UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

CODY FLACK,
SARA ANN MAKENZIE,
MARIE KELLY, and
COURTNEY SHERWIN

Plaintiffs,

v.

WISCONSIN DEPARTMENT OF HEALTH SERVICES and
LINDA SEEMEYER, in her official capacity as Secretary of the Wisconsin Department of Health Services,

Defendants.

Case No. 3:18-cv-00309
Judge William Conley

PLAINTIFFS' REPLY BRIEF IN SUPPORT OF MOTION TO MODIFY PRELIMINARY INJUNCTION

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INTRODUCTION

This Court only needs to answer two questions to resolve Plaintiffs' present motion. First, will members of the Proposed Class[1] be irreparably harmed by denied access to health care because of Defendants' ongoing enforcement of the Challenged Exclusion? And, if so, does the serious risk of harm to class members resulting from the categorical coverage ban on gender-confirming care outweigh the infinitesimal cost to the Wisconsin Department of Health Services ("DHS" or the "State") of covering gender-confirming care for all Wisconsin Medicaid beneficiaries who need it during the remainder of this litigation? Because Plaintiffs have provided this Court with substantial evidence demonstrating the necessity and effectiveness of surgeries to treat gender dysphoria in many transgender people—and the common, predictable, and avoidable harms to transgender individuals unable to access that care—the answer to each question is "yes."

The Court already found that Plaintiffs have shown a reasonable likelihood of success on their Section 1557 and Equal Protection Clause claims. Op. & Order 1-2, 25-35 [Dkt. No. 70] ("PI Op."). Because the Court found that the Challenged Exclusion treats transgender people as a group differently than others, PI Op. 29, the Court's analysis of these claims applies with equal force to the class-wide claims now. The Court should reject Defendants' invitation to reconsider these already-decided issues. Moreover, the Court's findings (and the State's admissions) that Wisconsin Medicaid covers chest and genital reconstructive surgeries to treat conditions other than gender dysphoria, PI Op. 25-26; Defs.' Opp. Br. 25 [Dkt. No. 116] ("Opp. Br."), warrant an

[1] Although the Court has not yet ruled on Plaintiffs' pending class certification motion [Dkt. No. 89], Defendants do not oppose certification [Dkt. No. 115]. The Proposed Class is defined as "[a]ll transgender individuals who are or will be enrolled in Wisconsin Medicaid, have or will have a diagnosis of gender dysphoria, and who are seeking or will seek surgical or medical treatments or services to treat gender dysphoria." Pls.' Mot. for Class Cert. 1 [Dkt. No. 89].

express ruling that Plaintiffs' likelihood of success on their Medicaid Act claims separately justifies the entry of a class-wide preliminary injunction.

Defendants once again treat so-called "transsexual surgery" as a single "service," which, they claim, is an unproven "procedure" that they have the right to categorically exclude. Opp. Br. 13-14. As Plaintiffs have shown—and the Court has recognized—there is no single service or procedure called "transsexual surgery." Rather, there are a range of surgeries and related services that are generally accepted, widely-used treatments for gender dysphoria in transgender people. PI Op. 4.[2] The State freely admits that Wisconsin Medicaid covers identical services to treat other conditions in cisgender people. Opp. Br. 25. At no point has the State put forward *any* evidence that it was motivated by—or even considered—peer-reviewed medical research on the treatment of gender dysphoria (or its predecessor conditions in earlier versions of the DSM) when it adopted the Challenged Exclusion and labeled all "transsexual surgery" unnecessary. Nor have they offered evidence that the State considered, at any time since then, the evolving medical consensus and standards of care on treating gender dysphoria in continuing to enforce the exclusion.

In response to this lawsuit, Defendants have come forward with reports from Lawrence Mayer, Chester Schmidt, and now Daniel Sutphin—none of whom have demonstrable expertise

[2] Although Plaintiffs recognize that Wisconsin Medicaid covers gender-confirming hormones at least some of the time, they dispute whether Wisconsin Medicaid applies the Challenged Exclusion to deny coverage for medically necessary hormone treatments for some beneficiaries. Indeed, Plaintiff Courtney Sherwin must pay out-of-pocket for her hormones. Decl. of Courtney Sherwin ¶ 13 [Dkt. No. 95] ("Sherwin Decl."). The Court need not resolve the question now of whether Wisconsin Medicaid or any of its participating HMOs have applied the exclusion to deny coverage for non-surgical transition-related services. The modified injunction, if granted, will eliminate any uncertainty and inconsistent application of the exclusion by Wisconsin Medicaid or specific HMOs to deny hormones or other services to transgender Medicaid beneficiaries.

on transgender health care, but who all have been hired by various defendants as experts in multiple transgender rights case around the country. The Court previously found Mayer's opinion in this case (and in *Boyden*) to be unpersuasive, PI Op. 21, *Boyden v. Conlin*, No. 17-cv-264-wmc, 2018 WL 4473347, at *18 n.17 (W.D. Wis. Sept. 18, 2018), and also found Schmidt's opinion largely irrelevant. PI Op. 22. Taking another bite at the apple, the State now offers a report from Sutphin—a plastic surgeon with no experience or expertise in treating gender dysphoria—to question the efficacy of gender-confirming surgeries. As explained below, his opinions are based on flawed factual predicates, and, in any event, represent a fringe view far outside the mainstream medical consensus. The Court should give little weight to his opinion.

For the reasons further explained in Plaintiff's opening brief and below, an expansion of the preliminary injunction to fully enjoin the State's enforcement of the Challenged Exclusion will protect many transgender Wisconsin Medicaid beneficiaries from unnecessary suffering and stigma, at little cost to the State. The equities tip in favor of the Proposed Class and the Court should grant Plaintiffs' motion.

ARGUMENT

I. THE COURT SHOULD REJECT THE STATE'S ATTEMPT TO RELITIGATE THE COURT'S FINDING THAT PLAINTIFFS ARE LIKELY TO SUCCEED ON THEIR SECTION 1557 AND EQUAL PROTECTION CLAUSE CLAIMS.

