the Minnesota Department of Human Services and their agents, employees, representatives, and all those acting in concert with them are now permanently enjoined from denying Medical Assistance and MinnesotaCare benefits to eligible transgender patients in need of medically necessary treatment, including transition-related surgery.

3. Plaintiffs shall have judgment against Defendant, together with their costs and disbursements herein.

LET JUDGMENT BE ENTERED ACCORDINGLY.

November 14, 2016

William H. Leary III
District Court Judge

MEMORANDUM

The State of Minnesota, in accordance with Minn. Stat. § 256B.0625, subd. 1 (2005), provides public-assistance benefits for indigent persons who require inpatient hospital services. However, subdivision 3a states that "Sex reassignment surgery is not covered." Plaintiff Evan Thomas is an indigent person who requires a bilateral mastectomy with chest reconstruction because of his transgender dysphoria. Defendant Commissioner of the Minnesota Department of Human Services, applying the subdivision, has denied coverage for the surgery. As a result of subdivision a, the public-assistance benefits for the same surgery that would be available to him as a female, i.e., the gender assigned to him at birth, when medically necessary are not available to him as a male, the gender with which he identifies. Because the subdivision discriminates on the basis of gender and violates a person's right to privacy, the subdivision violates the Minnesota Constitution and is void and unenforceable.

STATEMENT OF ISSUES

The following issues are presented by the parties' cross-motions for summary judgment:

1. Does Plaintiff Evan Thomas have standing to challenge the constitutionality of Minn. Stat. Minn. Stat. § 256B.0625, subd. 3a?

2. Does Plaintiff OutFront Minnesota have standing to challenge the constitutionality of Minn. Stat. § 256B.0625, subd. 3a?

3. Should the complaint be dismissed because OutFront Minnesota has not made Blue Cross Blue Shield of Minnesota a party to this litigation?

4. Does Minn. Stat. § 256B.0625, subd. 3a, violate the Equal Protection Clause of the Minnesota Constitution because the statute discriminates against transgender persons?

5. Does Minn. Stat. § 256B.0625, subd. 3a, violate the Equal Protection Clause of the Minnesota Constitution because the statute interferes with the fundamental right of privacy to control one's own body and make autonomous healthcare choices?

STATEMENT OF UNDISPUTED MATERIAL FACTS

The following facts are taken from Plaintiffs' Memorandum in Support of Their Motion for Summary Judgment and the evidence provided in support of their motion. Defendant does not dispute those facts other than to claim that they are irrelevant to the issues Defendant deems to be controlling.

Gender identity

1. Gender identity is an internal conviction of a person's maleness, femaleness, both, neither, or another gender. Most people have a gender identity of male or female, and this corresponds with the sex assigned to them at birth. Some people have a gender identity that does not correspond with the sex assigned to them at birth.

2. Someone whose gender identity corresponds with the sex assigned at birth matches is "cisgender."

3. Someone whose gender identity does not match the sex assigned at birth is "transgender."

4. Transgender males are males who were assigned "female" at birth, but have a male gender identity. Transgender females are females who were assigned "male" at birth, but have a female gender identity.

5. A gender identity that conflicts with a birth-assigned sex is a type of gender identity (i.e., being transgender), not a disorder.

6. Transgender people have existed throughout history and have been documented in nearly all cultures.

7. Transgender people constitute between 0.3% and 0.5% of the adult American population.

Gender Dysphoria

8. Most transgender people experience gender dysphoria, which is the clinical term for distress caused by the dissonance between the sex assigned at birth (including secondary sex characteristics) and the internal conviction of one's gender identity. *See Hare v. State Dept. of Human Services*, 666 N.W.2d 427, 429 n.1 (Minn. Ct. App. 2003) ("'Gender dysphoria' is a 'psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the sex role, as socially defined, which applies to that sex, and who requests hormonal and surgical sex reassignment.'"). For example, a transgender man with gender dysphoria may experience a level of distress with his anatomical gender (i.e., genital distress) and/or with his secondary sex characteristics (e.g., development of breasts, feminine features).

9. Gender dysphoria is a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)[1] and International Classification of Diseases-10 (ICD-10).[2]

10. The World Professional Association of Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA), is a multi-disciplinary organization of health professionals who work in the field of transgender health. WPATH publishes the Standards of Care (SOC) for treatment of gender dysphoria. The most recent version of SOC (Version VII) was published in 2011. The WPATH SOC are used by insurance companies and healthcare providers to set the requirements for medically necessary

[1] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the categorization of all recognized mental disorders by the American Psychiatric Association. It is used by medical and mental health professionals and insurance companies to define mental health diagnoses and to describe their presentation.

[2] The International Classification of Diseases is the categorization of all health diagnoses by the World Health Organization. It is used by all medical and mental health professionals for diagnosis.

interventions for the treatment of gender dysphoria. *See Hare*, 666 N.W.2d at 429 n1 ("The Benjamin Standards, which UCare uses when it reviews a request for coverage of gender reassignment surgery, 'are protocols used by qualified professionals in the United States to treat individuals suffering from gender identity disorders.'" (quoting *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 158 (D. Mass. 2002)). In Minnesota, courts have relied upon the WPATH SOC for nearly 40 years. *See Doe v. State of Minn., Dept. of Public Welfare*, 257 N.W.2d 816, 818-20 (Minn. 1977) (discussed further below).

Sex Reassignment Surgery

11. The WPATH SOC identify surgery as one of the medically necessary treatments for gender dysphoria. Numerous provider organizations – including the American Medical Association, the American Endocrine Society, the National Association of Social Workers, and the American Psychological Association – have formally adopted the WPATH SOC.

12. In 2008 the American Medical Association stated that sex-reassignment surgery is one of the medically necessary, empirically supported, and effective treatments for gender dysphoria.

13. Sex-reassignment surgery (also referred to as "gender-affirmation surgery") is not prescribed for any diagnosis other than gender dysphoria. The sex-reassignment surgeries considered medically necessary for treatment of gender dysphoria include, but are not limited, to double mastectomy with chest reconstruction. For many patients with gender dysphoria, sex-reassignment surgery is the only effective treatment.

Sex-reassignment surgery is safe and effective.

14. Surgical interventions for gender dysphoria have been empirically proven to be safe and effective. "Decades of extensive scientific and clinical research" have brought the medical community to a consensus that altering a transsexual individual's primary and secondary sex

characteristics is a safe and effective treatment for persons with severe gender dysphoria. Declaration F. Matthew Ralph Ex. 5 at 15. After an exhaustive consideration of the medical and other scientific evidence, the U.S. Department of Health and Human Services recently concluded that "advancements in surgical techniques have dramatically reduced the risk of complications from sex reassignment surgery and the rates of serious complications from such surgeries are low." *Id.* at 11. Further, procedures used to treat gender dysphoria in transgender men "are routinely performed in other contexts" such as the treatment of breast cancer. *Id.* The procedures "have low rates of complications" and are "generally identical whether performed on transgender men to treat gender dysphoria or to treat women for these other conditions." *Id. See also* Ex. 7 at 44; Ex. 8 at 724-26.

