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27 **UNITED STATES DISTRICT COURT**
28 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

No. 3:19-cv-02405-WHA

**MOTION FOR LEAVE TO FILE
AMICI CURIAE BRIEF BY
SCHOLARS OF THE LGBT
POPULATION**

Date: October 30, 2019
Time: 8:00 a.m.
Courtroom: Phillip Burton Federal
Building & United States Courthouse,
Courtroom 12, 19th Floor

Judge: Hon. William Alsup

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STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA, <i>Plaintiff,</i> v. ALEX M. AZAR, et al., <i>Defendants.</i>	No. 3:19-cv-02769-WHA
COUNTY OF SANTA CLARA, et al., <i>Plaintiffs,</i> v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., <i>Defendants.</i>	No. 3:19-cv-02916-WHA

Scholars of the LGBT population affiliated with the Williams Institute (“Scholars”), by and through their undersigned counsel, respectfully move the Court for leave to file the accompanying *amici curiae* brief in the above-captioned cases in support of Plaintiffs’ Cross-Motion for Summary Judgment and in opposition to Defendants’ Motion to Dismiss *or, in the alternative* Motion for Summary Judgment. Scholars file this brief pursuant to the Court’s scheduling order, dated July 1, 2019, allowing amicus briefs in support of Plaintiffs, provided such briefs are filed at or before noon on September 12, 2019. Dkt. 51 at 2. Scholars’ counsel conferred with the parties and they have each consented to its filing the accompanying brief.

DISTRICT COURTS LIBERALLY PERMIT AMICUS BRIEFS

“Whether to allow Amici to file a brief is solely within the Court’s discretion, and generally courts have ‘exercised great liberality’” in permitting amicus briefs.¹ “[T]here are no strict prerequisites that must be established prior to qualifying for amicus status.”² “District courts frequently welcome amicus briefs from non-parties concerning legal issues that have potential

¹ *Woodfin Suite Hotels, LLC v. City of Emeryville*, No. 06-cv-1254 SBA, 2007 WL 81911, at *3 (N.D. Cal. Jan. 9, 2007) (quoting *In re Roxford Foods Litigation*, 790 F.Supp. 987, 997 (E.D.Cal.1991).

² *Id.*

1 ramifications beyond the parties directly involved or if the amicus has ‘unique information or
 2 perspective that can help the court beyond the help that the lawyers for the parties are able to
 3 provide.’”³

4 MOVANTS’ INTEREST

5 Scholars are recognized experts on the health of lesbian, gay, bisexual, and transgender
 6 (“LGBT”) people. They are scholars of public health, medicine, social sciences, public policy, and
 7 law, who are affiliated with the Williams Institute, a research center at the UCLA School of Law
 8 dedicated to the rigorous study of sexual orientation and gender identity. They have conducted
 9 extensive research and authored numerous studies regarding LGBT people, including on the extent
 10 and effects of stigma and discrimination. Scholars thus have a substantial interest in the regulation
 11 that is the subject of this litigation. *See* Protecting Statutory Conscience Rights in Health Care;
 12 Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (“Final Rule”).

13 RELEVANCE OF SCHOLARS’ AMICI CURIAE BRIEF

14 Scholars are especially qualified to highlight the foreseeable harms to LGBT individuals
 15 from the Final Rule, and to assess the data and evidence in the administrative record. Scholars
 16 submit its brief out of concern that the Final Rule will exacerbate the already persistent and
 17 pervasive discrimination that LGBT people experience in health care, and will exacerbate the health
 18 disparities facing the LGBT population, such as higher rates of suicide ideation and attempts,
 19 compared to non-LGBT people. Scholars, among other commenters in the rulemaking, submitted
 20 a voluminous record of evidence on these and related topics to HHS, but the agency arbitrarily and
 21 capricious discounted and disregarded this evidence in violation of the Administrative Procedure
 22 Act, 5 U.S.C. § 706(2) (2018).

23 The U.S. Supreme Court and other federal courts have expressly relied on the research of
 24 the Williams Institute and several of the *amici* have served as expert witnesses in cases involving
 25 the rights of LGBT individuals. *See, e.g., Obergefell v. Hodges*, 135 S. Ct. 2584, 2600 (2015);

26 _____
 27 ³ *NGV Gaming, Ltd. v. Upstream Point Molate, LLC*, 355 F. Supp. 2d 1061, 1067 (N.D. Cal.
 28 2005) (quoting *Cobell v. Norton*, 246 F.Supp.2d 59, 62 (D.D.C.2003)), disapproved in later
 proceedings on other grounds sub nom. *Guidiville Band of Pomo Indians v. NGV Gaming Ltd.*,
 No.04-cv-3955-SC, 2005 WL 5503031 (N.D. Cal. Oct. 19, 2005).

1 *Baskin v. Bogan*, 766 F.3d 648, 663, 668 (7th Cir. 2014); *Campaign for S. Equality v. Bryant*, 64
2 F. Supp. 3d 906, 943 n.42 (S.D. Miss. 2014); *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 763–64 (E.D.
3 Mich. 2014); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, passim (N.D. Cal. 2010).

4 **CONCLUSION**

5 For the forgoing reasons, Scholars respectfully request that the Court grant this motion and
6 accept the accompanying *amici curiae* brief for filing.

7
8
9 DATED: September 12, 2019

Respectfully submitted,

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<p>COUNTY OF SANTA CLARA, et al., <i>Plaintiffs,</i> v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., <i>Defendants.</i></p>	<p>No. 3:19-cv-02916-WHA</p>

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TABLE OF CONTENTS

	Page
INTEREST OF AMICI CURIAE	- 1 -
SUMMARY OF ARGUMENT	- 1 -
ARGUMENT	- 2 -
I. HHS WAS OBLIGATED TO CONSIDER POTENTIAL HARM TO LGBT PATIENTS	- 2 -
II. THE ADMINISTRATIVE RECORD CONTAINS VOLUMINOUS EVIDENCE THAT THE RULE WILL EXACERBATE DISCRIMINATION AND HEALTH DISPARITIES FACING LGBT PEOPLE.....	- 3 -
A. LGBT People Face Pervasive Discrimination in Health Care and Other Settings.....	- 4 -
B. Stigma and Discrimination Lead to Health Disparities Between LGBT and Non-LGBT Populations	- 5 -
C. Anti-LGBT Discrimination is Often Religiously Motivated	- 8 -
D. The Rule Stands to Exacerbate Discrimination and Health Disparities Facing LGBT People	- 10 -
III. HHS’S TREATMENT OF THE EVIDENCE OF HARM TO LGBT PATIENTS WAS ARBITRARY AND CAPRICIOUS.....	- 10 -
A. HHS Improperly Disregarded Evidence of Foreseeable Harm to Patients	- 11 -
B. HHS Improperly Inflated the Benefits of the Rule.....	- 14 -
IV. Conclusion	- 15 -