The Court's conclusion that Plaintiffs Cody Flack and Sara Ann Makenzie are reasonably likely to succeed on their Section 1557 and Equal Protection Clause claims applies with equal force to the claims of the entire Proposed Class. The Court does not need to revisit those conclusions to resolve Plaintiffs' motion to expand the existing injunction. While Defendants maintain that the Challenged Exclusion does not discriminate against transgender Wisconsin Medicaid beneficiaries on the basis of sex or transgender status, the Court has already rejected

that position in both this case and in *Boyden*. PI Op. 25-31; *Boyden*, 2018 WL 4473347, at *12-14. Moreover, with respect to Plaintiffs' equal protection claim, the Court made a preliminary finding that heightened scrutiny would likely apply (whether the claim was based on sex or transgender status). Subsequently, in *Boyden*, the Court ruled conclusively that heightened scrutiny is indeed the correct standard. 2018 WL 4473347, at *16. Defendants' purported justifications for the Challenged Exclusion cannot survive such scrutiny.

A. The Court has already found the Challenged Exclusion to be facially discriminatory against transgender Wisconsin Medicaid beneficiaries, not just as applied to Cody Flack and Sara Ann Makenzie.

In granting the current injunction, the Court concluded that "plaintiffs have made a persuasive evidentiary showing, albeit a preliminary one, that the Challenged Exclusion prevents them from getting medically necessary treatments on the basis of both their natal sex *and* transgender status, which surely amounts to discrimination on the basis of sex." PI Op. 31. The Court reached this conclusion several ways, all of which are as applicable to members of the Proposed Class as they are to Cody Flack and Sara Ann Makenzie.

Noting that the Challenged Exclusion facially excludes coverage for "transsexual surgery," the Court observed that "'sex' would seem to encompass 'trans*sex*ual.'" *Id.* at 25. Without resolving that question, the Court found that "[e]ven accepting defendants' definition of sex, . . . the Challenged Exclusion certainly denies coverage for medically necessary surgical procedures based on a patient's *natal* sex," as Wisconsin Medicaid would cover the same surgeries for any individual whose "natally assigned sexes had *matched* their gender identities." *Id.* at 25-26. In addition, the Challenged Exclusion "creates a different rule governing the medical treatment of transgender people" by "directly singl[ing] out a Medicaid claimant's transgender status as the basis for denying medical treatment." *Id.* at 29. Since, "[b]y definition, a

transgender individual does not conform to the sex-based stereotypes of the sex that he or she was assigned at birth," *id.* at 27 (quoting *Whitaker v. Kenosha Unified Sch. Dist.*, 858 F.3d 1034, 1048 (7th Cir. 2017)), singling out transgender people as a group for different treatment is based on impermissible sex stereotypes. The Court specifically found that "the Challenged Exclusion feeds into sex stereotypes by requiring all transgender individuals receiving Wisconsin Medicaid to keep genitalia and other prominent sex characteristics consistent with their natal sex no matter how painful and disorienting it may prove for some." *Id.* at 31 (citing *EEOC v. Harris Funeral Homes, Inc.*, 884 F.3d 560, 576-77 (6th Cir. 2018)). Moreover, the Court found that "discriminating on the basis that an individual was going to, had, or was in the process of changing their sex – or the most pronounced physical characteristics of their sex – is *still* discrimination based on sex." *Id.* at 27.

Defendants now try to claim that the Challenged Exclusion is "facially neutral" because "the Exclusion itself does not draw any explicit sex-based (or even transgender-based) classifications" and that "the Exclusion does not even draw lines between different types of people." Opp. Br. 23. Nonsense. Even if the Court had not already found otherwise, it defies reason that a policy that expressly excludes "*transsexual* surgery," without defining the term, treats transgender and cisgender Wisconsin Medicaid beneficiaries equally. The Court rejected this argument both here and in *Boyden*. PI Op. 25-26; *Boyden*, 2018 WL 4473347, at *12-13. As with the exclusion at issue in *Boyden*, the Challenged Exclusion "on its face treats transgender individuals differently on the basis of sex." *Boyden*, 2018 WL 4473347, at *14.

The Court has also rejected Defendants other arguments—including its citation to the Supreme Court's 44-year-old decision in *Geduldig v. Aiello*, 417 U.S. 484, 497 (1974), for the proposition that heightened scrutiny was inappropriate for a policy that singularly affects

transgender people. Opp. Br. 30. The Court noted that Defendants' reliance on *Geduldig* was misplaced because the Court had found the exclusion at issue in *Boyden* to discriminate on the basis of sex. *Boyden*, 2018 WL4473347, at *16. So too here. In any event, Plaintiffs do not rely on the fact that the Challenged Exclusion, as applied, affects only transgender people. For the reasons stated above and already endorsed by this Court, the policy facially discriminates against transgender people as a group.

B. The State has offered no evidence that it ever studied the safety or efficacy of surgical treatments for gender dysphoria when the Challenged Exclusion was adopted or at any time before this lawsuit.

To survive heightened scrutiny, "[t]he State must show at least that the [challenged] classification serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Boyden*, 2018 WL 4473347, at *16 (quoting *United States v. Virginia*, 518 U.S. 515, 533 (1996)). "[I]n proffering a justification, the State must proffer reasons that are 'genuine, not hypothesized or invented *post hoc* in response to litigation.'" *Id.* (quoting same). "[T]he burden coming forward with such a reason 'rests entirely on the State.'" *Id.* (quoting same).

As in this case, the Defendants in *Boyden* submitted expert testimony to raise concerns about the efficacy of gender-confirming surgery. *Id.* at *17. The Court found that "without any evidence to support a finding that defendants were *actually* concerned about efficacy in reinstating the Exclusion," Defendants failed to meet their burden of showing the concerns raised by their experts were anything more than *post hoc* rationalizations. *Id.* at *17-18. Defendants attempt to distinguish the Court's equal protection finding in *Boyden* by claiming that their medical necessity defense is not a *post hoc* justification for the Challenged Exclusion. But, as in *Boyden*, Defendants have proffered *no* evidence that the State, either at the time of the policy's

implementation or in its enforcement over the years, has ever been motivated by genuine concerns of medical necessity. Simply labeling "transsexual surgery" as medically unnecessary on the face of the exclusion, without any regulatory record justifying that label, is insufficient to meet Defendants' burden that this was a legitimate interest motivating the policy. Significantly, all the evidence Defendants have submitted regarding the purported concerns with the safety, effectiveness, or medical necessity of gender confirming procedures for the treatment of gender dysphoria have been reports from purported experts hired specifically for the purposes of litigation. Moreover, the evidence put forward by those purported experts post-dates Defendants' adoption of the Challenged Exclusion. The State has offered no evidence whatsoever in the record that it ever studied or reviewed the medical necessity, safety, or efficacy of such treatments for gender dysphoria prior to adopting the exclusion at issue, or at any point prior to the initiation of this lawsuit.

