IN THE UNITED STATES U.S. DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

MAYOR AND CITY COUNCIL OF BALTIMORE, *Plaintiff*, v. ALEX M. AZAR, et al., *Defendants*.	Civil Action No. 1:19-cv-01672-GLR

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

Pursuant to this Court's Standing Order 2018-07, 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 opposition to Defendants' Motion to Dismiss *or, in the alternative*, for Summary Judgment. Scholars' counsel conferred with the parties and they have each consented to its filing the accompanying brief.

DISTRICT COURTS HAVE BROAD DISCRETION TO PERMIT AMICUS BRIEFS

District courts have broad discretion to accept amicus briefs that may provide useful analysis. *See Am. Humanist Ass'n v. Md.-Nat'l Capital Park & Planning Comm'n*, 303 F.R.D. 266, 269 (D. Md. 2014). "The aid of amici curiae has been allowed at the trial level where they provide helpful analysis of the law, they have a special interest in the subject matter of the suit, or existing counsel is in need of assistance." *Bryant v. Better Bus. Bureau of Greater Md., Inc.*, 923 F. Supp. 720, 728 (D. Md. 1996).

MOVANTS' INTEREST

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

DESIRABILITY OF *AMICUS* BRIEF AND RELEVANCE TO DISPOSITION OF THE CASE

Scholars are especially qualified to highlight the foreseeable harms to LGBT individuals from the Final Rule, and to assess the data and evidence in the administrative record. Scholars submit their brief out of concern that the Final Rule will exacerbate the already persistent and pervasive discrimination that LGBT people experience in health care, and will exacerbate the health disparities facing the LGBT population, such as higher rates of suicide ideation and attempts, compared to non-LGBT people. Scholars, among other commenters in the rulemaking, submitted a voluminous record of evidence on these and related topics to HHS, but the agency arbitrarily and capricious discounted and disregarded this evidence in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2) (2018). Thus, Scholars' brief is desirable and relevant to the disposition of this case because *Amici* draw on their extensive expertise in the study of LGBT health to highlight and clarify the specific harms the Final Rule threatens to inflict on LGBT individuals.

The U.S. Supreme Court and other federal courts have expressly relied on the research of the Williams Institute and several of the *amici* have served as expert witnesses in cases involving the rights of LGBT individuals. *See, e.g.*, *Obergefell v. Hodges*, 135 S. Ct. 2584, 2600 (2015); *Baskin v. Bogan*, 766 F.3d 648, 663, 668 (7th Cir. 2014); *Campaign for S. Equality v. Bryant*, 64 F. Supp. 3d 906, 943 n.42 (S.D. Miss. 2014); *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 763–64 (E.D. Mich. 2014) *rev'd by Obergefell v. Hodges*, 135 S. Ct. 2584 (2015); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010).

THE WILLIAMS INSTITUTE IS NOT AFFILIATED WITH ANY PARTY

Scholars are not affiliated with any of the parties to any of the cases captioned above. No party has authored the attached brief in whole or in part, nor has any party contributed money to fund the preparation and/or submission of the brief.

CONCLUSION

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

DATED: September 12, 2019

Respectfully submitted,

/s/ Charles A. Patrizia

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CERTIFICATE OF SERVICE

I hereby certify that on September 12, 2019, I electronically filed the foregoing document with Clerk of the United States District Court for the Southern District of New York by using the CM/ECF system. I certify that the participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: September 12, 2019

Respectfully submitted,

/s/ Charles A. Patrizia

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IN THE UNITED STATES U.S. DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

MAYOR AND CITY COUNCIL OF BALTIMORE,

Plaintiff,

v.

ALEX M. AZAR, et al.,

Defendants.