TABLE OF AUTHORITIES

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
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1 **INTEREST OF AMICI CURIAE**

2 *Amici curiae* are experts on the health of lesbian, gay, bisexual, and transgender
 3 (“LGBT”) people. Scholars of public health, medicine, social sciences, public policy, and law,
 4 *amici* are affiliated with the Williams Institute, a research center at the UCLA School of Law
 5 dedicated to the rigorous study of sexual orientation and gender identity. *Amici* have conducted
 6 extensive research and authored numerous studies regarding LGBT people, including on the
 7 extent and effects of stigma and discrimination. *Amici* thus have a substantial interest the subject
 8 of this litigation. *See* Protecting Statutory Conscience Rights in Health Care; Delegations of
 9 Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (codified at 45 C.F.R Pt. 88) (the “Rule”). The
 10 Supreme Court and other courts have expressly relied on the Williams Institute’s research, and
 11 several *amici* have served as expert witnesses. *See, e.g., Obergefell v. Hodges*, 135 S. Ct. 2584,
 12 2600 (2015); *Baskin v. Bogan*, 766 F.3d 648, 663, 668 (7th Cir. 2014); *Campaign for S. Equality*
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 15 *Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010).

16 **SUMMARY OF ARGUMENT**

17 Congress drafted the Church Amendments, 42 U.S.C. § 300a-7 (2018), and the other
 18 statutes that the Rule purports to implement (the “provider-conscience statutes”) to protect
 19 religious liberty, which is a core principle of our democracy. At the same time, recognizing the
 20 importance of health care and the consequences of its denial, Congress drafted the Church
 21 Amendments, among other provider-conscience statutes, to apply only to a circumscribed set of
 22 services offered by a specified group of health providers who receive identified streams of federal
 23 funds. The Rule, by contrast, is expressly designed to expand the circumstances in which health
 24 care workers are authorized to deny care. Elevating religious objections to care over all other
 25 interests, the Department of Health & Human Services (“HHS”) declined to include in the Rule
 26 even minimal protections for patients, such as an exception for emergency situations or an
 27 express statement in the Rule that people cannot be turned away based on their demographic
 28 characteristics. As the plaintiffs in this case argue, the Rule exceeds the authority granted to HHS

1 by the provider-conscience statutes and conflicts with numerous other laws in violation of the
2 Administrative Procedure Act (“APA”), 5 U.S.C. § 706(2) (2018).

3 In this brief, *amici* focus on the harms that the Rule stands to impose on LGBT people.
4 *Amici* do not believe that the provider-conscience statutes are properly applied to deny care based
5 on sexual orientation or gender identity. But the Rule is broadly worded in ways that would
6 enable HHS to assert – and health care providers and LGBT people to believe – that care to
7 LGBT people can be refused on religious grounds, and the agency declined to rule out that
8 application. As a result, HHS was obligated to address the wealth of evidence in the
9 administrative record that LGBT people face pervasive stigma and discrimination in health care
10 and elsewhere; that such stigma and discrimination drive a variety of health disparities between
11 LGBT people and non-LGBT people, such as higher prevalence of suicide ideation and attempts
12 among LGBT people; and that such stigma and discrimination are commonly motivated by
13 religious beliefs – which indicate that the Rule will harm LGBT people. HHS’s improper decision
14 to ignore or discount this evidence, while relying on speculative benefits, is alone sufficient to
15 invalidate the Rule.

16 ARGUMENT

17 I. HHS WAS OBLIGATED TO CONSIDER POTENTIAL HARM TO LGBT PATIENTS

18 *Amici* do not believe that the provider-conscience statutes are properly applied to deny
19 care to people based on their sexual orientation, gender identity, or other demographic
20 characteristics. For example, these statutes do not authorize providers who provide services to
21 non-LGBT people to deny cardiovascular or orthopedic care to an individual based on the
22 provider’s disapproval of that individual’s LGBT identity. However, the preamble to the Rule is
23 equivocal, at best, on this point. For example, HHS dismissed concerns that the Rule would
24 disparately impact women, LGBT people, and religious minorities, stating only “[t]he terms
25 defined in this rule do not apply to women, LGBT persons, or religious minorities in any way that
26 differs from how Congress applied the terms in the statutes it adopted.” 84 Fed. Reg. at 23,197.
27 HHS also rejected commenter requests that the Rule expressly state that it does not authorize
28

1 denials of care based on sexual orientation and gender identity. *See, e.g., id.* at 23,215. In
 2 response to commenters who argued that the protections related to sterilization in the Church
 3 Amendments do not apply to treatment for gender dysphoria, HHS stated only that it would
 4 consider this issue on a case-by-case basis. *Id.* at 23,205. HHS has, at a minimum, left the door
 5 wide open to apply the Rule’s terms to a broad spectrum of care provided to LGBT people.

6 Regardless of HHS’s own view as to application of the provider-conscience statutes to
 7 denials of care based on sexual orientation or gender identity, moreover, the breadth and
 8 vagueness of the Rule invite providers and LGBT people to believe that the Rule does authorize
 9 such denials of care. As a result, HHS was obligated to consider the evidence of harm to LGBT
 10 people that could result from the Rule as part of its required assessment of the Rule’s impact on
 11 patients. And although HHS did purport to consider this evidence as part of its cost-benefit
 12 analyses, it did so in an arbitrary and capricious manner. In the next Part, we summarize the
 13 evidence presented to HHS on foreseeable harms to LGBT patients of the Rule and, in Part III,
 14 show that HHS’s treatment of this evidence violated the APA.