15. Sex-reassignment surgery "is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals." *Id.* Ex. 6 at 215. For many patients "sex reassignment surgery is the *only* effective treatment." *Id.* at 188 (emphasis added). In its most recent Standards of Care, WPATH reports that multiple studies examining satisfaction rates after surgery have found that emotional, psychological, and overall functioning all improve following surgery. This is particularly true for transgender men pursuing chest surgery, as the appearance of breasts can be a great hindrance to being perceived as male. Removal of the breasts can significantly decrease anxiety and overall gender dysphoria. Satisfaction rates for transgender individuals who underwent hormone therapy and surgical interventions were 87% for transgender women and 97% for transgender men. Regrets are extremely rare (1–1.5% of transgender women patients and <1% of transgender men patients).

Transgender Discrimination

16. Transgender people face discrimination in every aspect of life and particularly in accessing healthcare. Discrimination and stigma are the source of the increased rates of suicide

attempts, depression, and anxiety. Transgender people are more likely to be rejected by family and peers and to have difficulty in school, with housing, and with employment, all due to discrimination based on their gender identity.

17. Transgender people have experienced persecution and stigma throughout history and across cultures. They have experienced gender-based violence. Many transgender people are killed each year because of their transgender status. Many are fired from their jobs when their gender identity is discovered, and are not allowed to use a bathroom that corresponds to their gender identity.

18. In the U.S., transgender people struggle to receive appropriate healthcare services. In a 2011 study, 50% of transgender and gender non-conforming respondents reported having to educate their medical provider about transgender health; 19% were outright denied healthcare; and 25% delayed seeking care as a result of past discrimination.

19. Untreated gender dysphoria can have negative mental and physical health consequences. The most extreme consequence of untreated gender dysphoria is suicide. The attempted suicide rate for transgender and gender non-conforming people is 41%. The national average for all other individuals is 1.6%.

Plaintiff Evan Thomas

20. Evan Thomas is a 64-year-old transgender male living in St. Paul, Minnesota. As early as Mr. Thomas can remember, he knew he was a boy. Mr. Thomas resisted his mother's efforts to socialize him as a girl.

21. After graduating from high school and college, Mr. Thomas attended Boston University to study the interplay of brain and behavior and obtained his Ph.D. in Behavioral Neuroscience. Upon completion of his Ph.D. Mr. Thomas worked on the research faculty at Johns

Hopkins University. Mr. Thomas was unable to meet the university's gender-normative expectations that women, for instance, act feminine and wear skirts to work.

22. Mr. Thomas left Johns Hopkins after two years and changed careers in order to cope with the distress surrounding his inability to meet the university's gender-normative expectations. He graduated from a program in woodworking and furniture restoration and began working in furniture restoration in Massachusetts. In 2004 Mr. Thomas left Massachusetts and opened a furniture-restoration business in St. Paul.

23. In 2010, at the height of the economic crisis, Mr. Thomas's business began to fail. At the same time, Mr. Thomas's gender-identity depression become severe. He entertained thoughts of suicide. Mr. Thomas's depression kept him from preventing, or coping with, the failure of his business.

24. In September 2012 Mr. Thomas closed the business and became unemployed. He applied for and received various forms of public assistance, including Medical Assistance (MA). At the time he enrolled in MA, his legal name was his birth name, [redacted] To this day, Mr. Thomas remains qualified for and receives MA. Mr. Thomas receives MA coverage through Blue Cross Blue Shield of Minnesota.

25. In the Fall of 2013 Mr. Thomas sought assistance for his increased depression through the University of Minnesota Center for Sexual Health.

26. In December 2013 Mr. Thomas was diagnosed as having gender dysphoria. In March 2014 he began receiving testosterone-hormone therapy.

27. MA has been covering Mr. Thomas's mental-health services and hormone therapy.

28. Although hormone therapy has relieved some of Mr. Thomas' depression and anxiety, he remains distressed because his breast anatomy is incongruent with his masculine

presentation. For that reason Mr. Thomas uses chest-compression clothing to bind and obscure his breasts (hereinafter referred to as "binding").

29. Binding is extremely uncomfortable and unhealthy for long-term use. For example, compression of the rib cage from binding can lead to musculoskeletal problems, rashes and yeast infections under the breasts, and respiratory problems. In Mr. Thomas's case, binding has caused chest infections and acute bronchitis, requiring him to cease binding his chest for the duration of the infections. In turn, Mr. Thomas's inability to bind his chest during these infections has led to increased distress associated with his gender identity. Thus, in addition to being extremely uncomfortable and unhealthy, binding is insufficient to alleviate the distress Mr. Thomas feels as a consequence of his gender dysphoria.

30. In March 2015 Alex Iantaffi, Ph.D., M.Sc., LMFT, who is Mr. Thomas's mental-health therapist at the Center for Sexual Health, concluded that sex-reassignment surgery was medically indicated to address Mr. Thomas' gender dysphoria. Dr. Iantaffi referred Mr. Thomas to Dr. Marie-Claire Buckley, MD, a surgeon at the University of Minnesota who is the only surgeon in Minnesota who performs double mastectomies for transgender male patients.

31. In recommending sex-reassignment surgery for Mr. Thomas, Dr. Iantaffi wrote the following to Dr. Buckley:

> [Mr. Thomas] meets the World Professional Association for Transgender Health (WPATH) Standards of Care for surgical gender reassignment of gender dysphoric persons, as well as internal prerequisites for gender reassignment surgery. Chest surgery is considered an early intervention that many transgender men undergo in order to relieve body dysphoria, and increase congruence of their male presentation and their bodies. It is considered appropriate and needed surgical intervention by the WPATH Standards of Care for transgender persons.
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> * * *
>
> Chest surgery is expected to alleviate [Mr. Thomas's] dysphoria, increase comfort with self, and improve interpersonal, sexual, and vocational functioning. Therefore I deem the surgery medically necessary.

32. On March 24, 2015, Dr. Buckley met with Mr. Thomas and concluded that chest-reconstruction surgery was medically necessary for treatment of his gender dysphoria.

33. On April 6, 2015, Dr. Buckley requested that Blue Cross Blue Shield authorize the surgery. Minn. Stat. § 256B.0625, subd. 1, provides for medically necessary, inpatient hospital services. Such services include bilateral mastectomies with chest reconstruction.

34. On April 13, 2015, Blue Cross Blue Shield denied Dr. Buckley's request, citing the exclusion in subdivision 3a. Absent subdivision 3a, Mr. Thomas would be eligible for a bilateral mastectomy.