Even if the State was legitimately interested in protecting transgender Medicaid beneficiaries from "unproven" treatments, for the reasons this Court has already found, a categorical prohibition on coverage for gender-confirming surgeries is not substantially related to that interest because gender-confirming surgeries are safe, effective, generally accepted treatments for gender dysphoria.

C. The State's purported justifications for the Challenged Exclusion have been rejected by this Court and the mainstream medical community.

As this Court has already found, gender-confirming services are medically necessary, effective treatments for many transgender people with gender dysphoria. PI Op. 16-22; *see also Boyden*, 2018 WL 4473347, at *4-5. This Court has already determined that for many transgender people with gender dysphoria, gender-confirming surgeries, including chest and genital reconstructions, "meet the prevailing standard of care" and constitute "medically

necessary treatment." PI Op. 16. And the Court has already recognized that gender-confirming surgeries are "commonly offered and performed across the country to ease the suffering of those with gender dysphoria." *Id.* at 26 n.22.

The State has failed to demonstrate that this Court's conclusions were erroneous, or that gender-confirming treatments are unproven, unnecessary, or ineffective treatments for gender dysphoria. To the contrary, Plaintiffs have firmly established that gender-confirming surgical care is "generally accepted by the professional medical community as an effective and proven treatment" for gender dysphoria. *See* Decl. of Loren Schechter, MD ¶¶ 35-39 [Dkt. No. 27] ("Schechter Decl."); Supp. Decl. of Loren Schechter, MD ¶¶ 4-6, 11-14 ("Schechter Supp. Decl."); Decl. of Daniel Shumer, MD, MPH ¶ 31 [Dkt. No. 25] ("Shumer Decl."). And this Court has found as much. PI Op. 26 n. 22; *Boyden*, 2018 WL 4473347, at *5. As the Court noted in *Boyden*, "[w]hen individuals diagnosed with gender dysphoria do not obtain competent and necessary treatment, serious and debilitating psychological distress often occurs," and that mainstream medical organizations "recognize the medical necessity of transition-related care for transgender people with gender dysphoria." 2018 WL 4473347, at *5.

Notwithstanding this medical consensus and the Court's findings, Defendants imply now that the Challenged Exclusion is permissible because gender-confirming surgeries are "experimental." *See* Opp. Br. 9-14. First, the record has established that gender-confirming surgeries are not experimental, but are generally-accepted, commonly used, and safe and effective treatments for gender dysphoria. *See* PI Op. at 21; *see also infra* 16-18. Indeed, Defendants previously conceded that gender-confirming surgeries are *not* experimental. PI Op. 26 n.22 (noting Defendants "acknowledged this type of surgery was not experimental in nature" at oral argument); Jul. 19, 2018 Hr'g on Mot. for Prelim. Inj. Tr. 33:10-13 [Dkt. No. 69]. Thus,

the Court should disregard the State's self-serving attempt to argue otherwise now. *See McCaskill v. SCI Mgmt. Corp.*, 298 F.3d 677, 680 (7th Cir. 2002) ("The verbal admission by [] counsel at oral argument is a binding judicial admission, the same as any other formal concession made during the course of proceedings.")

D. The opinions of Dr. Daniel Sutphin, who has no demonstrated expertise on the treatment of gender dysphoria, are factually flawed, unsupported by reliable research, and fall well outside the medical consensus that gender-confirming surgeries are safe and effective treatments for gender dysphoria.

Having failed to persuade the court with the unreliable opinion of their initial expert, Dr. Lawrence Mayer,[3] Defendants now turn to Dr. Daniel Sutphin to try to convince the court to disregard the substantial evidence that gender-confirming surgeries, when performed consistent with the WPATH Standards of Care, are safe and effective treatments for gender dysphoria for many transgender individuals. They fare little better this time around.

As an initial matter, Dr. Sutphin's qualifications to opine on the effectiveness of gender-confirming surgeries are doubtful, at best. As he testified in another case, he has never treated patients for gender dysphoria or performed or assisted with any gender-confirming surgery. Dep. of Daniel Sutphin, *Bruce v. State of South Dakota*, No. 17-5080 (D.S.D. July 17, 2018) 21:3-10, 25:18-25 ("Sutphin Dep.") (excerpts attached as Exhibit A). Nor has he conducted any research (let alone peer-reviewed research) relating to surgical treatments for gender dysphoria. Sutphin Dep 27:13-28:9. His qualifications falls short of what would be required to provide expert testimony on the gender-confirming surgical care under the requirements of *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993).

[3] This Court previously noted in *Boyden* its "serious concerns with the reliability of Dr. Mayer's opinion that no credible studies demonstrate that gender confirming surgery and hormone therapy are effective treatments for gender dysphoria." *Boyden*, 2018 WL 4473347, at *18 n.17.

Furthermore, even if Dr. Sutphin were qualified to offer expert testimony on this subject, the opinions he offers here are based on flawed factual premises and do not withstand even cursory examination. Gender-confirming surgeries are not, as Dr. Sutphin claims, "unique in all of medicine." Even if they were, any number of conditions have "unique" treatments that are nevertheless medically necessary. Dr. Sutphin contends that gender-confirming surgeries are unique because "an otherwise physiologic organ is removed based on the seminal impetus of patient desire and perception" and are solely intended to alleviate psychological symptoms. Decl. of Daniel Sutphin ¶ 54 ("Sutphin Decl.") [Dkt. No 118]. First, this statement miscasts transgender individuals' medical need for gender dysphoria treatment as a subject "desire." Schechter Supp. Decl. ¶ 10 ("[G]ender-confirming surgery is performed to treat a recognized medical condition, and is more properly characterized as a health need, not a 'want.'"). Nor are gender-conforming surgeries "unique" because they are conducted on physiologically healthy tissue, as Dr. Sutphin claims. Surgical procedures may be conducted on physiologically healthy tissue for a number of reasons—for example, where a cisgender woman who carries a predisposition to breast and/or ovarian cancer obtains a prophylactic mastectomy or oophorectomy, although the tissue at issue is not cancerous. *Id.*

Moreover, gender-confirming surgeries are not unique in having, as one of their aims, the alleviation of psychological symptoms. Other medically-necessary surgeries are also performed in part for psychological benefits. *Id*. For example, a cisgender woman who has had a mastectomy due to breast cancer may choose to have reconstructive surgery to alleviate psychological distress associated with the absence of breasts. *Id.* Indeed, Dr. Sutphin himself recognizes that some surgical treatments provided to cisgender individuals are performed, all or in part, to alleviate psychological symptoms and social stigma. For example, he acknowledges

that cisgender men with persistent gynecomastia, a condition that causes them to develop female-appearing breasts, may seek surgical treatment, in some cases purely to alleviate the resulting psychological distress and social stigma. Sutphin Dep. 181:8-182:12. And despite his professed concerns with such surgery when performed for the purposes of treating gender dysphoria, he has no such concerns when performed to help cisgender individuals—he considers bringing a cisgender man's physical body into alignment with the typical male phenotype an "entirely appropriate medical consideration," and would not hesitate to perform such surgery himself. *Id.* 179:22-25, 181:8-182:12.