15 **II. THE ADMINISTRATIVE RECORD CONTAINS VOLUMINOUS EVIDENCE**
 16 **THAT THE RULE WILL EXACERBATE DISCRIMINATION AND HEALTH**
 17 **DISPARITIES FACING LGBT PEOPLE**

18 Vast evidence before HHS established that: (A) LGBT people experience high levels of
 19 rejection and discrimination in health care; (B) both the experience and expectation of rejection
 20 and discrimination create “minority stress,” which leads to adverse health outcomes for LGBT
 21 people and is a major cause of health disparities between LGBT and non-LGBT Americans; and
 22 (C) anti-LGBT discrimination in health care and beyond is often religiously motivated.¹ This
 23 uncontroverted evidence indicates that the Rule, to the extent it applies or is viewed as applying

24 ¹ The sources discussed in this brief are part of the administrative record, submitted to HHS in
 25 response to the proposed rule, by the Williams Institute (72082) (“Williams Institute Comment”);
 26 American Medical Association (70564) (“AMA Comment”); County of Santa Clara (54930)
 27 (“Santa Clara Comment”); Empire Justice Center (71892) (“EJC Comment”); Human Rights
 28 Watch (71217) (“HRW Comment”); Human Rights Campaign (70848) (“HRC Comment”),
 Lambda Legal (72186) (“Lambda Comment”); National Center for Lesbian Rights (69074)
 (“NCLR Comment”), and National Center for Transgender Equality (71274) (“NCTE
 Comment”), among others.

1 to LGBT people qua LGBT people, will exacerbate discrimination, ill health, and health
2 disparities facing this population.

3 **A. LGBT People Face Pervasive Discrimination in Health Care and Other Settings**

4 LGBT people have faced a long, painful history of public and private discrimination in the
5 United States. In *Obergefell*, the Supreme Court observed that gay men and lesbians have been
6 “prohibited from most government employment, barred from military service, excluded under
7 immigration laws, targeted by police, and burdened in their rights to associate.” 135 S. Ct. at
8 2596. The Seventh Circuit has explained that “homosexuals are among the most stigmatized,
9 misunderstood, and discriminated-against minorities in the history of the world[.]” *Baskin*, 766
10 F.3d at 658; *see also Windsor v. United States*, 699 F.3d 169, 182 (2d Cir. 2012), *aff’d*, 570 U.S.
11 744 (2013); *Brocksmith v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014) (“The hostility and
12 discrimination that transgender individuals face in our society today is well-documented.”). While
13 social acceptance and the legal rights of LGBT people in the United States have generally
14 improved over the past few decades (in some places more than others), ample research confirms
15 that anti-LGBT violence, stigma, and discrimination remain widespread.

16 With respect to health care in particular, the Institute of Medicine – now the Health and
17 Medicine Division of the National Academies – which operates under a congressional charter and
18 provides independent, objective analysis of scientific research, has observed:

19 LGBT individuals face discrimination in the health care system that can lead to an
20 outright denial of care or to the delivery of inadequate care. There are many
21 examples of manifestations of enacted stigma against LGBT individuals by health
22 care providers. LGBT individuals have reported experiencing refusal of treatment
23 by health care staff, verbal abuse, and disrespectful behavior, as well as many other
24 forms of failure to provide adequate care.

25 Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, & Transgender People* at 62 (2011)
26 (hereinafter “IOM”; cited in Williams Institute Comment at 8).

27 Surveys of LGBT people reveal widespread discrimination in health care. Among other
28 findings from a recent nationally-representative survey, 8% of LGBT people and 29% of
transgender people who had visited a health care provider *in the preceding year* reported that a
provider refused them care because of their sexual orientation or gender identity. Mirza &

1 Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018),
 2 [https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-](https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care)
 3 [lgbtq-people-accessing-health-care](https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care) (hereinafter “Mirza & Rooney”; cited in Lambda Comment at
 4 11, 13). According to another large survey, almost 56% of LGB respondents and 70% of
 5 transgender respondents reported experiencing at least one of several forms of discrimination in
 6 care. Lambda Legal, *When Health Care Isn’t Caring* 5 (2010) (hereinafter “Lambda Survey”;
 7 cited in Lambda Comment at 10-12); *see also* James et al., *The Report of the 2015 U.S.*
 8 *Transgender Survey* 97 (2016) (hereinafter “USTS”; cited in NCTE Comment at 4).

9 The stigma and discrimination that LGBT people experience are not limited to health care.
 10 A variety of research finds that LGBT people face persistent and pervasive prejudice at work and
 11 school, in housing and by businesses, and from their families of origins. *See* Brief of Amici
 12 Curiae Ian H. Meyer, PhD, and Other Social Scientists and Legal Scholars Who Study the LGB
 13 Population in Support of Respondents 11-12, *Masterpiece Cakeshop Ltd. v. Colo. Civil Rights*
 14 *Comm’n*, 138 S. Ct. 1719 (2018) (filed Oct. 30, 2017) (hereinafter “Meyer Brief”; cited in and
 15 appended to Williams Institute Comment). Even among high schoolers – perhaps the population
 16 most likely to have adopted more-accepting norms – LGBT youth continue to be
 17 disproportionately targeted for harassment. *Id.* at 11 n.9, 31-32.

18 **B. Stigma and Discrimination Lead to Health Disparities Between LGBT and Non-**
 19 **LGBT Populations**

20 Denials of health care can have harmful repercussions for LGBT people’s health, well-
 21 being, and dignity. An individual who, or family that, is denied care must, at a minimum,
 22 experience the inconvenience and expense of seeking alternative providers. This can be especially
 23 difficult for those who live in communities where no such alternatives are available or readily
 24 available. *See, e.g.*, Mirza & Rooney (nearly a fifth of LGBT individuals reported it would be
 25 “very difficult” or “not possible” to find the same type of service at a different hospital, health
 26 center, or clinic; higher percentages of LGBT people living outside of a metropolitan area
 27 reported such difficulty or impossibility); Frazer & Howe, *LGBT Health & Human Services*
 28 *Needs in New York State* at 16-18 & fig. 19 (2016) (refusals of care and long distances are

1 obstacles for LGBT people across New York, but especially for those living Upstate) (cited in
2 EJC Comment at 2). Where delay in obtaining care has consequences for physical or mental
3 health, those damaging repercussions are exacerbated and could, in some cases, result in needless
4 suffering, disability, or death. Discrimination related to sexual orientation or gender identity can
5 also be psychologically damaging to the victim, because such discrimination carries a strong
6 symbolic message of disapprobation of something core to that person's identity. Williams
7 Institute Comment at 9; Meyer Brief at 15.