35. In summary, Defendant, through the MA insurance vendor, has denied Mr. Thomas coverage for a procedure available to him if he were to identify as a female, the gender assigned to him at birth, but not to him as a transgender male.

OutFront Minnesota

36. Shortly after the denial of coverage, Mr. Thomas changed his legal name to Evan Tysilio Thomas. He contacted Plaintiff OutFront Minnesota (OFM) for advice and information about his options following the denial of coverage. He considered appealing the denial, but concluded that an appeal would have been futile because of the statute.

37. OutFront Minnesota and OutFront Minnesota Community Services (OFMCS) are nonprofit corporations with headquarters in Minneapolis, Minnesota. OFMCS is organized for charitable and educational purposes to provide education, training, and support services. OFM is the sole corporate member of OFMCS, and the Board of Directors and Officers of OFMCS are the same as those of OFM. Collectively OFM and OFMCS are known as "OutFront."

38. For nearly thirty years, OutFront has provided comprehensive programs, services, and training to Minnesota's lesbian, gay, bisexual, transgender, queer, (collectively "LGBTQ")

and allied communities in matters relating to community organizing, public policy, anti-violence, law, and education.

39. OutFront has between 1,500 and 2,000 members throughout Minnesota, including many transgender Minnesotans.

40. As a population subgroup, transgender Minnesotans are poorer than cisgender Minnesotans. Ralph Decl. Ex. 18 at 22. Transgender respondents have reported much lower household incomes than the population as a whole, with many living in dire poverty. 15% of OouFront respondents reported making under $10,000/year, a percentage nearly four times the rate for the general population. 12% reported that they made between $10,000 and $20,000/year. 14% said they made $100,000/year or more, compared to 25% of the general population.

41. As a population subgroup, transgender Minnesotans also experience more discrimination based on gender identity/expression—including housing and employment discrimination—than cisgender Minnesotans. *Id.* at 50-69, 106-122.

42. OutFront members experience despair, depression, and anxiety; physical effects such as ailments arising out of measures to conceal their discordant gender features; social effects like discrimination and violence; and economic effects like loss of employment and difficulty getting hired. OutFront provides them with support and guidance as a result.

43. Transgender Minnesotans seek OutFront's assistance for a variety of reasons such as navigating gender-identity issues in schools, gaining access to restrooms and other facilities, obtaining insurance coverage, and receiving appropriate correctional placements when incarcerated.

44. OutFront supports transgender Minnesotans who confront legal issues such as obtaining a name change, amending official documents (e.g. driver's license, birth certificate,

social security record, passport, immigration documents), and obtaining public benefits for transition-related care.

45. Outfront assists transgender persons on MA or MinnesotaCare who seek coverage for transition services, including transition-related surgery.

46. Phil Duran, Legal Director of OFM, has represented many individuals over the last 16 years in their attempts to secure coverage for medically-necessary, transition-related services.

47. Between 1998 and 2005, during which the Minnesota legislature restricted gender-affirmation surgery for all except those who obtained "gender reassignment services" prior to July 1, 1998, OutFront worked with several individuals to demonstrate that they had met this requirement and were qualified for surgical services, despite the efforts of the Minnesota Department of Human Services to further restrict access.

48. After the Minnesota legislature amended the statute in 2005 to eliminate state coverage for all sex-assignment surgery, OutFront succeeded in obtaining coverage for sex-reassignment surgery claims based on approvals for certain other transitioning treatments individuals had received before the statute's effective date. DHS again opposed these claims.

49. In the eleven years since sex-reassignment surgery was totally eliminated from coverage, numerous transgender individuals have consulted OutFront regarding treatment for gender dysphoria, including sex-reassignment surgery, and coverage under MA or MinnesotaCare. OutFront has had to advise persons seeking sex-reassignment surgery that coverage for such treatment is unavailable through MA or MinnesotaCare.

50. OutFront members experience violence, discrimination, and mental suffering when they cannot receive medically necessary care.

51. OutFront expends significant staff resources to support its members who cannot obtain surgical treatment and to avoid or eliminate exclusions such as those found in the statute.

Minn. Stat. 256B.0625, subds. 1 and 3

52. In 1977 the Minnesota Supreme Court considered the case of Jane Doe, an enrollee in Minnesota's Medical Assistance ("MA") program who had been diagnosed with gender dysphoria. *Doe v. State Dept. of Public Welfare*, 257 N.W.2d 816, 817 (Minn. 1977). Born with male genitalia, Jane Doe had dressed in women's clothing since the 1950s, legally acquired a traditionally female name, lived life as a female for ten years, and undergone hormonal therapy at the University of Minnesota. *Id.* When MA denied coverage for surgical treatment of gender dysphoria, Jane Doe sued. *Id.* at 818.

53. The Minnesota Supreme Court, in considering the denial of coverage, first noted that, "[a]lthough for most members of society sex and gender are synonymous, it is possible for each to develop independently," and in such "cases when sex and gender do develop independently, the end product is often a transsexual person plagued by the serious problem of 'gender role disorientation, a painful cross-gender identity.'" *Id.* Further, the court concluded, "[b]y the time an individual reaches adulthood, the problem of gender role disorientation and the transsexual condition resulting therefrom are so severe that the only successful treatment known to medical science is sex conversion surgery." *Id.* at 819.

54. The court observed that "transsexual surgery is the only surgical treatment which, if recommended by a physician and related to a patient's health, is not covered by" the state's MA program. *Id.* at 820. Greeting this distinction with skepticism, the court held that the total exclusion of transsexual surgery from eligibility for MA benefits was void. *Id.*

55. Following that decision in 1977 and until 1998, Minnesota provided MA coverage for medically necessary, transition-related care, including surgery, without restriction.

56. In 1993, the Minnesota legislature amended the Minnesota Human Rights Act (MHRA) to ban discrimination on the basis of "sexual orientation." 1993 Session Law Ch. 22, §§ 8-15. The law defined "sexual orientation" as "having or being perceived as having an emotional, physical, or sexual attachment to another person without regard to the sex of that person or having or being perceived as having an orientation for such attachment, or having or being perceived as having a self-image or identity not traditionally associated with one's biological maleness or femaleness." 1993 Session Law Ch. 22, § 1, subd. 45; Minn. Stat. § 363A.03, subd. 44. This amendment made Minnesota the first state in the nation to protect transgender persons from discrimination.

57. Following the MHRA amendment there were several legislative efforts to curtail transgender benefits.

58. The 1994 Minnesota legislature passed a bill to restrict coverage for gender-reassignment surgery in state medical programs. The bill was vetoed by the state's governor.