Civil Action No. 1:19-cv-01672-GLR

[PROPOSED] ORDER

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 GEORGE LEVI RUSSELL, III
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES U.S. DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

MAYOR AND CITY COUNCIL OF BALTIMORE, *Plaintiff*, **v.** ALEX M. AZAR, et al., *Defendants*.	Civil Action No. 1:19-cv-01672-GLR

<u>*AMICI CURIAE* BRIEF BY SCHOLARS OF THE LGBT POPULATION</u>

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INTEREST OF AMICI CURIAE

Amici curiae are experts on the health of lesbian, gay, bisexual, and transgender ("LGBT") people. Scholars of public health, medicine, social sciences, public policy, and law, *amici* are affiliated with the Williams Institute, a research center at the UCLA School of Law dedicated to the rigorous study of sexual orientation and gender identity. *Amici* have conducted extensive research and authored numerous studies regarding LGBT people, including on the extent and effects of stigma and discrimination. *Amici* thus have a substantial interest the subject of this litigation. *See* Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (codified at 45 C.F.R. Pt. 88) (the "Rule"). The Supreme Court and other courts have expressly relied on the Williams Institute's research, and several *amici* have served as expert witnesses. *See, e.g.*, *Obergefell v. Hodges*, 135 S. Ct. 2584, 2600 (2015); *Baskin v. Bogan*, 766 F.3d 648, 663, 668 (7th Cir. 2014); *Campaign for S. Equality v. Bryant*, 64 F. Supp. 3d 906, 943 n.42 (S.D. Miss. 2014); *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 763-64 (E.D. Mich. 2014) *rev'd by Obergefell v. Hodges, 135 S. Ct. 2584 (2015)*; *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, (N.D. Cal. 2010).

SUMMARY OF ARGUMENT

Congress drafted the statutes that the Rule purports to implement (the "provider-conscience statutes") to protect religious liberty, which is a core principle of our democracy. But recognizing the importance of health care and the consequences of its denial, Congress drafted those laws narrowly. The Rule, by contrast, is expressly designed to expand the circumstances in which health care workers are authorized to deny care. Elevating religious objections to care over all other interests, the Department of Health & Human Services ("HHS") declined to include in the Rule even minimal protections for patients, such as an exception for emergency situations. As the plaintiffs in this case argue, the Rule exceeds the authority granted to HHS by

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

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

ARGUMENT

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

Amici do not believe that the provider-conscience statutes are properly applied to deny care to people based on their sexual orientation, gender identity, or other demographic characteristics. For example, these statutes do not authorize providers who provide services to non-LGBT people to deny cardiovascular or orthopedic care to an individual based on the provider's disapproval of that individual's LGBT identity. However, the preamble to the Rule is

equivocal, at best, on this point. For example, HHS dismissed concerns that the Rule would disparately impact women, LGBT people, and religious minorities, stating only "[t]he terms defined in this rule do not apply to women, LGBT persons, or religious minorities in any way that differs from how Congress applied the terms in the statutes it adopted." 84 Fed. Reg. at 23,197. HHS also rejected commenter requests that the Rule expressly state that it does not authorize denials of care based on sexual orientation and gender identity. *See, e.g.*, *id.* at 23,215, 23,205. Moreover, the breadth and vagueness of the Rule invite providers and LGBT people to believe that the Rule does authorize such denials of care. HHS was, therefore, obligated to consider the evidence of harm to LGBT people that could result from the Rule as part of its required assessment of the Rule's impact on patients. And although HHS did purport to consider this evidence as part of its cost-benefit analyses, it did so arbitrarily and capriciously. In the next Part, we summarize the evidence presented to HHS on foreseeable harms to LGBT patients of the Rule and, in Part III, show that HHS's treatment of this evidence violated the APA.

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

Vast evidence before HHS established that: (A) LGBT people experience high levels of discrimination in health care; (B) both the experience and expectation of discrimination lead to adverse health outcomes for LGBT people; and (C) anti-LGBT discrimination in health care and beyond is often religiously motivated.[1] This uncontroverted evidence indicates that the Rule, to the extent it applies or is viewed as applying to LGBT people qua LGBT people, will exacerbate discrimination, ill health, and health disparities facing this population.