8 Beyond these immediate impacts, health care refusals can also result in LGBT people –
9 who experience discrimination or who learn about it happening to others in the community –
10 deferring or outright avoiding needed care in order to minimize the risk of discriminatory
11 encounters. “Fear of stigmatization or previous negative experiences with the health care system
12 may lead LGBT individuals to delay seeking care.” IOM at 63. In the nationally-representative
13 survey cited above, “8 percent of all LGBTQ people – and 14 percent of those who had
14 experienced discrimination on the basis of their sexual orientation or gender identity in the past
15 year – avoided or postponed needed medical care because of disrespect or discrimination from
16 health care staff.” Mirza & Rooney; *see also* Lambda Survey at 12-13. This chilling effect results
17 in disparities in LGBT people's utilization of health care, such as lesbians being less likely than
18 straight women to get preventive services for cancer, and transgender individuals facing barriers
19 to accessing HIV prevention and care. *See* Office of Disease Prevention & Health Promotion,
20 *Lesbian, Gay, Bisexual, & Transgender Health*, [https://www.healthypeople.gov/2020/topics-](https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health)
21 [objectives/topic/lesbian-gay-bisexual-and-transgender-health](https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health) (last visited Sept. 3, 2019)
22 (hereinafter “ODPHP”; cited in Williams Institute Comment at 10); IOM at 222-25.

23 Not only do health care refusals stand to worsen LGBT people's access to and utilization
24 of health care, they stand to exacerbate well-documented health disparities facing the LGBT
25 population, including: disproportionately high prevalence of psychological distress, depression,
26 anxiety, substance-use disorders, and suicidal ideation and attempts – many of which are two to
27 three times greater among sexual and gender minorities than the non-LGBT majority. *See*
28 *generally* ODPHP; IOM at 4-5; Williams Institute Comment at 7-10; Meyer Brief at 20-24. HHS

1 has also recognized that LGBT youth face higher rates of homelessness and that “[e]lderly LGBT
2 individuals face additional barriers to health because of isolation and a lack of social services and
3 culturally competent providers.” ODPHP; *see also* IOM at 4-5.

4 Substantial research identifies anti-LGBT stigma and discrimination as the drivers of
5 health disparities between LGBT and non-LGBT populations. According to HHS itself,
6 “[r]esearch suggests that LGBT individuals face health disparities linked to societal stigma,
7 discrimination, and denial of their civil and human rights” and that “[s]ocial determinants
8 affecting the health of LGBT individuals largely relate to oppression and discrimination.”
9 ODPHP. Likewise, “[c]ontemporary health disparities based on sexual orientation and gender
10 identity are rooted in and reflect the historical stigmatization of LGBT people.” IOM at 32.

11 The relationship between stigma and health has most clearly been articulated in the
12 “minority stress” research literature, which establishes that stigma and prejudice negatively
13 impact the health of LGBT people. The minority stress model – which IOM has recognized to be
14 a core perspective for understanding LGBT health, IOM at 20 – describes how LGBT people
15 experience chronic stress stemming from their stigmatization. While stressors – such as loss of a
16 job – are ubiquitous in society and experienced by LGBT and non-LGBT people alike, LGBT
17 people are uniquely exposed to chronic stress arising from anti-LGBT stigma and prejudice.
18 Prejudice leads LGBT people to experience *excess* exposure to stress compared with non-LGBT
19 people who are not exposed to anti-LGBT prejudice (all other things being equal). This excess
20 stress exposure confers an elevated risk for diseases caused by stress, including many mental and
21 physical disorders. *See* Meyer Brief at 12-24; Williams Institute Comment at 7-10.

22 When an LGBT person is turned away from health care because of their sexual orientation
23 or gender identity, that is a “prejudice event,” a type of minority stress, that has effects that are
24 both tangible (i.e., the implications of needing to find new a provider) and symbolic (i.e., the
25 personal rejection and reverberation of social disapprobation). Further, being denied – and even
26 the threat of being denied – health care increase expectations of future rejection and
27 discrimination among LGBT people. This expectation is another form of minority stress because
28 it leads to vigilance by LGBT people seeking to defend themselves against potential

1 discrimination. Unlike tangible prejudice events, expectations of rejection and discrimination are
2 stressful even in the absence of a specific event because they are based on what the LGBT person
3 has learned from repeated exposure to stigma. For example, when an LGBT person needs to seek
4 a health care provider in a world where discrimination in health care settings are common
5 experiences, that person is likely to experience stress around whether to even seek the needed
6 health care service; whether to come out to the provider; whether to show up with a spouse that
7 may “out” the patient; and, generally, how and from whom to disguise their LGBT identity. Thus,
8 LGBT people become vigilant to protect themselves from mistreatment in healthcare settings. To
9 avoid discrimination, many LGBT people will delay or altogether skip obtaining care. *See* Meyer
10 Brief at 12-24; Williams Institute Comment at 7-10.

11 **C. Anti-LGBT Discrimination is Often Religiously Motivated**

12 While many people and institutions of faith are welcoming and affirming of LGBT people
13 – and many LGBT people are themselves people of faith – the record contains many examples of
14 anti-LGBT discrimination done in the name of religion. According to HHS, “[m]ultiple
15 comments provided lists of various incidents in which providers declined to participate in a
16 service or procedure to which they had a religious or moral objection.” 84 Fed. Reg. at 23,252;
17 *see also, e.g.*, Lambda Comment at 14-17; NCLR Comment at 9-11; Human Rights Watch, “*All*
18 *We Want Is Equality*”: *Religious Exemptions and Discrimination Against LGBT People in the*
19 *United States* 20-26 (2018) (providing numerous examples) (hereinafter “HWR”; cited in HRW
20 Comment at 3).

21 Among those incidents are outright denials of care. For example, in 2015, a Michigan
22 doctor refused to treat a same-sex couple’s infant based on her religious views about the parents’
23 sexual orientation. *See* Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents &*
24 *There’s Nothing Illegal About It*, Wash. Post (Feb. 19, 2015) (cited in Santa Clara Comment at 5).
25 In *N. Coast Women’s Care Med. Grp., Inc. v. Super. Ct. (Benitez)*, 189 P.3d 959, 963-64 (Cal.
26 2008) (cited in Lambda Comment at 14), doctors refused on religious grounds to perform donor
27 insemination for lesbians. Similarly, an Alabama clinic refused a lesbian couple fertility services
28 because of the doctor’s “religious belief that he only treats straight married couples.” HRW at 20-

1 21. In *Conforti v. St. Joseph's Healthcare Sys.*, No. 2:17-cv-0050 (D.N.J., Jan. 5, 2017), a
 2 transgender man was denied a medically necessary hysterectomy that his treating physician was
 3 ready to perform, because the religiously-affiliated hospital where the physician had admitting
 4 privileges did not permit gender-transition care. *Cited in Lambda Comment at 16.*

5 In addition to outright denials of care, anti-LGBT proselytizing and harassment is
 6 common in health care settings. According to the Human Rights Campaign, among over 13,000
 7 public comments and stories it collected from individuals in this rulemaking, “[o]ne of the most
 8 common stories of hostility and harassment . . . included unwanted proselytizing by hospital or
 9 clinic staff.” HRC Comment at 2. For example, according to one person:

10 “As my being transgender is a relevant piece of medical information . . . I revealed
 11 this information to [the doctor] when he entered the treatment room. His immediate
 12 response was, ‘I believe the transgender lifestyle is wrong and sinful.’”