59. The 1994 legislative effort was not based on reassignment surgery being experimental or unnecessary. To the contrary, when an early draft asserted that services were "not medically necessary," DHS urged the legislature to instead say services were "not covered." DHS cautioned that the assertion that transition surgery is not medically necessary could not be successfully defended in court.

60. In 1995 the Minnesota Legislature successfully restricted transition coverage in the former General Assistance Medical Care program. Laws 1995, Ch. 178, art. 2 § 28. Audio recordings of the legislative floor session considering this measure recorded audible laughter upon a member's request for a roll-call vote on the amendment. Ralph Decl. Ex. 14. Two legislators who spoke expressed concern about the laughter. *Id.*

61. In 1998 the legislature amended the MA statute to exclude "[g]ender reassignment surgery and other gender reassignment medical procedures including drug therapy for gender reassignment . . . unless the individual began receiving gender reassignment services prior to July 1, 1998." Minn. Stat. § 256B.0625, subd. 3a (2004). The legislative record did not include legislative findings or any statement explaining the purpose or rationale of the statute. Observing that MA had only paid for three surgeries in the three years preceding the amendment at a total cost of $20,000, a legislator remarked, "I don't think that's a lot, but I don't think it's something many of our tax payers [sic] want to be paying for with their taxes." Ralph Decl. Ex. 9.

62. After the 1998 amendment, a diminishing number of people were still able to receive coverage for medically necessary, transition-related care, including surgery, through 2005. As long as they had begun "gender reassignment services" prior to the July 1, 1998, deadline, transgender Minnesotans could continue receiving treatment. *Id.* For that reason, determining what constituted "gender reassignment services" became an issue of critical importance to Minnesotans seeking transition-related care.

63. In 2003 the Minnesota Court of Appeals concluded it was "clear that the legislature intended the phrase 'gender reassignment services' to comprise more than just surgery and hormone therapy." *Hare v. State of Minn., Dept. of Human Servs.*, 666 N.W.2d 427, 432 (Minn. Ct. App. 2003). Where a transgender individual had begun chemical-dependency treatment as an initial step in the treatment of her gender dysphoria prior to the 1998 deadline, chemical-dependency treatment was "a necessary first step in the process of obtaining the physically transformative procedures of hormone therapy and gender reassignment surgery" and MA was required to cover her gender-reassignment surgery. *Id.* at 432-33.

64. In 2005, however, the Minnesota Legislature amended the statute again. The legislature restored coverage of drug therapy, but eliminated the grandfather provision authorizing surgical treatment of persons who had begun receiving gender-reassignment services prior to July 1, 1998. Minn. Stat. § 256B.0625, subd. 3a (2014). The legislature also adopted subdivision 3 to exclude sex-reassignment surgery from coverage under MA and MinnesotaCare. *Id.*

65. The 2005 version of the statute also did not include legislative findings or any statement explaining the purpose or rationale of the statute. Cost did not appear to be a significant consideration in the amendment. When the House Health Policy and Finance Committee considered the 2005 legislation, the state estimated it paid for two surgeries per year. The committee projected Minnesota would save $15,000 per year by completely eliminating coverage for transition-related surgery.

66. The State of Minnesota now estimates that if the statute was overturned or preempted, and coverage for sex-reassignment surgery was a covered benefit, the fiscal impact to MinnesotaCare per surgery would be $43,333 in FY 2017, $52,000 in FY 2018, and $52,000 in FY 2019. The state anticipates that just three people per year would receive MA coverage for surgery, with a fiscal impact to MA totaling $130,000 in FY 2017, $156,000 in FY 2018, and $156,000 in FY 2019.

67. For FY 2017, the State of Minnesota is expected to spend $17,146,040,000 on Health and Human Services.

Defendant, through DHS, enforces the statute.

68. The Department of Human Services (DHS) is responsible for administering Minnesota's healthcare programs for low-income individuals. Minnesota has two such programs.

69. Medical Assistance is Minnesota's Medicaid program and receives federal funding. The federal Medicaid program provides reimbursement funding to states for medical care for

disabled and economically disadvantaged individuals. 42 U.S.C. 1396 *et seq*. As long as a participating state has established its program to meet the minimal standards for care under the Medicaid programs, the state can be reimbursed by the federal government for the medical costs of providing care under the state's program. *Id.*

70. Minnesota's other low-income health program, MinnesotaCare, is funded by a combination of state and federal dollars.

71. Defendant is the current head of DHS. DHS purports to provide essential services to Minnesota's most vulnerable residents so that they can meet their basic needs and have the opportunity to reach their full potential. Ralph Decl. Ex. 24. DHS's largest financial responsibility is to provide health-care coverage for low-income Minnesotans. *Id.* DHS administers approximately one-third of the state budget. (*Id.*)

72. DHS has promulgated a publication entitled "Working with Lesbian, Gay, Bisexual, Transgender and Questioning/Queer Youth." Ralph Decl. Ex. 27. This publication states, in pertinent part:

> Lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) youth and their families live in all regions of the state, yet are often invisible to communities and institutions, including the child welfare system.
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> * * *
>
> Although active homophobia, or anti-LGBTQ attitudes and actions have decreased over time, violence and bullying against LGBTQ individuals still occurs regularly across the country.
>
> * * *
>
> Although this community is sometimes invisible, LGBTQ youth live in all regions, including urban, suburban, tribal and rural areas. Many LGBTQ youth face discrimination and lack of understanding from school personnel, peers, social service staff, medical providers, religious communities and their families. It is the ethical and professional responsibility of child welfare social workers to support and strengthen all youth and families that they serve, regardless of sexual orientation or gender identity.

* * *

> LGBT individuals have been subjected to historical discrimination and oppression in American society, causing attendant challenges to their well-being. LGBT youth in out-of-home care are especially vulnerable to discrimination and stigma based on their sexual orientation or gender identity.

Id. at 1.

73. While recognizing that that the "historical discrimination and oppression in American society" has challenged the "well–being" of the LGBT community, including LGBT youth, DHS administers the statute and enforces it. Under the MA and the MinnesotaCare programs, DHS provides transgender people with gender-dysphoria coverage for hormone therapy, but, in deference to the statute, not sex-reassignment surgery.

74. The State of Minnesota's own health plan for state employees, including employees of DHS, provides coverage for sex-reassignment surgery. Ralph Decl. Ex. 19 at 58.

Defendant's enforcement of the statute conflicts with the policies of other Minnesota state agencies.