A large percentage of Dr. Sutphin's declaration is devoted to detailing the implications and limitations of gender-confirming surgical treatments for gender dysphoria, and the types of complications that can arise from such treatments. Sutphin Decl. ¶¶ 8-21. Yet complication rates are no higher when these procedures are performed as treatment for gender dysphoria than when performed on cisgender people for other reasons, Schechter Supp. Decl. ¶¶ 14-15, as even Dr. Sutphin acknowledges. Sutphin Dep. 22:8-21. In fact, the medical literature indicates that complication rates for some procedures are in fact *lower* for gender-confirming surgery than they are for the same or similar procedures performed on cisgender individuals. Schechter Supp. Decl. ¶ 14. There is, therefore, no basis for concluding that the risk of complications poses any greater concern or barrier to coverage for gender-confirming surgeries than it would for any other surgical treatment—as this Court has recognized. *Boyden*, 2018 WL 4473347, at *7 (noting that "[s]tudies show overall complication rates for surgical procedures to treat gender dysphoria are similar to the rates for similar surgical procedures for treating other medical conditions.").

Dr. Sutphin's conclusions regarding the safety and effectiveness of these treatments are predicated on the same Dhejne and Meyer studies the Court found to have "serious flaws" when

they were relied on by Dr. Mayer in *Boyden*. *Boyden*, 2018 WL 4473347, at *18 n.17. *See also* Schechter Supp. Decl. ¶¶ 17-18 (discussing flaws inherent in these studies); Second Supp. Decl. of Stephanie Budge, PhD, LP ¶¶ 8-11 ("Budge Second Supp. Decl."). Dr. Sutphin's declaration therefore provides no basis for disputing the clear medical consensus that gender-confirming surgeries are safe and effective treatments for gender dysphoria. Schechter Decl. ¶¶ 35-39; Schechter Supp. Decl. ¶¶ 11, 17-23. Indeed, even Dr. Sutphin agrees that it is not unreasonable to permit individual doctors to determine that surgery for gender dysphoria is medically necessary for a given patient, and presumes that it can be executed safely and effectively in the hands of an experienced surgeon. Sutphin Dep. 193:3-9; 216:21-217:2.

Dr. Sutphin suggests that transgender people experience elevated rates of suicidal behavior and other risk factors after gender-confirming surgery. Sutphin Decl. ¶ 42. This is, at best, misleading. First, the study cited by Dr. Sutphin compares the suicide rates of transgender individuals who obtained gender-confirming surgeries to the rates in the *general population*, not to similarly-situated transgender individuals who did not obtain treatment for surgery. Although, for a variety of reasons including lack of equitable access to health care, widespread discrimination and stigma, and other factors, there is no dispute that transgender people as a group face higher rates of suicidality than the general population. The relevant question is whether appropriate treatments for gender dysphoria can help *reduce* these risks, not eliminate them altogether. Research shows that it does. For example, a 2015 study found a 62 percent relative risk reduction post-surgery for transgender people. Budge Second Supp. Decl. ¶ 11. Another 2015 study found that transgender women who underwent chest reconstruction surgery reported lower rates of suicidal ideation than transgender women who had no had not received gender-confirming treatments. *Id.* As Dr. Budge has concluded based on her professional clinical

experience and review of the peer-reviewed research, transgender individuals "are *less* likely to experience suicidal ideation or attempt/complete suicide after receiving medically necessary surgical care for gender dysphoria." *Id.* ¶ 12. Dr. Sutphin's opposite conclusion is not supported by the research and is simply incorrect. *Id.*

Finally, Dr. Sutphin offers no support for his claim that the possibility that individuals who receive gender-confirming treatments may "regret" them later suggests that these treatments are not effective. Nor does he provide support that anecdotal stories of "regret" are a basis to categorically foreclose Medicaid coverage for gender-confirming surgeries performed in accordance with the WPATH Standards of Care. Dr. Sutphin offers general concerns that some patients may regret undergoing a medical transition. However, he provides nothing beyond citations to three articles in the popular press and a vague reference to a sole scholarly article from a surgeon, Dr. Miroslav Djordjevic. Sutphin Decl. ¶¶ 27-28. He does not offer more detail, and for good reason—his sources simply do not support his assertion that there is any significant regret experienced by transgender individuals diagnosed with gender dysphoria who receive appropriate transition-related treatments under the supervision of their doctors. According to Dr. Djordejevic's article, the patients who reported regret (a total of seven people) had all been *misdiagnosed* with gender identity disorder prior to their original surgical treatment, and did not receive surgery consistent with the WPATH Standards of Care. Budge Second Supp. Decl. ¶ 4; Schechter Supp. Decl. ¶ 24. Unlike these seven people, all members of the Proposed Class have (or will have) a gender dysphoria diagnosis under the diagnostic criteria in the DSM-5 before seeking gender-confirming treatment consistent with the WPATH Standards of Care. In short, this study is irrelevant to this case. As Dr. Budge points out, Dr. Sutphin also appears to misunderstand the opinion of another expert, Dr. Charles L. Ihlenfeld, who he suggests opposes

gender-confirming surgeries. Budge Second Supp. Decl. ¶ 9. To the contrary, Dr. Ihlenfeld supports such surgeries when medically necessary. *Id.*

In fact, the weight of the research shows that the number of patients who express any degree of regret after undergoing gender-confirming surgery is extremely low. *Id.* ¶¶ 5-6. The vast majority of transgender individuals who have obtained surgical treatments for gender dysphoria have experienced significant improvements in their gender dysphoria, overall health and well-being, and life outcome. *Id.* ¶¶ 14-15. The lived experience of one of the Plaintiffs, Cody Flack, is further evidence of these benefits. Mr. Flack, who experienced severe gender dysphoria, depression, social anxiety, and other distress prior to obtaining chest reconstruction surgery in September, reported immediate and marked improvements in his overall well-being, his comfort going out in public, and his future after his surgery. Supp. Decl. of Cody Flack ¶ 3-4 [Dkt. No. 91].