13 NCTE Comment at 10. According to another:

14 “Since coming out, I have avoided seeing my primary physician because when she
 15 asked me my sexual history, I responded that I slept with women and that I was a
 16 lesbian. Her response was, ‘Do you know that’s against the Bible, against God?’”

17 Lambda Comment at 15. Similarly, in *Knight v. Conn. Dep’t of Pub. Health*, 275 F.3d 156, 161
 18 (2d Cir. 2001) (cited in Lambda Comment at 15), a nurse consultant “visited the home of a same-
 19 sex couple, one of whom was in the end stages of AIDS[,]” and proselytized against “the
 20 ‘homosexual lifestyle.’”

21 The record also includes incidents where health care providers sought to practice or urged
 22 conversion therapy on LGBT people. For example, according to one gay man:

23 “The doctor I went to see told me that it was not medicine I needed but to leave my
 24 ‘dirty lifestyle.’ He recalled having put other patients in touch with ministers who
 25 could help gay men repent and heal from sin, and he even suggested that I simply
 26 needed to ‘date the right woman’ to get over my depression. The doctor even went
 27 so far as to suggest that his daughter might be a good fit for me.”

28 Lambda Comment at 15. In *Keeton v. Anderson-Wiley*, 664 F.3d 865, 868-69 (11th Cir. 2011)
 (cited in Lambda Comment at 14), a religious counseling student intended to practice conversion
 therapy on her LGBT clients, in violation of an applicable professional code of ethics.

1 Beyond the health care context, there are numerous examples of anti-LGBT
 2 discrimination done in the name of religion. *E.g.*, *Masterpiece Cakeshop*, 138 S. Ct. 1719
 3 (business refused to serve same-sex couple); *State v. Arlene’s Flowers, Inc.*, 389 P.3d 543 (Wash.
 4 2017), *cert. granted & rev’d.*, 138 S. Ct. 2671 (2018) (business refused to serve same-sex
 5 couple). Other record evidence indicates that much anti-LGBT discrimination is rooted in
 6 religious or faith-based belief systems. For example, in the largest survey to date of transgender
 7 people (with more than 27,700 respondents), 19% of respondents who had been part of a faith
 8 community were rejected from it, and 39% of respondents who had been part of a faith
 9 community left due to fear of rejection. USTS at 77.

10 **D. The Rule Stands to Exacerbate Discrimination and Health Disparities Facing LGBT**
 11 **People**

12 The Rule is expressly designed to expand the circumstances in which health care
 13 providers can deny care, and according to HHS, “as a result of this rule, more individuals, having
 14 been apprised of those rights, will assert them,” 84 Fed. Reg. at 23,250. By inevitably increasing
 15 the risk and expectation that LGBT people will be denied health care – as discussed above in Part
 16 I – the Rule serves to increase incidents of discrimination and increase stress related to seeking
 17 healthcare. In turn, the Rule risks reducing the health and well-being of LGBT people and
 18 exacerbating health disparities between LGBT and non-LGBT populations. As we next explain,
 19 HHS improperly discounted or disregarded all of the evidence summarized above, and improperly
 20 inflated the supposed benefits of the Rule.

21 **III. HHS’S TREATMENT OF THE EVIDENCE OF HARM TO LGBT PATIENTS**
 22 **WAS ARBITRARY AND CAPRICIOUS**

23 Under Executive Orders 12,866 and 13,563, HHS was required to fully analyze the costs
 24 and benefits of the Rule. As part of that analysis, HHS arbitrarily and capriciously concluded that
 25 “this final rule [will] produce a net increase in access to health care, improve the quality of care
 26 that patients receive, and secure societal goods that extend beyond health care.” 84 Fed. Reg. at
 27 23,246. HHS’s calculus contained at least two “serious flaw[s] that... render the rule
 28 unreasonable,” *Nat’l Ass’n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012).

1 HHS, first, failed to reasonably assess the costs of the Rule in terms of harms to patients (LGBT
2 or otherwise) and, second, unreasonably relied on speculative benefits of the Rule. Moreover,
3 HHS applied inconsistent evidentiary standards that allowed the agency to dismiss foreseeable
4 harms while relying on speculative benefits. Because HHS “inconsistently and opportunistically
5 framed” the Rule’s effects, among other flaws, the Rule violates the APA. *Bus. Roundtable v.*
6 *SEC*, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011); *see also Ctr. for Biological Diversity v. Nat’l*
7 *Highway Traffic Safety Admin.*, 538 F.3d 1172, 1198 (9th Cir. 2008) (agency “cannot put a thumb
8 on the scale by undervaluing the benefits and overvaluing the costs...”).

9 **A. HHS Improperly Disregarded Evidence of Foreseeable Harm to Patients**

10 “Agencies have long treated cost as a centrally relevant factor when deciding whether to
11 regulate. . . [and] any disadvantage could be termed a cost.” *Michigan v. EPA*, 135 S. Ct. 2699,
12 2707 (2015). The preamble to the Rule acknowledges that “[d]ifferent types of harm can result
13 from denial of a particular procedure based on an exercise of [a religious] belief or [moral]
14 conviction[,]” including harm to the patient’s health “if an alternative is not readily found,
15 depending on the condition” and “search costs for finding an alternative.” 84 Fed. Reg. at 23,251.
16 HHS also “recognize[d] that, in some circumstances, some patients do experience emotional
17 distress as a consequence of providers’ exercise of religious beliefs or moral convictions.” *Id.*
18 HHS concluded that “[t]hese three potential harms [] would also be applicable for denials of care
19 based on, for example, inability to pay the requested amount.” *Id.* But this conclusion is flatly
20 contrary to the minority stress research provided to HHS. Whereas a denial of care based on an
21 inability to pay would be a general stressor that LGBT and non-LGBT people alike might
22 experience, a denial of care related to a person’s status as a sexual or gender minority is a
23 prejudice event that imposes unique tangible and symbolic harms on the LGBT victim, and has
24 more severe health implication than a similar event not related to prejudice (as discussed above).
25 HHS seems to acknowledge this, in part, when it concedes two additional harms to patients – the
26 harm caused by a provider refusing to provide even a referral and the possibility that “others in
27 the community to which the patient belongs may be less willing to seek medical care” – that
28 would not occur for someone who is unable to pay. *Id.*

1 Though HHS purported to recognize these various harms, it deemed irrelevant
2 commenters’ voluminous evidence related to patients from being turned away from care.
3 Specifically, HHS brushed this evidence aside because “comment[ers] [did not] establish[] a
4 causal relationship between this rule and how it would affect health care access, and [did not]
5 provid[e] any data the Department believes enables a reliable quantification of the effect of the
6 rule on access to providers and to care.” 84 Fed. Reg. at 23,250. Similarly, while HHS
7 acknowledged that the LGBT population (among other demographic groups) “face[s] health care
8 disparities of various forms,” *id.* at 23,251, it deemed that evidence irrelevant because
9 commenters did not “explain the extent to which such disparities are the product of the lawful
10 exercise of religious beliefs or moral convictions.” *Id.* at 23,252.