75. On November 24, 2015, the Minnesota Departments of Health and Commerce issued an insurance bulletin stating that private insurance policies with categorical bans on coverage for transition-related healthcare illegally discriminately on the basis of sex and gender identity. *See* Ralph Decl. Ex. 3. The bulletin further stated that the "[d]etermination of medical necessity and prior authorization protocols for gender dysphoria-related treatment must be based on the most recent, published medical standards set by nationally recognized medical experts in the transgender health field." *Id.* Under the bulletin, it is currently illegal for a private-insurance company to issue an insurance policy with the same categorical exclusion of coverage mandated by Minn. Stat. § 256B.0625, subd. 3a, for the MA and MinnesotaCare health programs. *See id.*

76. MA and MinnesotaCare health programs cover similar surgeries, such as bilateral mastectomies, when such treatments are deemed medically necessary as a result of breast cancer or other medical conditions other than gender dysphoria. Ralph Decl. Ex. 2 at 9-10.

The statute conflicts with developing federal and state law barring discriminatory treatment of transgender persons.

77. Medicare, the federal healthcare program for elderly and disabled individuals, began covering gender-affirming surgeries in 2014. Declaration of Katie Spencer, Ph.D., Ex. A at 12-13.

78. Several states have issued bulletins mandating that insurance companies cannot discriminate against transgender patients by excluding medically necessary treatments for gender dysphoria. *Id.* To date 16 states have issued bulletins banning trans-exclusionary insurance policies. Spencer Decl. Ex. A at 12; Ralph Decl. Ex. 4.

Defendant has recently admitted the statute is discriminatory.

79. While Defendant and DHS purport not to believe that Section 1557(a) of the Affordable Care Act preempts the state statute, Defendant and DHS nevertheless admit that a recent, final, nondiscrimination rule promulgated under ACA § 1557(a) applies to, and preempts, the statute. Ralph Decl. Ex. 21 ¶¶ 3-8.

80. On May 13, 2016, the U.S. Department of Health and Human Services issued its final rule on nondiscrimination in health programs and activities, to be codified at 45 C.F.R. Part 92 ("nondiscrimination rule"). *Id.* ¶ 3.

81. The nondiscrimination rule provides, among other things, that state Medicaid programs shall not deny or limit "coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual" based on their transgender status. *Id.* ¶ 4.

82. The nondiscrimination rule also provides, among other things, that state Medicaid programs shall not "[h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition." *Id.* ¶ 4.

83. DHS has stated that the nondiscrimination rule applies to the state statute and will preempt it when the nondiscrimination rule becomes effective. *Id.* ¶¶ 4-5, 8.

84. DHS has concluded that, because the nondiscrimination rule will require changes to health insurance or benefit designs that include the MA and MinnesotaCare programs, the effective date of the nondiscrimination rule in Minnesota is January 1, 2017. *Id.* ¶ 6-7.

85. It remains uncertain whether the nondiscrimination rule will become effective when DHS anticipates. If the nondiscrimination rule is stayed or invalidated by a court, superseded by congressional action, or materially amended by subsequent rulemaking by the U.S. Department of Health and Human Services, DHS will continue to enforce the statute. *Id.* ¶ 10.

ANALYSIS

Plaintiffs and Defendant seek judgment as a matter of law. The law in that regard is well-known and need not be repeated here. None of the parties claim that there are material issues of fact that preclude the other from judgment as a matter of law. Rather, all parties claim that the issues presented only invoke questions of law. This court is mindful that any appellate review of this decision would be *de novo*.

1. Does Evan Thomas have standing to challenge the constitutionality of Minn. Stat. § 256B.0625, subd. 3a?

To have standing, a plaintiff must have "a sufficient stake in a justiciable controversy to seek relief from a court." *State by Humphrey v. Philip Morris Inc.*, 551 N.W.2d 490, 493 (Minn. 1996) (citing *Sierra Club v. Morton,* 405 U.S. 727, 731-32, 92 S.Ct. 1361, 1364-65, 31 L.Ed.2d

636 (1972)). This includes "a bona fide legal interest which has been or ... is about to be affected in a prejudicial manner." *State ex rel. Smith v. Haveland*, 223 Minn. 89, 92 (1946).

Mr. Thomas is a transgender male who is enrolled in the Minnesota MA program. Throughout his life, he has had difficulty adjusting to his transgender identity. He eventually was diagnosed with gender dysphoria. His physicians determined that sex-reassignment surgery was medically necessary to treat his condition. Mr. Thomas's surgeon submitted a request to the MA insurance vendor, Blue Cross Blue Shield of Minnesota, to authorize the surgery. The insurer denied the request, citing Defendant's reliance on Minn. Stat. § 256B.0625, subd. 3a.

Defendant argues that "the requisite personal interest that must exist at the commencement of the litigation (standing) must continue throughout its existence (mootness)." *Kahn v. Griffin*, 701 N.W.2d 815, 821 (Minn. 2005) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 189, (2000)). Defendant concedes that Mr. Thomas had a personal interest in this lawsuit when it was filed in December 2015. However, Mr. Thomas, Defendant further argues, lost his standing when the federal government promulgated a regulation that prohibited a state from receiving federal funds for a medical-assistance program if the state discriminated on the basis of gender. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92). In light of the regulation, Defendant has stated that, as of January 1, 2017, Defendant will not enforce subdivision 3a. Therefore, the issue Plaintiffs wish to adjudicate has become moot.

Defendant's argument lacks merit. The "mootness doctrine is a flexible discretionary doctrine, not a mechanical rule that is invoked automatically whenever the underlying dispute between the particular parties is settled or otherwise resolved." *Mutual Service Cas. Ins. Co. v. Midway Massage, Inc.*, 695 N.W.2d 138, 141 (Minn. Ct. App. 2005). Defendant has stated that

it will not consider approval of Mr. Thomas's request until after the regulation takes effect on January 1, 2017. As of this moment, Defendant has not made a binding commitment to provide MA coverage for Mr. Thomas's surgery. Moreover, the present federal regulation does not preclude the federal government from changing the regulation or repealing the legislation under which the regulation was adopted, i.e., the Affordable Care Act. Should such an event occur, Defendant has always maintained that DHS will enforce subdivision 3a.

2. Does OutFront have standing to challenge the constitutionality of Minn. Stat. § 256B.0625, subd. 3a?

An organization has standing if the organization or one or more of its members have been injured in fact. *Alliance for Metropolitan Stability v. Metropolitan Council*, 671 N.W.2d 905, 914 (Minn. App. 2003). As to organizational injury, "Minnesota courts recognize impediments to an organization's activities and mission as an injury sufficient for standing. *See Snyder's Drug Stores, Inc. v. Minn. State Bd. of Pharmacy*, 301 Minn. At 35, 221 N.W.2d 162 at 166 [Minn. 1974]." *Id.*

OutFront has between 1,500 and 2,000 members throughout Minnesota, many of whom are transgender. As Defendant and DHS recognize, OutFront's transgender members often experience discrimination, abuse, and significant health issues when they cannot receive medically necessary care. Those members seek OutFront's assistance when navigating gender-identity issues such as obtaining state-funded health insurance, transition-related care, and legal representation.