[1] The sources discussed in this brief are part of the administrative record, submitted to HHS by the Williams Institute (72082) ("Williams Cmt."); American Medical Association (70564) ("AMA Cmt."); County of Santa Clara (54930) ("Santa Clara Cmt.");; Human Rights Watch (71217) ("HRW Cmt."); Human Rights Campaign (70848) ("HRC Cmt."), Lambda Legal (72186) ("Lambda Cmt."); National Center for Lesbian Rights (69074) ("NCLR Cmt."), and National Center for Transgender Equality (71274) ("NCTE Cmt."), among others.

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

LGBT people have faced a long, painful history of public and private discrimination in the United States. *See, e.g.*, *Obergefell*, 135 S. Ct. at 2596; *Baskin*, 766 F.3d at 663; *Windsor v. United States*, 699 F.3d 169, 182 (2d Cir. 2012), *aff'd*, 570 U.S. 744 (2013); *Brocksmith v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014). While social acceptance and the legal rights of LGBT people in the United States have generally improved over the past few decades (in some places more than others), ample research confirms that anti-LGBT violence, stigma, and discrimination remain widespread.

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

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

Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, & Transgender People, at* 62 (2011) (hereinafter "IOM"; cited in Williams Cmt. at 8) .

Surveys of LGBT people reveal widespread discrimination in health care. Among other findings from a recent nationally-representative survey, 8% of LGB 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 & Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care (hereinafter "Mirza & Rooney"; cited in Lambda Cmt. at 11,

13). According to another large survey, almost 56% of LGB respondents and 70% of transgender respondents reported experiencing at least one of several forms of discrimination in care. Lambda Legal, *When Health Care Isn't Caring* 5 (2014) (hereinafter "Lambda Survey"; cited in Lambda Cmt. at 10-12); *see also* James, et al., *The Report of the 2015 U.S. Transgender Survey* 97 (2016) (hereinafter "USTS"; cited in NCTE Cmt. at 4).

B. Stigma and Discrimination Adversely Impact LGBT People's Health

Health care denials can have harmful repercussions for LGBT people's health, well-being, and dignity. An individual who, or family that, is denied care must, at a minimum, experience the inconvenience and expense of seeking alternative providers. This can be especially difficult for those who live in communities where no such alternatives are available or readily available. *See, e.g.*, Mirza & Rooney (nearly a fifth of LGBT individuals reported it would be "very difficult" or "not possible" to find the same type of service at a different hospital, health center, or clinic; higher percentages of LGBT people living outside of a metropolitan area reported such difficulty or impossibility). Where delay in obtaining care has consequences for physical or mental health, those damaging repercussions could, in some cases, result in needless suffering, disability, or death. Discrimination related to sexual orientation or gender identity can also be psychologically damaging to the victim, because such discrimination carries a strong symbolic message of disapprobation of something core to that person's identity. Williams Cmt. at 9.

Beyond these immediate impacts, health care refusals can also result in LGBT people – who experience discrimination or who learn about it happening to others in the community – deferring or outright avoiding needed care in order to minimize the risk of discriminatory encounters. "Fear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care." IOM at 63. In the nationally-representative

survey cited above, "8 percent of all LGBTQ people – and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year – avoided or postponed needed medical care because of disrespect or discrimination from health care staff." Mirza & Rooney; *see also* Lambda Survey at 12-13. This chilling effect results in disparities in LGBT people's utilization of health care, such as lesbians being less likely than straight women to get preventive services for cancer, and transgender individuals facing barriers to accessing HIV prevention and care. *See* Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, & Transgender Health*, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health (last visited Sept. 3, 2019) (hereinafter "ODPHP"; cited in Williams Cmt. at 10); IOM at 222-25.

Not only do health care refusals stand to worsen LGBT people's access to and utilization of health care, they stand to exacerbate well-documented health disparities facing the LGBT population, including: disproportionately high prevalence of psychological distress, depression, anxiety, substance-use disorders, and suicidal ideation and attempts – many of which are two to three times greater among sexual and gender minorities than the non-LGBT majority. *See generally* ODPHP; IOM at 4-5; Williams Cmt. at 7-10. HHS has also recognized that LGBT youth face higher rates of homelessness and that "[e]lderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers." ODPHP; *see also* IOM at 4-5.