11 HHS has improperly shifted the burden to commenters instead of evaluating the evidence
12 presented. The agency, not commenters, is required “to use the best available techniques to
13 quantify anticipated present and future benefits and costs as accurately as possible.” *See* 76 Fed.
14 Reg. 3821 Exec. Order No. 13,563 § 1(c). Executive Order 12,866 further instructs agencies to
15 consider not just “direct cost . . . in complying with the regulation,” but also “any adverse effects”
16 the Rule might have on “health and safety[.]” Exec. Order No. 12,866 § 6(a)(3)(C)(ii).

17 More importantly, HHS’s requirement that commenters prove a *causal* relationship
18 between the Rule and harm to LGBT people is an impossible standard because the Rule was not
19 finalized at the time commenters made their submissions and has yet to go into effect. Moreover,
20 if sufficient evidence was not available, HHS should have followed White House guidance to
21 conduct “additional research prior to rulemaking” to address significant uncertainties about net
22 benefits, because “[t]he costs of being wrong may outweigh the benefits of a faster decision.”
23 Office of Mgmt. & Budget, Exec. Office of the President, Circular A-4 at 39 (Sept. 17, 2003).

24 In an ideal world with ideal data, we would be able to “isolat[e] the impact of the
25 exercises of religious belief or moral conviction attributable to this rule specifically, over and
26 above whatever impact is attributable to the pre-existing base rate of exercise of religious belief
27 or moral conviction.” 84 Fed. Reg. at 23,251. Absent such ideal circumstances, however, HHS
28 was not relieved of its obligation to fully and fairly consider the evidence before it – evidence

1 establishing that the Rule will lead to an increase in denials of care to all types of patients, and
2 that the Rule risks exacerbating the discrimination in health care and health disparities that LGBT
3 people face. *See supra* Part II. Indeed, HHS cannot simply disregard costs that are uncertain or
4 difficult to quantify. *See, e.g., Ctr. for Biological Diversity*, 538 F.3d at 1190, 1198 (agency acted
5 arbitrarily and capriciously when it excluded from a cost-benefit analysis benefits that the agency
6 deemed “too uncertain to support their explicit valuation”). Ultimately, while there may be “a
7 range of values” for the costs to patients of the Rule, that value “is certainly not zero” and must
8 be “accounted for.” *Id.* at 1200.² In violation of the APA, HHS turned a blind eye to the
9 voluminous evidence documenting the significant adverse impact the regulation would have on
10 patient health. *See, e.g., Motor Vehicle Mfrs. Ass’n of U.S., Inc., v. State Farm Mut. Auto. Ins.*
11 *Co.*, 463 U.S. 29, 43 (1983) (“Normally, an agency rule would be arbitrary and capricious if the
12 agency . . . offered an explanation for its decision that runs counter to the evidence before the
13 agency[.]”); *Competitive Enter. Inst. v. Nat’l Highway Traffic Safety Admin.*, 956 F.2d 321, 326-
14 27 (D.C. Cir. 1992) (agency failed to consider impact on safety); *Corrosion Proof Fittings v.*
15 *EPA*, 947 F.2d 1201, 1225 (5th Cir. 1991) (same); *Gresham v. Azar*, 363 F. Supp. 3d 165, 177-78
16 (D.D.C. 2019) (“Despite acknowledging at several points that commenters had predicted
17 coverage loss, the agency did not engage with that possibility.”).

18 That HHS discounted all of the evidence about potential harms to patients is even more
19 remarkable and arbitrary considering the agency’s firm expectation that “as a result of this rule,
20 more individuals, having been apprised of those rights, will assert them.” 84 Fed. Reg. at 23,250.
21 If HHS is correct that the Rule will increase denials of care, then its position that the Rule does
22 not erect barriers to care that can be accounted for is contradictory. HHS’s arbitrariness is more
23 pronounced when considering that the agency recognized in a 2011 rule that the exercise of
24 provider-conscience rights “could limit access to reproductive health services and information,
25 including contraception, and could impact a wide range of medical services, including care for

26 _____
27 ² Even when presented with reliable data on certain metrics related to providers’ moral objections
28 to abortion, because the data provided a range instead of “a single measure,” HHS dismissed it
wholesale without considering the impact of any values within the range. 84 Fed. Reg. at 23,252,
n.346.

1 sexual assault victims, provision of HIV/AIDS treatment, and emergency services.” 76 Fed. Reg.
2 9968, 9974 (Feb. 23, 2011). HHS has failed provide a “reasoned explanation” for disregarding
3 these findings underlying the 2011 rule. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-
4 16 (2009).

5 Ultimately, HHS’s position seems to be that it does not matter that patients will be harmed
6 by the Rule. HHS analogized harms to patients that would result from denials of health care to the
7 costs borne by building and apartment owners having to “ensure that facilities are accessible to
8 persons with disabilities” to comply with the Fair Housing Act and the Americans with
9 Disabilities Act. 84 Fed. Reg. 23,251. But unlike patients seeking care, such landlords are not
10 innocent third parties; rather, it is their facilities and practices that created barriers for people with
11 disabilities and it is they who are obligated to comply these civil rights statutes. Further, much
12 more is at stake for patients here than mere inconvenience and expense. Being denied health care
13 can be devastating, and being denied health care for discriminatory reasons compounds that harm
14 and can result in avoidance of necessary care in the future. In turn, the minority stress associated
15 with health care denials contributes to health disparities for the LGBT population. HHS’s analogy
16 is not merely inapt; it reveals an entire lack of concern for patients denied care and betrays HHS’s
17 mission “to enhance and protect the health and well-being of all Americans.”