OutFront provides comprehensive programs, services, and training to Minnesota's LGBTQ and allied communities for community organizing, public policy, anti-violence, law, and education. Because of the statute at issue, OutFront expends significant staff time supporting

members who cannot obtain surgical treatment for gender dysphoria and trying to change or eliminate the statutory exclusion.

Defendant argues that OutFront lacks standing because OutFront's complaint does not allege that it has brought this case on behalf of its members. To the contrary, the complaint clearly indicates that OutFront and its members have been injured by the statute. *See* Compl. ¶ 4 (some of OutFront's members are transgender enrollees in MA and MinnesotaCare); ¶ 42 (transgender individuals regularly seek OutFront's help regarding transition-related surgery); ¶ 46 (OutFront devotes resources to address the statute).

Defendant also argues that an organization does not have standing if it "has not identified a member who is suffering immediate or threatened injury." *St. Paul Police Fed'n v. City of St. Paul*, No. A05-2186, 2006 WL 2348481, at *2 (Minn. Ct. App. Aug. 15, 2006). Defendant reads *St. Paul Police* too narrowly. The case, in its entirety, acknowledges the holding in *Alliance* that an organization has standing if the organization or one or more of its members have been injured in fact. OutFront has demonstrated that the application of the statute has, and may continue, to injure OutFront and its members.

In short, OutFront has standing as an organization to represent its interests and that of its members.

3. Should the complaint be dismissed because OutFront Minnesota has not made Blue Cross Blue Shield of Minnesota a party to this litigation?

Plaintiffs seek two forms of relief:

1. A declaration that, by categorically excluding coverage for medically necessary transition-related surgery, Minn. Stat. § 256B.0625, subd. 3a (1) violates the equal protection guarantee of Minnesota Constitution Article 1, § 2; and (2) violates the fundamental constitutional right to privacy and medical autonomy protected by the Minnesota Constitution.

2. An order permanently enjoining the Defendant and her agents, employees, representatives, and all those acting in concert with her, from denying Medical

Assistance and MinnesotaCare benefits to eligible transgender patients in need of medically necessary treatment, including transition-related surgery.

Defendant argues that the state's insurance vendor for its MA and MinnesotaCare programs, Blue Cross and Blue Shield of Minnesota, must be joined as indispensable parties to this lawsuit. Minn. Stat. § 555.11 states that "[w]hen declaratory relief is sought, all persons shall be made parties who have or claim any interest which would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceeding." When necessary parties are not joined, the case is not justiciable. *Cincinnati Ins. Co. v. Franck*, 621 N.W.2d 270, 276 (Minn. Ct. App. 2001). Defendants' argument lacks merit.

First, the core issue in this lawsuit is whether Minn. Stat. § 256B.0625, subd. 3a, violates the Minnesota Constitution. The presence of BCBM in this lawsuit could not alter the determination of that issue.

Second, the State of Minnesota, through its DHS, is ultimately responsible for the payment of benefits to its eligible citizens. That the state may have contracted with a vendor to administer benefits that did not include all benefits the state was obligated to provide does not relieve the state of its own obligation to provide those benefits.

4. Is Minn. Stat. § 256B.0625, subd. 3a, unconstitutional because the statute violates the right of transgender persons to equal protection under the law?

Minn. Stat. § 256B.0625, subd. 3a, applies exclusively to transgender individuals and prohibits a type of treatment – sex-reassignment surgery – that is prescribed exclusively for transgender people.

The Minnesota Constitution guarantees Minnesotans equal protection under the laws. "No member of this state shall be disenfranchised or deprived of any of the rights or privileges secured to any citizen thereof, unless by the law of the land or the judgment of his peers." *See* Minn. Const.

Art. 1 § 2 Minn. The equal protection of persons "is confirmed in our state constitution as an 'unenumerated' constitutional right. Minn. Const. Art. 1, Sec. 16 ('the enumeration of rights in this constitution shall not deny or impair others retained by and inherent in the people.')." *State v. Russell*, 477 N.W.2d 886, 893 (Minn. 1991 (Simonett concurring).

The standards of review under Minnesota's equal protection clause has been expressed as follows:

> If an equal protection challenge under the Minnesota Constitution involves either a suspect classification or a fundamental right, we apply strict scrutiny, which requires the classification to be "narrowly tailored and reasonably necessary to further a compelling governmental interest." [Citations omitted.] We apply intermediate scrutiny to gender-based classifications. *See State ex rel. Forslund v. Bronson,* 305 N.W.2d 748, 750 (Minn.1981). Otherwise, we apply Minnesota's rational-basis test. *Gluba ex. rel. Bitzan & Ohren Masonry*, 735 N.W.2d 713, 719 (Minn. 2007). We have characterized the Minnesota rational-basis test as "a more stringent standard of review" than its federal counterpart. *See Russell,* 477 N.W.2d at 889. Under Minnesota's rational-basis test, a statute must satisfy three requirements:
>
> "(1) The distinctions which separate those included within the classification from those excluded must not be manifestly arbitrary or fanciful but must be genuine and substantial, thereby providing a natural and reasonable basis to justify legislation adapted to peculiar conditions and needs; (2) the classification must be genuine or relevant to the purpose of the law; that is there must be an evident connection between the distinctive needs peculiar to the class and the prescribed remedy; and (3) the purpose of the statute must be one that the state can legitimately attempt to achieve." *Id.* at 888 (quoting *Wegan v. Vill. of Lexington,* 309 N.W.2d 273, 280 (Minn.1981)).

In re Guardianship & Conservatorship of Durand, 859 N.W.2d 780, 784 (Minn. 2015).

The standard of review for a gender-based classification is that it must "serve important governmental objectives and must be substantially related to achievement of those objectives." *State ex rel. Forslund v. Bronson,* 305 N.W.2d 748, 750 (Minn.1981) (citations omitted).

While duly enacted laws are presumed valid, the burden to prove a law's constitutionality shifts to the state if the law discriminates against a suspect class or impinges upon a fundamental

right explicitly or implicitly protected by the Minnesota Constitution. *Skeen v. State*, 505 N.W.2d 299, 312 (Minn. 1993). A suspect class is entitled to equal protection even if the law does not expressly identify the suspect class. *See State v. Russell*, 477 N.W.2d 886, 888 n2 (Minn. 1991) (invalidating a law that imposed harsher sentences for possession of crack than cocaine because it irrationally discriminated *and* it had a disparate racial impact, recognizing that "there comes a time when we cannot and must not close our eyes when presented with evidence that certain laws, regardless of the purpose for which they were enacted, discriminate unfairly[.]")