Based on his deposition testimony in the *Bruce* case, Dr. Sutphin's opinions on gender-confirming surgeries appear to be influenced at least as much by his personal religious views as by scientific evidence. Dr. Sutphin agrees with the position statement of the Christian Medical & Dental Associations ("CMDA") on gender-confirming care, including CMDA's statement that "attempts to alter gender surgically or hormonally for psychological indications . . . are medically inappropriate, as they repudiate nature, are unsupported by the witness of Scripture, and are inconsistent with Christian thinking on gender in every prior age." Sutphin Dep. 37:6-16 (referencing CMDA, Transgender Identification, https://cmda.org/article/transgender-identification/). Consistent with this statement, Dr. Sutphin believes that gender-confirming procedures "repudiate nature" and are contrary to "what is natural." *Id.* 38:15-16, 39:17-19. Because he believes "that God does not make mistakes," he accords his practice with Biblical

principles and refuses to perform any surgeries he believes are "cosmetic." *Id.* 38:21, 41:2-17. While Dr. Sutphin is entitled to his personal religious views and to limit his own surgical practice accordingly, the *Bruce* deposition testimony makes clear that those beliefs color his purported scientific conclusions and render his opinions here unreliable.

In sum, Dr. Sutphin's opinions provide no basis for concluding that the gender-confirming surgeries the Plaintiff Class seeks access to can never be medically necessary.

II. BECAUSE THE STATE CANNOT CATEGORICALLY EXCLUDE TREATMENTS FOR GENDER DYSPHORIA THAT IT ADMITTEDLY COVERS FOR OTHER DIAGNOSES, PLAINTIFFS ARE LIKELY TO SUCCEED ON THEIR MEDICAID ACT CLAIMS.

A. DHS's reliance on the Medicaid Act and its own Medicaid regulations to justify the blanket exclusion is misplaced.

Defendants are wrong that the Challenged Exclusion constitutes an appropriate exercise of the State's discretion to exclude medically unnecessary services from its Medicaid program. While Defendants may exclude unnecessary services from Medicaid coverage, the categorical exclusion at issue here exceeds their discretion under the law and therefore violates the Medicaid Act. The categorical exclusion on "transsexual surgeries" is *per se* unreasonable, since it makes a broad range of medically necessary services that treat gender dysphoria completely unavailable to transgender Medicaid beneficiaries despite substantial evidence that these services are safe and effective treatments for gender dysphoria for many people.

There is no dispute that the Medicaid Act gives states the discretion to "place appropriate limits on a service based on such criteria as medical necessity." *Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 608 (7th Cir. 2012) (quoting 42 C.F.R. § 440.230(d)). The parties agree that the test for whether a service is medically necessary is "whether the service has come to be generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is being used" and whether there is "'authoritative

evidence' . . . that attests to a procedure's safety and effectiveness." *Miller v. Whitburn*, 10 F.3d 1315, 1320 (7th Cir. 1993). As Defendants acknowledge, Opp. Br. 9, a state may only restrict access to a service based on standards that are "'reasonable' and 'consistent with the objectives' of the Act." *Beal v. Doe*, 432 U.S. 438, 444 (1977) (quoting 42 U.S.C. § 1396a(a)(17)); *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 125 (1st Cir. 1979). Consistent with the Medicaid Act, the Wisconsin Medicaid regulations mandate that in determining whether a service is medically necessary, the Department must consider "whether the procedure is 'of proven medical value or usefulness,' 'experimental,' 'generally accepted' in the medical community, and 'safe[ ] and effective[ ].'" Opp. Br. 26-27 (quoting Wis. Admin. Code § DHS 101.03(96m)(a), (b)(3), (b)(5), (b)(9)). As stated above, the State has not put forward any evidence that it has ever undertaken this type of review for any gender-confirming surgical treatment for gender dysphoria. In the absence of such evidence, they are not entitled to any deference.

Defendants fail to establish, however, that the State's categorical exclusion of *all* gender-confirming surgical treatments for gender dysphoria is an appropriate limit based on medical necessity, or that it is reasonable and consistent with the objectives of the Medicaid Act or its own regulations defining medical necessity. Nor can they do so. This Court has already recognized that gender-confirming surgeries are "commonly offered and performed across the country to ease the suffering of those with gender dysphoria." PI Op. 26 n.22; *see also* Schechter Decl. ¶¶ 23-28; Shumer Decl. ¶¶ 29-31. The Court has also recognized that "surgeons used many of the same procedures to treat other medical conditions," which "would also appear to support a finding that the procedures are safe." *Boyden*, 2018 WL 4473347, at *7 & n.5. Indeed, the treatments sought by Plaintiffs are medically necessary according to all the criteria set forth in Defendants' regulation: they have proven medical value or usefulness, they are not experimental,

they are generally accepted in the medical community, and they are safe and effective. In fact, the Court determined that the gender-confirming chest and genital reconstruction surgeries "meet the prevailing standard of care" and constitute "medically necessary treatment" when recommended by treating providers consistent with the WPATH Standards of Care. PI Op. 2, 16. Defendants' claim that "the effectiveness of surgery to treat gender dysphoria is unproven," Opp. Br. 20, is simply incorrect and unsupported by the record before the Court.

Defendants' assertion that the Challenged Exclusion is "justified by the lack of quality evidence," Opp. Br. 27, is insufficient to overcome Plaintiffs' showing that gender-confirming surgeries are safe, effective treatments for gender dysphoria for many transgender individuals, and are recognized as such by the mainstream medical community.[4] The quality of the evidence supporting gender-confirming surgeries is comparable to that supporting other surgical procedures, and plastic surgery in particular. Schechter Supp. Decl. ¶ 19. As Dr. Schechter explains, "while randomized, double-blind, placebo-controlled studies are the gold standard for scientific studies, they cannot always be used to test clinical procedures" because of practical and ethical limitations on conducting such research. *Id.* In particular, "it is not possible to perform a double-blind study of surgeries that modify body parts, nor is there a placebo that can mimic such a surgery." *Id.* Nevertheless, the medical literature definitively establishes that gender-confirming surgeries are safe and effective treatments for gender dysphoria in many transgender individuals. *See id.* ¶¶ 4-6, 11-14.