Substantial research identifies anti-LGBT stigma and discrimination as the drivers of health disparities between LGBT and non-LGBT populations. According to HHS itself, "[r]esearch suggests that LGBT individuals face health disparities linked to societal stigma,

discrimination, and denial of their civil and human rights" and that "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination." ODPHP. Likewise, "[c]ontemporary health disparities based on sexual orientation and gender identity are rooted in and reflect the historical stigmatization of LGBT people." IOM at 32.

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

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

discrimination are stressful even in the absence of a specific event because they are based on what the LGBT person has learned from repeated exposure to stigma. For example, when an LGBT person needs to seek a health care provider in a world where discrimination in health care settings are common experiences, that person is likely to experience stress around whether to even seek the needed health care service; whether to come out to the provider; whether to show up with a spouse that may "out" the patient; and, generally, how and from whom to disguise their LGBT identity. Thus, LGBT people become vigilant to protect themselves from mistreatment in healthcare settings. To avoid discrimination, many LGBT people will delay or altogether skip obtaining care. *See* Williams Cmt. at 7-10.

C. Anti-LGBT Discrimination is Often Religiously Motivated

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

Among those incidents are outright denials of care. For example, in 2015, a Michigan doctor refused to treat a same-sex couple's infant based on her religious views about the parents' sexual orientation. *See* Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents & There's Nothing Illegal About It*, Wash. Post (Feb. 19, 2015) (cited in Santa Clara Cmt. at 5). In *North Coast Women's Care Med. Grp., Inc. v. Super. Ct. (Benitez)*, 189 P.3d 959, 963-64 (Cal.

2008) (cited in Lambda Cmt. at 14), doctors refused on religious grounds to perform donor insemination for lesbians. Similarly, an Alabama clinic refused a lesbian couple fertility services because of the doctor's "religious belief that he only treats straight married couples." HRW at 20-21. In *Conforti v. St. Joseph's Healthcare Sys.*, No. 2:17-cv-0050 (D.N.J., Jan. 5, 2017), a transgender man was denied a medically necessary hysterectomy that his treating physician was ready to perform, because the religiously-affiliated hospital where the physician had admitting privileges did not permit gender-transition care. Lambda Cmt. at 16.

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

> "As my being transgender is a relevant piece of medical information . . . I revealed this information to [the doctor] when he entered the treatment room. His immediate response was, 'I believe the transgender lifestyle is wrong and sinful.'"

NCTE Cmt. at 10. According to another:

> "Since coming out, I have avoided seeing my primary physician because when she asked me my sexual history, I responded that I slept with women and that I was a lesbian. Her response was, 'Do you know that's against the Bible, against God?'"

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

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

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

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

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

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

The Rule is expressly designed to expand the circumstances in which health care providers can deny care, and according to HHS, "as a result of this rule, more individuals, having been apprised of those rights, will assert them[,]" 84 Fed. Reg. at 23,250. By inevitably increasing the risk and expectation that LGBT people will be denied health care – as discussed above in Part I – the Rule serves to increase incidents of discrimination and increase stress related to seeking healthcare. In turn, the Rule risks reducing the health and well-being of LGBT people and exacerbating health disparities between LGBT and non-LGBT populations. As we

next explain, HHS improperly discounted or disregarded all of the evidence summarized above, and improperly inflated the supposed benefits of the Rule.