18 **B. HHS Improperly Inflated the Benefits of the Rule**

19 In stark contrast to its treatment of the vast evidence related to foreseeable harms to
20 patients of the Rule, HHS found no obstacle to concluding – based on scant or no data – that the
21 Rule will result in “a net increase in access to health care, improve the quality of care that patients
22 receive, and secure societal goods that extend beyond health care.” 84 Fed. Reg. at 23,246. HHS
23 came to this conclusion even though it was “not aware of a source for data on the percentages of
24 providers who have religious beliefs or moral convictions against each particular service or
25 procedure that is the subject of this rule[.]” *id.* at 23,252; even though there was “no empirical
26 data on how previous legislative or regulatory actions to protect conscience rights have affected
27 access to care or health outcomes[.]” *id.* at 23,251; and even though HHS held such a lack of data
28 against commenters concerned about the Rule’s impact on patients, *see supra* Part III.A.

1 For example, in concluding that the Rule will have a positive impact on the recruitment
2 and retention of health care professionals, HHS cited only two sources – a 2009 convenience-
3 sample survey of members of the Christian Medical Association, and a letter from the American
4 Association of Pro-Life Obstetricians and Gynecologists. *See* 84 Fed. Reg. at 23,246-47. But it
5 was arbitrary and capricious for HHS to elevate these sources over the wealth of data provided on
6 the harms the Rule stands to impose on vulnerable patients, as well as over comments from the
7 American Medical Association, among other professional associations, that the Rule “would
8 undermine patients’ access to medical care and information[.]” AMA Comment at 1. *See, e.g.,*
9 *Gen. Chem. Corp. v. United States*, 817 F.2d 844, 857 (D.C. Cir. 1987) (conclusion arbitrary and
10 capricious where supporting analysis was “internally inconsistent”).

11 Even when HHS conceded that an asserted benefit could not be quantified, it still assigned
12 that benefit a significant value – unlike its treatment of foreseeable harms to patients. *See, e.g.,* 84
13 Fed. Reg. at 23,249-50 (assigning benefits related to patient care where HHS was not “aware of
14 data that provides a basis of quantifying these effects”); *id.* at 23,250 (“It is difficult to monetize
15 the benefits of respect for conscience to the individual and society as a whole, but they are clearly
16 significant.”). HHS also made wholly unsupported assertions that should not be credited, such as:

17 Some persons, out of respect for the beliefs of providers, may want a service but not
18 take any offense, nor deem it any burden on themselves, for the provider to not
19 provide that service to them. Some patients may even value the health care
20 provider’s willingness to obey his or her conscience, because the patient feels that
21 provider can be trusted to act with integrity in other matters as well.

22 *Id.* at 23,251.

23 The scant data on which HHS relied to estimate the benefits of the Rule cannot be squared
24 with HHS’s treatment of the vast and diverse evidence of the harms caused by the Rule. HHS’s
25 dismissal of commenters’ evidence and reliance on speculative benefits reflect differing
26 evidentiary standards that alone demonstrate that the Rule is arbitrary and capricious.

27 **IV. CONCLUSION**

28 For the foregoing reasons, we urge the court to grant Plaintiffs’ Cross-Motion for
Summary Judgment, to deny Defendants’ Motion to Dismiss *or, in the alternative* Motion for
Summary Judgment, and to hold that that the Rule violates the APA.

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DATED: September 12, 2019

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APPENDIX
LIST OF AMICI CURIAE

1. **Andrew R. Flores**, Ph.D., is Assistant Professor of Government at American University and Visiting Scholar at the Williams Institute at UCLA School of Law. He is a political scientist studying public opinion and public policy on LGBTQ politics and policy. His research has appeared in numerous peer reviewed journals including the *Proceedings of the Nationals Academy of Sciences*, the *American Journal of Public Health*, *Public Opinion Quarterly*, and *Political Psychology*. He is presently on the American Political Science Association’s Committee on the Status of LGBT People in the Profession and a member of the Consensus Committee on sexual and gender diversity convened by the National Academies of Sciences, Engineering, and Medicine.

2. **Nanette Gartrell**, M.D., is a Visiting Distinguished Scholar at the Williams Institute at UCLA School of Law. She has a Guest Appointment at the University of Amsterdam, and she was formerly on the faculties of Harvard Medical School and UCSF. She is a psychiatrist, researcher, and writer whose 48 years of scientific investigations have focused primarily on sexual minority parent families. She is the principal investigator of the U.S. National Longitudinal Lesbian Family Study, which is the largest, longest running prospective investigation of American lesbian mothers and their children. She has authored numerous books, articles, and chapters. She has received numerous awards for her research and her article, “The U.S. National Longitudinal Lesbian Family Study: Psychological Adjustment of the 17- year-old Adolescents”, published in *Pediatrics*, was cited by Discover Magazine as one of the top 100 science stories of 2010. Her research has been cited internationally in litigation and legislation concerning equality in marriage, foster care, and adoption, and it contributed to the American Academy of Pediatrics’ 2013 endorsement of marriage equality.

1 3. **Shoshana K. Goldberg**, Ph.D., is Research Assistant Professor in the Department of
2 Maternal and Child Health at the Gillings School of Global Public Health at University of North
3 Carolina Chapel Hill. She specializes in LGBT health. Currently, she also is a research consultant
4 with the Williams Institute at the UCLA School of Law, where she uses federal and state data to
5 explore the impact of public policy on LGBT demography and health. In addition to co-authoring
6 numerous scientific manuscripts and policy-oriented research briefs throughout her 10 years in
7 the field, she has received training from the Fenway Institute, as well as taught an annual graduate
8 level seminar since 2016 on LGBT Population Health.

9
10 4. **Jody L. Herman**, Ph.D., is a Scholar of Public Policy at the Williams Institute at UCLA
11 School of Law. She holds a Ph.D. in Public Policy and Public Administration from The George
12 Washington University. Her research focuses on measures of gender identity in survey research
13 and the prevalence and impacts of discrimination based on gender identity or expression. At the
14 Williams Institute, her work has included the development of trans-inclusive questions for
15 population-based surveys and research on minority stress, health, and suicidality among
16 transgender people, among other topics. Before joining the Williams Institute, Dr. Herman co-
17 authored *Injustice at Every Turn*, based on the National Transgender Discrimination Survey.
18 More recently, she served as Co-Principal Investigator for the 2015 U.S. Transgender Survey. She
19 currently serves as a Co-Investigator on the U.S. Transgender Population Health Survey
20 (“TransPop”; NICHD R01HD090468; PI Ilan Meyer). She is a current awardee of the National
21 Institutes of Health Loan Repayment Program through the National Institute on Minority Health
22 and Health Disparities.