[4] Unlike Dr. Sutphin, who has no personal experience providing gender-confirming care, and appears to possess only a passing familiarity with the literature, Dr. Schechter has performed hundreds of gender-confirming surgeries, has authored the surgical chapter of the WPATH Standards of Care as well as several peer-reviewed articles about gender-affirming surgeries, and trains other surgeons to perform these surgeries. Schechter Decl. ¶¶ 7-13.

Defendants have not put forth any reliable evidence to contradict Plaintiffs' preliminary evidentiary showing that gender-confirming surgeries are safe, effective, and medically necessary treatments for gender dysphoria. Nor have their experts adduced any evidence to support Defendants' claim that "the procedure [sic] may actually be more harmful than helpful." Opp. Br. 27. As discussed above, the rates of complication and regret among individuals who have received gender-affirming surgeries is comparable to, if not lower than, the rates of those who receive the same surgeries to treat other conditions. Schechter Supp. Decl. ¶¶ 14-15, 24-25; Budge Second Supp. Decl. ¶¶ 4-12. Defendants have simply been unable to rebut Plaintiffs' evidence showing that both the medical community and the clinical literature agree that gender-confirming surgery is a safe and effective treatment for gender dysphoria. *See* Schechter Supp. Decl. ¶¶ 4-16, 11-14; Schechter Decl. ¶¶ 34-39; Shumer Decl. ¶¶ 29-31.

Without factual support for their contention that surgical treatments for gender dysphoria are unproven, Defendants rely instead on decades-old cases, *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980) and *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001), that found that certain gender-affirming treatments could be excluded from Medicaid because they are experimental or not generally accepted in the medical community. Even assuming *arguendo* that those cases were correct when decided, both the scientific literature and clinical practice have developed significantly in the intervening decades since those decisions. Schechter Decl. ¶¶ 25, 35-37. *Cf.* PI Op. 20 n.15 (distinguishing a Tenth Circuit case that refused to consider scientific advances in

the treatment of gender dysphoria since a prior decision in 1986).[5] Indeed, the policy at issue in *Smith*—Iowa's categorical exclusion on Medicaid coverage for gender-confirming health care—was recently found by an Iowa court to be unlawful under Iowa law and inconsistent with current medical standards. *See Good v. Iowa Dep't of Human Servs.*, CVCV054956., slip op. 20, 28 (Iowa Dist. Ct. June 6, 2018) [Dkt. No. 62-1]; *see also* Pls.' Reply Br. in Supp. of Mot. for Prelim. Inj. 3 n.3 [Dkt. No. 62].

B. Plaintiffs are likely to succeed on their Medicaid Act claims.

For the reasons stated in Plaintiffs' opening brief, Plaintiffs are also likely to succeed on their Medicaid Act claims. Nothing in Defendants' response rebuts Plaintiffs' arguments.

First, since Plaintiffs have established that gender-affirming care is medically necessary for many transgender individuals with gender dysphoria, it must be covered in Medicaid under the Medicaid Act's Availability Provision. 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. § 440.230(b). The Medicaid Act requires states to make mandatory medical services (as well as optional

[5] Moreover, while Defendants cite a more recent case from the First Circuit, that case did not hold that gender-affirming surgeries are unproven treatments, or not generally accepted. Rather, that case considered under the Eighth Amendment whether gender-confirming surgery was a "medically necessary component of [a particular individual's] care, such that any course of treatment not including surgery is constitutionally inadequate." *Kosilek v. Spencer*, 774 F.3d 63, 86 (1st Cir. 2014) (en banc). Notably, the standard for determining whether a prison's denial of care is so inadequate that it constitutes unconstitutional cruel and unusual punishment under the Eighth Amendment sets a much higher bar than Medicaid's "medical necessity" standard. *See id.* (noting that even "simple medical malpractice does not rise to the level of cruel and unusual punishment") (quoting *Watson v. Caton*, 984 F.2d 537, 540 (1st Cir. 1993)). The fact that medical experts in that case disagreed as to whether surgery was the only adequate treatment option for a particular individual with gender dysphoria given her specific circumstances does not establish that all gender-affirming care is experimental or not generally accepted in the medical community. *See id.* at 90-91. Moreover, there was a dispute among the experts in *Kosilek* about whether the plaintiff could, while in prison, meet the requirements for "real-life experience" then required as a precondition of surgery under an earlier version of the WPATH Standards of Care. *See id.* at 88-89. That question, while arguably material to the decision in an Eighth Amendment case, has no bearing on a case outside the prison context.

medical services that a state has decided to cover) available in a sufficient amount, duration, and scope. 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. § 440.230(b). Defendants do not dispute that the gender-affirming treatments at issue here are coverable services under the Medicaid Act, only that they are not medically necessary for transgender beneficiaries with gender dysphoria. *See* Opp. Br. 9-10. Because, as described in detail above, Plaintiffs have established that these services are medically necessary for many individuals, Defendants are obligated to cover them in an amount, duration, and scope that is sufficient. Because Defendants completely exclude all gender-affirming surgical treatments from coverage, they have violated the Medicaid Act. *See Bontrager*, 697 F.3d at 608 (holding that state may not "den[y] coverage for medically necessary" services outright); *see also Collins v. Hamilton*, 349 F.3d 371, 376 (7th Cir. 2003). As an Indiana court found last month, this extends to categorical exclusions on gender-confirming surgeries. *S.K.J. v. Walthall*, No. 49D03-1709-MI-034611, slip op. Conc. of Law ¶¶ 21-25 (Super. Ct. of Marion Cty., Ind., Nov. 9, 2018) (attached as Exhibit B).

Second, since Defendants cover the treatments sought by Plaintiffs to treat conditions other than gender dysphoria, their failure to provide them to treat gender dysphoria violates the Medicaid Act's Comparability Provision. *See* 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. §§ 440.230(c), 440.240(a). That provision requires that services available to any individual enrolled in Medicaid "shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B). Here, Defendants have conceded that they provide the same treatments sought by Plaintiffs to treat conditions other than gender dysphoria. Opp. Br. 25. Thus, they *must* provide them to treat gender dysphoria when medically necessary. *See, e.g.*, *Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016); *Cruz v. Zucker*, 195 F. Supp. 3d 554, 576 (S.D.N.Y. 2016), *reconsideration granted on other grounds*,

218 F. Supp. 3d 246 (S.D.N.Y. 2016). Because gender-confirming surgical procedures are often medically necessary to treat gender dysphoria, as established above, Defendants may not categorically exclude them from their Medicaid program. *See S.K.J.*, No. 49D03-1709-MI-034611, Concl. of Law ¶ 21-25.