Defendant does not deny that the statute applies only to transgender people and to their disadvantage. Rather, Defendant argues that the equal-protection analysis must begin with Plaintiffs showing "that similarly situated persons have been treated differently." Def. Mem. at 9. This argument is simply untrue. The Minnesota Supreme Court has said that "[w]hile we have applied such a test in certain equal protection cases, we need not decide whether or how to apply it" in cases where it is possible to determine "the proper degree of scrutiny." *Durand*, 859 N.W.2d 780, 784.

The statute discriminates against transgender persons, a suspect class.

Where a medical condition afflicts only members of a suspect class, denial of that treatment constitutes discrimination against that class. *See Dahl v. Regents*, No. 27-CV-11-18834, 2013 WL 1187996 *3 (Minn. Ct. App. 2013) (pregnancy discrimination *is* sex discrimination); *see also Norman-Bloodshaw v. Lawrence Berkeley Lab.*, 135 F.3d 1260, 1271-73 (9th Cir. 1998) (pre-employment testing for sickle-cell trait created a cause of action for discrimination based on race). Minn. Stat. § 256B.0625, subd. 3a, discriminates against transgender individuals because it categorically bars them from receiving medical assistance for medically necessary, sex-reassignment surgery.

While it would seem clear that transgender persons are a suspect class in Minnesota under the Minnesota Human Rights Act, Defendant disagrees even though the Minnesota Department of Human Rights concluded in 2012 that the University of Minnesota's Student Health Benefit Plan violated the MHRA because it did not cover treatment for gender dysphoria. Ralph Decl. Ex. 28. The Department of Human Rights concluded that the coverage exclusion for treatment discriminated against plaintiff on the basis of her sexual orientation.

Transgender persons are a suspect class.

Even if it is assumed that transgender persons are not a suspect class by definition, the Minnesota Supreme Court has determined that a statute targets a suspect class when it works to the disadvantage of a social group with identifiable characteristics that has either been subject to a history of purposeful, unequal treatment or is politically powerless. *Skeen v. State*, 505 N.W.2d 299, 314 (Minn. 1993) (quoting *Lujan v. Colo. State Bd. of Educ.*, 649 P.2d 1005, 1021 (Colo. 1982)). *See also Demare v. State Dep't of Human Servs.*, 2006 WL 2533922 at *4 (Minn. Ct. App.) ("Generally, a suspect class is one whose members have been subjected to discrimination; exhibit obvious, immutable, or distinguishing characteristics that define them as a discrete group; and are a minority or politically powerless.") (citing *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307 (1976)). Transgender persons meet the standard for protection as a suspect class.

Transgender persons constitute between 0.3% and 0.5% of the adult American population. They have experienced discrimination, persecution, and stigma throughout history and across cultures. They face severe economic, relational, and health risks solely as a consequence of their transgender status. In the U.S., transgender people have been refused healthcare, rejected by family members and peers, and denied housing. They have experienced employment discrimination and gender-based violence. Transgender people often are not allowed to use the

bathroom that corresponds to their gender identity and are fired from jobs when their transgender status is discovered.

Transgender people face discrimination in significant aspects of life and particularly in accessing healthcare. In a 2011 study, 50% of transgender and gender non-conforming respondents reported having to educate their medical provider about transgender health; 19% were outright denied healthcare; and 25% reported delaying medical care because of past discrimination. Plaintiffs' Mem. ISO M. Sum. J., Undisputed Material Facts (UMF) ¶ 8. Discrimination and stigma are the source of the increased rates of depression, anxiety, and suicide attempts. Transgender people are more likely to be rejected by family and peers and to have difficulty in school and with employment, all due to discrimination based on their gender identity.

The statute's discriminatory effect is underscored by the fact that "sex-reassignment surgery" is a generic term for a large number of medical procedures, including (as is pertinent here) a double mastectomy. The MA and MinnesotaCare programs cover many of the medical procedures that fall within the category of "sex-reassignment surgery" – including double mastectomies – when they are prescribed for conditions other than gender dysphoria. UMF ¶ 38. But the statute blocks coverage of these procedures when they are prescribed as medically necessary for transgender people who suffer from gender dysphoria.

In sum, transgender persons meet the criteria for a suspect class. Applying the standard adopted in *Skeen*, they are an identifiable minority that is historically the subject of unequal treatment and cannot protect itself in the political process.

Defendant recognizes that transgender persons are a suspect class.

DHS provides essential services to Minnesota's most vulnerable residents so they can meet their basic needs and have the opportunity to reach their full potential. UMF ¶ 43. Transgender people are a societal group that DHS knows it is to protect.

To this end, DHS has promulgated a publication entitled "Working with Lesbian, Gay, Bisexual, Transgender and Questioning/Queer Youth." UMF ¶ 44. This publication states, in pertinent part:

> Lesbian, gay, bisexual, transgender and questioning/queer (LGBTQ) youth and their families live in all regions of the state, yet are often invisible to communities and institutions, including the child welfare system.
>
> * * *
>
> Although active homophobia, or anti-LGBTQ attitudes and actions, have decreased over time, violence and bullying against LGBTQ individuals still occurs regularly across the country.
>
> * * *
>
> Although this community is sometimes invisible, LGBTQ youth live in all regions, including urban, suburban, tribal and rural areas. Many LGBTQ youth face discrimination and lack of understanding from school personnel, peers, social service staff, medical providers, religious communities and their families. It is the ethical and professional responsibility of child welfare social workers to support and strengthen all youth and families that they serve, regardless of sexual orientation or gender identity.
>
> * * *
>
> LGBT individuals have been subjected to historical discrimination and oppression in American society, causing attendant challenges to their well-being. LGBT youth in out-of-home care are especially vulnerable to discrimination and stigma based on their sexual orientation or gender identity.

Id. Thus DHS can hardly deny that transgender people are a suspect class for purposes of constitutional analysis.

Defendant admits the statute discriminates against transgender people.

Defendant and DHS have advised the court that a recent, final, nondiscrimination rule, promulgated under the Affordable Care Act § 1557(a), applies to, and conflicts with, the Minnesota statute. On May 13, 2016, the U.S. Department of Health and Human Services issued its final rule on nondiscrimination in health programs and activities, to be codified at 45 C.F.R. Part 92 (the "nondiscrimination rule").

The nondiscrimination rule provides, among other things, that state Medicaid programs shall not deny or limit "coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual" based on their transgender status. The nondiscrimination rule also provides that state Medicaid programs shall not "[h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition." UMF ¶ 52.

Defendant now admits that the non-discrimination provisions of the ACA (and related rules promulgated under them) apply to the Minnesota statute, and, consequently, that, as of January 1, 2017, Defendant will not enforce the statute because it discriminates against transgender people.

As DHS has admitted that the nondiscrimination rule applies to the statute and will preempt it when the nondiscrimination rule becomes effective, (UMF ¶ 53), DHS has thus admitted the statute discriminates against transgender people.[3]

Defendant has not addressed all elements that apply to heightened scrutiny of a suspect class.