23
24 5. **Christy Mallory**, J.D., is the Director of State & Local Policy at the Williams Institute at
25 UCLA School of Law. Her research focuses on sexual orientation and gender identity non-
26 discrimination protections, laws limiting the practice of conversion therapy, laws banning the use
27 of the gay and trans panic defenses, and other state and local level policies impacting LGBT
28

1 people. Her work has been published in several media outlets, journals, and books including
2 *When Mandates Work* (UC Press, 2013), *Loyola of Los Angeles Law Review*, *LGBTQ Policy*
3 *Journal at the Harvard Kennedy School*, and *Albany Government Law Review*.

4
5 6. **Ilan H. Meyer**, Ph.D., is Distinguished Senior Scholar for Public Policy at the Williams
6 Institute at UCLA School of Law, and Professor Emeritus of Sociomedical Sciences at Columbia
7 University. He studies public health issues related to minority health, including stress and illness
8 in minority populations, in particular, the relationship of minority status, minority identity,
9 prejudice and discrimination and health outcomes in sexual minorities and the intersection of
10 minority stressors related to sexual orientation, race/ethnicity, and gender. In several highly cited
11 papers, he has developed a model of minority stress that describes the relationship of social
12 stressors and adverse health outcomes and helps to explain LGBT health disparities. The model
13 has guided his and other investigators' population research on lesbian, gay, bisexual, and
14 transgender health disparities by identifying the mechanisms by which social stressors impact
15 health and by describing the harm to LGBT people from prejudice and stigma. For this work, he
16 received the Outstanding Achievement Award from the Committee on Lesbian, Gay, Bisexual,
17 and Transgender Concerns of the American Psychological Association (APA) and Distinguished
18 Scientific Contribution award from the APA's Division 44. He has served as an expert in several
19 court cases and hearings, including *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal.
20 2010) and United States Commission on Civil Rights briefing on peer-to-peer violence and
21 bullying in K-12 public schools (2011). He has been a principal investigator for over 20 research
22 projects and is currently the principal investigator of two important NIH-funded studies: the
23 Generations, a study of stress, identity, health, and health care utilization across three cohorts of
24 lesbians, gay men, and bisexuals in the U.S.; and TransPoP, the first national probability sample
25 of transgender individuals in the U.S.

1 7. **Esther D. Rothblum**, Ph.D., is Professor of Women’s Studies at San Diego State
2 University and Visiting Distinguished Scholar at the Williams Institute at UCLA School of Law.
3 She is editor of the *Journal of Lesbian Studies*, a former president of Division 44 (Society for the
4 Psychological Study of LGBT Issues) of the American Psychological Association, and a Fellow
5 of seven divisions of APA. Her research and writing have focused on LGBT relationships and
6 mental health, focusing on using heterosexual and cisgender siblings as a comparison group.
7 Since 2001, she has compared same-sex couples in legal relationships with their heterosexual
8 married siblings. She has edited 27 books and has over 130 publications in academic journals and
9 books.

10
11 8. **Brad Sears**, J.D., is Associate Dean for Public Interest Programs and David Sanders
12 Distinguished Scholar of Law and Policy at UCLA School of Law. Sears teaches courses on
13 sexual orientation law, disability law, and U.S. legal and judicial systems. He has published a
14 number of research studies and articles, primarily on discrimination against LGBT people in the
15 workplace and HIV discrimination in health care. He has testified before Congress and a number
16 of state legislatures, authored amicus briefs in key court cases, and helped to draft state and
17 federal legislation.

18
19 9. **Luis A. Vasquez**, J.D., is the Daniel H. Renberg Law Fellow at the Williams Institute at
20 the UCLA School of Law. His work focuses on uncovering and addressing various forms of
21 discrimination against LGBT individuals and people living with HIV, with particular focus on
22 people of color, immigrants, and those targeted by criminal laws based on their LGBT or HIV-
23 positive status. For this work, he has received recognition from the Mexican American Legal
24 Defense Education Fund, the LGBT Bar Association of Los Angeles, the Beverly Hills Bar
25 Foundation, and the Mexican American Bar Foundation.

1 10. **Bianca D.M. Wilson**, Ph.D., is Senior Scholar of Public Policy at the Williams Institute at
2 UCLA School of Law and is affiliated faculty with the UCLA California Center for Population
3 Research. She earned a Ph.D. in Psychology from the Community and Prevention Research
4 program at the University of Illinois at Chicago (UIC) with a minor in Statistics, Methods, and
5 Measurement, and received postdoctoral training at the UCSF Institute for Health Policy Studies
6 through an Agency for Health Research and Quality (AHRQ) postdoctoral fellowship. Her
7 research focuses on the relationships between culture, oppression, and health, with an emphasis
8 on racial and sexual and gender minorities. Her most current work focuses on LGBT economic
9 instabilities and population research among foster youth, homeless youth, and youth in juvenile
10 custody, with a focus on sampling, data collection, and assessing disproportionality in these
11 systems.

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27 **UNITED STATES DISTRICT COURT**
28 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

No. 3:19-cv-02405-WHA

**[PROPOSED] ORDER GRANTING
MOTION FOR LEAVE TO FILE
AMICI CURIAE BRIEF BY
SCHOLARS OF THE LGBT
POPULATION**

Date: October 30, 2019
Time: 8:00 a.m.
Courtroom: Phillip Burton Federal
Building & United States Courthouse,
Courtroom 12, 19th Floor

Judge: Hon. William Alsup

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<p>STATE OF CALIFORNIA, by and through ATTORNEY GENERAL XAVIER BECERRA, <i>Plaintiff,</i> v. ALEX M. AZAR, et al., <i>Defendants.</i></p>	<p>No. 3:19-cv-02769-WHA</p>
<p>COUNTY OF SANTA CLARA, et al., <i>Plaintiffs,</i> v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., <i>Defendants.</i></p>	<p>No. 3:19-cv-02916-WHA</p>

On September 12, 2019, Scholars of the LGBT Population filed a Motion for Leave to File *Amici Curiae* Brief. Having considered the pleadings and papers connected therewith, it is hereby ORDERED that Scholars of the LGBT Population’s motion is GRANTED, and the *amici curiae* brief submitted with Scholars of the LGBT Population’s motion shall be filed.

SO ORDERED.

Dated: _____, 2019. _____
HONORABLE WILLIAM ALSUP
UNITED STATES DISTRICT JUDGE