III. THE RISK OF IRREPARABLE HARM TO MEMBERS OF THE PROPOSED CLASS IS CONTRARY TO THE PUBLIC INTEREST AND FAR OUTWEIGHS THE IMMATERIAL COST IMPACT TO THE STATE OF COVERING GENDER-CONFIRMING TREATMENTS UNDER A PRELIMINARY INJUNCTION.

A. All members of the Proposed Class face the risk of irreparable harm from delayed or denied treatment for gender dysphoria.

As explained in Plaintiffs' opening brief, all members of the Proposed Class face the common, serious risk of irreparable harm from untreated or inadequately treated gender dysphoria, including psychological distress, physical health harms, and stigma, if the Challenged Exclusion is not fully enjoined. Pls.' Mem. in Supp. of Mot. to Modify Prelim. Inj. 16-18 [Dkt. No. 108] ("Pls.' Br."). These harms are not speculative. As Plaintiffs' experts have explained, denied or improperly treated gender dysphoria predictably results in adverse effects on transgender individuals' health and well-being. Decl. of Stephanie L. Budge, PhD, LP ¶¶ 72-73 [Dkt. No. 24] ("Budge Decl."); Decl. of Jaclyn White Hughto, PhD, MPH ¶¶ 41-46, 50 [Dkt. No. 26] ("Hughto Decl."). Although not every class member will experience identical injuries, delayed or denied health care to *all* members of the proposed class, and the attendant health risks, are sufficient to justify a class-wide injunction. Pls.' Br. 17-18. Defendants do not dispute that delayed or denied medical care is an irreparable harm warranting preliminary injunctive relief, as many courts have found. Rather, they resort to their assertion that these treatments are unproven. As explained above, the Court has already rejected these arguments as contrary to the weight of the scientific and medical evidence.

Defendants mistakenly claim that "Plaintiffs have made no showing of irreparable harm for potential Medicaid beneficiaries in the putative class," falsely asserting that Plaintiffs "have not presented evidence from treating doctors that gender reassignment surgeries are necessary treatments for anyone but themselves." Opp. Br. 45. First, Defendants wholly ignore that the expert testimony from Dr. Budge, Dr. Schechter, Dr. Shumer, and Dr. Hughto of the harms to transgender Medicaid beneficiaries that will predictably result from the Challenged Exclusion is evidence of irreparable harm. As Dr. Budge has opined, the "*failure* to provide transition-related medical care can lead to significant harm." Budge Decl. ¶¶ 34, 36. Dr. Schechter similarly opined that denial of gender-confirming treatments to individuals in need "is likely to perpetuate gender dysphoria and create or exacerbate other medical issues, such as depression and anxiety, leading to an increased possibility of self-harm, negative health outcomes, and even suicide." Schechter Decl. ¶¶ 41-42. Dr. Shumer concluded that the Challenged Exclusion "is at complete odds with the prevailing standards of care" and "puts the lives of individuals living with gender dysphoria at risk." Shumer Decl. ¶ 43. Dr. Hughto similarly noted that "Wisconsin's categorical policy barring access to gender-affirming care has harmful health implications for those [transgender Wisconsin Medicaid beneficiaries] who currently require such care as well as those who will require this care in the future." Hughto Decl. ¶ 49.

Defendants also ignore the declarations of two primary care providers in Wisconsin—Kathy Oriel, MD, MS, and Linda Wesp, MSN, RN, APNP, FNP-C, AAHIV-S—who recounted the harms to their patients who have been denied coverage for gender-confirming care. Decl. of Kathy Oriel, MD, MS ¶¶ 9-10, 13 [Dkt. No. 109] ("Oriel Decl."); Decl. of Linda Wesp, MSN, RN, APNP, FNP-C, AAHIV-S ¶ 15 [Dkt. No. 94] ("Wesp. Decl."). Dr. Oriel shared stories of patients denied gender-confirming care who experienced adverse health effects, self-harm, and

suicidality, and wrote that the Challenged Exclusion "limits my ability to provide my patients with treatments I know would alleviate their gender dysphoria and suffering." Oriel Decl. ¶¶ 9-14.[6] Ms. Wesp similarly wrote that the Challenged Exclusion "has categorically eliminated [her] ability to provide [her] patients with the care they need," resulting in inadequate treatments for gender dysphoria. Wesp Decl. ¶ 16.

And, finally, Defendants ignore the declarations of newly-named Plaintiffs Courtney Sherwin and Marie Kelly, as well as those of several members of the Proposed Class who describe the multiple adverse effects to their health and well-being, and their experiences feeling stigmatized, from being unable to access gender-confirming care. *See* Decl. of Marie Kelly ¶¶ 14-17 [Dkt. No. 93]; Sherwin Decl. ¶¶ 10, 12, 19-21, 23-25, 30-31; Decl. of Tori Vancil ¶¶ 10-14 [Dkt. No. 97]; Decl. of Emma Grunenwald-Ries ¶¶ 14-18 [Dkt. No. 98]; Decl. of Lexie Vordermann ¶¶ 7, 12-13 [Dkt. No. 99].[7]

Even without all this evidence, the deprivation of class members' Constitutional right to equal protection is, on its own, a cognizable irreparable harm. *See* Pls.' Br. in Supp. of Mot. for Prelim. Inj. 20 [Dkt. No. 19]. Given Plaintiffs' likelihood of success on the merits of their Equal Protection Clause claim, PI Op. at 2, this alone would justify modifying the injunction to provide class-wide relief. *Id.*

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[6] In addition, Dr. Oriel is the treating provider for two of the class member declarants, Tori Vancil and Emma Grunenwald-Ries, and has recommended gender-confirming surgeries for each of them. Decl. of Tori Vancil Decl. ¶ 13 [Dkt. No. 97]; Decl. of Emmar Grunenwald-Ries Decl. ¶ 17 [Dkt. No. 98].

[7] While Defendants dismiss the class member declarants' treating physicians' recommendations as "hearsay," statements made for medical diagnosis or treatments are not hearsay. Fed. R. Evid. 803(4). Even if those recommendations were hearsay, the Court can consider evidence at the preliminary injunction stage that might be inadmissible at trial. *Dexia Crédit Local v. Rogan*, 602 F.3d 879, 885 (7th Cir. 2010).