Defendant does not argue and thereby satisfy its burden that the statute withstands the "heightened scrutiny" that applies to transgender persons as a suspect class, i.e., that the exclusion "serve[s] important governmental objectives" that are "substantially related to achievement of those objectives." *Forslund*, 305 N.W.2d at 750.

The statute violates rational-basis review.

Defendant argues that, because transgender persons are not a suspect class, the proper standard to be applied is the rational-basis standard and the three-part analysis adopted in *State v.*

[3] Other Minnesota agencies have barred private insurers from doing what the Statute does – namely, refusing to cover sex -reassignment surgery – on the ground that such refusals are discriminatory. UMF ¶¶ 35, 47-48.

Russell:

> (1) The distinctions which separate those included within the classification from those excluded must not be manifestly arbitrary or fanciful but must be genuine and substantial, thereby providing a natural and reasonable basis to justify legislation adapted to peculiar conditions and needs; (2) the classification must be genuine or relevant to the purpose of the law; that is there must be an evident connection between the distinctive needs peculiar to the class and the prescribed remedy; and (3) the purpose of the statute must be one that the state can legitimately attempt to achieve.

Russell, 477 N.W.2d at 888; *Durand*, 859 N.W.2d 780, 784 (Minn. 2015). Defendant's memoranda ignore the first two parts of the analysis and only discusses the third part.

As to the first part of the *Russell* test, the *Russell* court observed, "In order to meet this standard, the state must provide more than anecdotal support for [distinguishing between classes of persons impacted by legislation]." *Id.* at 889. Defendant has not offered ant such evidence.[4]

As to the second part, classifying transgender persons as persons who should be deprived of treatment medically necessary to improve their health in order to "save money" fails to demonstrate "an evident connection between the distinctive needs peculiar to the class and the

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[4] A state senator, Arlene Lesewski, offered the following *statement before passage of a prior amendment of the statute in 1998* that also restricted MA benefits for transgender persons:

> Throughout the last few weeks and in years past, I listened constantly to how we should try to save money within our programs. Granted this is not a lot, but when we are always mandating coverages be it in our Medicaid budgets or our health insurance policies we drive the costs up.

No fiscal note or other evidence was offered.

The senator's statement as to another amendment, if relevant at all, applies generically to all funding decisions. It is anecdotal and fails to establish "genuine and substantial," and not "manifestly arbitrary or fanciful," reasons for the exclusion, that would thereby provide "a natural and reasonable basis to justify legislation adapted to peculiar conditions and needs." Not surprisingly, a recent calculation of actual cost-savings achieved by the present statute are miniscule –one-thousandth of one percent (0.001011%) of DHS's annual budget. UMF ¶¶ 32-33.

prescribed remedy."

As to the third part, any argument that the statute is justified because it "saves money" relies on illegitimate means to achieve that purpose. It deprives a small class of individuals, admittedly the subject of every conceivable form of discrimination, from medically necessary treatment for the assumed purpose of saving a *de minimis* portion of the state budget. To assume that such a distinction is other than "arbitrary and capricious" is to ignore the right to equal protection under the law.

6. **Does Minn. Stat. § 256B.0625, subd. 3a, violate the Equal Protection Clause of the Minnesota Constitution because the statute interferes with the fundamental right of privacy to control one's own body and make autonomous healthcare choices?**

The Minnesota Constitution also protects the fundamental right of privacy. *See Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 19 (Minn. 1995) (a right of privacy is guaranteed under Article I, Sections 2, 7 and 10 of the Minnesota Constitution); *State v. Gray*, 413 N.W.2d 107, 111 (Minn. 1987); *State v. Muraski*, No. A07-1705, 2008 WL 4628598, at *1 (Minn. Ct. App. Oct. 21, 2008).

Minnesota's fundamental right of privacy is centered, in significant part, on each individual's authority over his or her own body. *See Price v. Sheppard*, 239 N.W.2d 905, 910 (Minn. 1976) ("At the core of the privacy decisions, in our judgment, is the concept of personal autonomy—the notion that the Constitution reserves to the individual, free of governmental intrusion, certain fundamental decisions about how he or she will conduct his or her life.").

"The right [of privacy] begins with protecting the integrity of one's own body and includes the right not to have it altered or invaded without consent." *Jarvis v. Levine,* 418 N.W.2d 139, 148 (Minn.1988). The right of privacy includes "'the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and

unquestionable authority of law.'" *Women of State of Minn.*, 542 N.W.2d at 27; *see also Doe v. Ventura*, No. MC 01-489, 2001 WL 543734, at *6 (Minn. Dist. Ct. May 15, 2001).

Implicit in the right to control one's own body is the right to engage in autonomous decision-making concerning one's own body, including choosing among medical treatments regarding one's own health. *Women of State of Minn.*, 542 N.W.2d at 29-30. Laws that burden or impair medical choices violate the fundamental right to privacy. *Id.*

The statute denies transgender persons the right to control their own bodies.

The statute bars a category of medical treatments even if medically necessary. The statute thus constrains the healthcare decisions of transgender recipients of MA or MinnesotaCare benefits because it covers one medically necessary treatment for gender dysphoria (hormone therapy) but not another (sex-reassignment surgery). Thus the statute impermissibly impairs transgender people's autonomous decision-making concerning their own bodies and impairs their medical treatment choices.

This case is indistinguishable from *Women of State of Minnesota*, where plaintiffs argued that "the state may not fund childbirth-related health services without funding abortion-related health services because this interferes with a woman's [constitutionally protected] decision-making process." *Id.* at 28. The Supreme Court observed that "[t]he relevant inquiry . . . is whether, having elected to participate in a medical assistance program, the state may selectively exclude from such benefits otherwise eligible persons solely because they make constitutionally protected health care decisions with which the state disagrees." *Id.* The Supreme Court concluded the law violated the fundamental right of privacy:

> We simply cannot say that an indigent woman's decision whether to terminate her pregnancy is not significantly impacted by the state's offer of comprehensive medical services if the woman carries the pregnancy to term. We conclude, therefore, that these statutes constitute an infringement on the fundamental right of privacy.

Id. at 31. The Minnesota Supreme Court subjected the law to strict scrutiny and struck it down. *Id.* at 31-32.

Here, too, the statute significantly impacts the medical choices of indigent transgender people because it covers some treatment options (hormone therapy) but not others (sex-reassignment surgery). The statute therefore makes a value judgment about medical treatments that impermissibly steers the choices of transgender people.

7. **Conclusion**

Minn. Stat. § 256B.0625, subd. 3a, violates the Minnesota Constitution in that it deprives transgender persons of equal protection under the law and their right to privacy. The statute is void and unenforceable.

WHL