In sum, Plaintiffs have provided ample evidence that members of the Proposed Class are experiencing and will continue to face irreparable harm as long as the Challenged Exclusion remains in effect. And the State's purported interests in categorically denying health care pale in comparison to these harms.

B. The monetary impact to the State of eliminating the Challenged Exclusion is insignificant and immaterial.

Defendants continue to urge the Court to deny the motion to modify the injunction because of the potential cost impact to the State of covering Wisconsin Medicaid beneficiaries' gender-confirming treatments during the pendency of this case. As a threshold matter, the Seventh Circuit recognized in *Bontrager* that, in a case involving Medicaid coverage, the cost to a state Medicaid agency of covering medically necessary care in a nondiscriminatory manner is not a cognizable harm to that agency. *See Bontrager*, 697 F.3d at 611-12.

But even if the cost impact has some bearing on the Court's equities analysis, the estimated costs to the State from a preliminary injunction are insignificant and immaterial. Defendants have offered various projections of the cost to the State of a class-wide preliminary injunction. In their response, they now project a cost impact ranging from $240,000 to $960,000. Opp. Br. 39 (based on their assumption that the preliminary injunction will be in place, at most, for approximately nine months until the trial set for September 2019). Although the precise impact is unknown, the cost to the State under *any* of these estimates would represent nothing more than a rounding error in the State's annual Medicaid spending. In *Boyden*, the Court concluded that the estimated cost impact to the State of covering gender-confirming care for state employees—representing 0.1 to 0.2 percent of overall health insurance spending—was "minuscule" and "immaterial." *Boyden*, 2018 WL 4473347, at *17. Here, even the State's

highest projected cost impact is, by orders of magnitude, a significantly tinier portion of Wisconsin Medicaid's annual spending.

The State's actuarial expert originally estimated that the annual cost impact of a class-wide injunction would be only about $300,000. Report of David Williams 3 [Dkt. No. 74-1] ("Williams Report") (adjusted to $240,000 for a nine-month period); Opp. Br. 39. A $240,000 cost impact represents only about 0.006 percent (six thousandths of one percent) of the State's $3.9 billion share of the $9.7 billion annual Wisconsin Medicaid spending. This is 16 to 33 times smaller than the 0.1 to 0.2 percent cost impact this Court deemed "immaterial" in *Boyden*.

Williams now speculates that the actual annual cost impact from an injunction could be closer to $1.2 million (or $960,000 over the nine-month life of the injunction estimated by the State). Supp. Decl. of David Williams ¶¶ 25-28 [Dkt. No. 119] ("Williams Supp. Decl."). In reaching this higher estimate, Williams relies on the estimated size of the Proposed Class calculated by Plaintiffs' expert, Jaclyn White Hughto. *Id.* Based on Hughto's estimate that "at least 5,000 Wisconsin Medicaid recipients are transgender adults who may be affected by the surgical exclusion *at some point in their lives*," Hughto Decl. ¶ 49 (emphasis added); Supp. Decl. of Jaclyn White Hughto ¶ 21 [Dkt. No. 96] ("Hughto Supp. Decl."), Williams inexplicably assumes that all 5,000 individuals would obtain surgery in the next ten years. Williams Supp. Decl. ¶¶ 25-28. He thus assumes that Wisconsin Medicaid would need to cover 500 surgeries over the next year. *Id.* Williams concedes his estimate is based on "broad and simplified assumptions," *id*., and, in fact, there is no support at all for his assumption that Hughto's estimate that class members may seek gender-confirming surgeries during their *lifetime* translates into all class members obtaining surgery over the next *decade*. As such, Williams' higher cost estimate based on this faulty assumption should be given no weight. Regardless, even if the higher

estimate were accurate, it would still be immaterial. $960,000 represents only about 0.03 percent of Defendants' share of the annual Wisconsin Medicaid budget—still a fraction of the cost impact projected in *Boyden*.

Despite the State's contention otherwise, Dr. Hughto, a public health expert, did not purport to quantify the total cost savings for Wisconsin Medicaid. Instead, she merely pointed out that the already minimal additional costs to the State from covering gender-confirming care are likely to be mitigated further by the cost savings to the State associated with properly treated gender dysphoria. Hughto Supp. Decl. ¶¶ 8-20. Although Defendants describe Dr. Hughto's conclusions as "unreliable," Dr. Hughto has provided thorough analysis based on her professional experience as an epidemiologist and her review of peer-reviewed scientific (and testable) studies, showing that providing the full range of transition-related medical care is likely to result in improved outcomes for transgender Wisconsin Medicaid beneficiaries with gender dysphoria, and therefore, reduced expenses to the State and other public health benefits. *Id*.

Simply put, the actuarial cost estimate put forth by the State was an incomplete analysis because it did not include the broader public health and policy benefits associated with lifting the Challenged Exclusion. Williams admits as much. Williams Supp. Decl. ¶¶ 5-7. As Plaintiffs' experts have shown, covering the full range of transition-related medical care is likely to result in improved psychosocial, socioeconomic, and health outcomes for transgender Medicaid recipients. Budge Decl. ¶¶ 35-37; Hughto Supp. Decl. ¶¶ 8-20. As the Court has recognized, these improved outcomes are in the public interest. PI Op. at 37. Further, these improved outcomes can, in turn, be expected to reduce the costs to Wisconsin Medicaid, and to the State generally, of providing medical services related to suicide attempts, substance abuse, assault, and other risk factors. Hughto Supp. Decl. ¶¶ 8-20. It is worth noting that while the State concedes

that some cost savings may accrue from lower suicide rates following gender-confirming surgery, Opp. Br. 7 (citing Williams Supp. Decl. ¶¶ 8-17), the State does not acknowledge that the public interest in saving human lives is infinitely more valuable than mere cost savings—and a necessary consideration in this analysis.

Ultimately, the Parties agree on the essential point: the cost impact to the State of a class-wide preliminary injunction will be low. That suffices to show both that Defendants will suffer no irreparable harm from the entry of a class-wide preliminary injunction and will be unable to justify the Challenged Exclusion based on marginal cost savings.

CONCLUSION

For the reasons stated herein and in Plaintiffs' opening brief, the Court should modify the preliminary injunction to enjoin Defendants from denying any member of the Proposed Class coverage for gender-confirming care during the pendency of this lawsuit.

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Respectfully submitted,

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