III. HHS'S TREATMENT OF THE EVIDENCE OF HARM TO LGBT PATIENTS WAS ARBITRARY AND CAPRICIOUS

Under Executive Orders 12,866 and 13,563, HHS was required to fully analyze the costs and benefits of the Rule. As part of that analysis, HHS arbitrarily and capriciously concluded that "this final rule [will] produce a net increase in access to health care, improve the quality of care that patients receive, and secure societal goods that extend beyond health care." 84 Fed. Reg. at 23,246. HHS's calculus contained at least two "serious flaw[s] that . . . render the rule unreasonable[,]" *Nat'l Ass'n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012). HHS, first, failed to reasonably assess the costs of the Rule in terms of harms to patients (LGBT or otherwise) and, second, unreasonably relied on speculative benefits of the Rule. Moreover, HHS applied inconsistent evidentiary standards that allowed the agency to dismiss foreseeable harms while relying on speculative benefits. Because HHS "inconsistently and opportunistically framed" the Rule's effects, among other flaws, the Rule violates the APA. *Bus. Roundtable v. SEC*, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011); *see also Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1198 (9th Cir. 2008) (agency "cannot put a thumb on the scale by undervaluing the benefits and overvaluing the costs . . . .").

A. HHS Improperly Disregarded Evidence of Foreseeable Harm to Patients

The preamble to the Rule acknowledges that "[d]ifferent types of harm can result from denial of a particular procedure based on an exercise of [a religious] belief or [moral] conviction." 84 Fed. Reg. at 23,251. But HHS incorrectly concluded that "three [of these] potential harms . . . would also be applicable for denials of care based on, for example, inability to pay the requested amount." *Id.* This conclusion is flatly contrary to the minority stress

research provided to HHS and discussed above: denials of care based on one's sexual orientation or gender identity are uniquely harmful. HHS seems to acknowledge this, in part, when it concedes two other potential harms that would *not* occur for someone who is unable to pay. *Id.*

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

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

More importantly, HHS's requirement that commenters prove a *causal* relationship between the Rule and harm to LGBT people is an impossible standard because the Rule was not finalized at the time commenters made their submissions. Moreover, if sufficient evidence was not available, HHS should have followed White House guidance to conduct "additional research

prior to rulemaking" to address significant uncertainties about net benefits, because "[t]he costs of being wrong may outweigh the benefits of a faster decision." Office of Mgmt. & Budget, Exec. Office of the President, Circular A-4 at 39 (Sept. 17, 2003).

In an ideal world with ideal data, we would be able to "isolat[e] the impact of the exercises of religious belief or moral conviction attributable to this rule specifically, over and above whatever impact is attributable to the pre-existing base rate of exercise of religious belief or moral conviction." 84 Fed. Reg. at 23,251. Absent ideal data, however, HHS was not relieved of its obligation to fully and fairly consider the evidence before it – evidence establishing that the Rule will lead to an increase in denials of care to all types of patients, and that the Rule risks exacerbating the discrimination in health care and health disparities facing LGBT people. *See supra* Part II. Indeed, HHS cannot disregard costs that are uncertain or difficult to quantify.[2]

That HHS discounted all of the evidence about potential harms to patients is even more arbitrary considering the agency's firm expectation that "more individuals, having been apprised of th[eir] rights, will assert them." 84 Fed. Reg. at 23,250. If HHS is correct that the Rule will increase denials of care, then its position that the Rule does not erect barriers to care that can be accounted for is contradictory. HHS's arbitrariness is more pronounced when considering that is failed to explain why it disregarded its prior finding in a 2011 rule that the exercise of provider-conscience rights could harm patients. *See* 76 Fed. Reg. 9968, 9974 (Feb. 23, 2011).

Ultimately, HHS's position seems to be that it does not matter that patients will be harmed by the Rule. HHS analogized harms to patients that would result from denials of health

[2] *See, e.g.*, *Motor Vehicle Mfrs. Ass'n of U.S., Inc., v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) ("Normally, an agency rule would be arbitrary and capricious if the agency . . . offered an explanation for its decision that runs counter to the evidence before the agency[.]"); *Ctr. for Biological Diversity*, 538 F.3d at 1190, 1200 (arbitrary and capricious to exclude from a cost-benefit analysis benefits that the agency deemed "too uncertain to support their explicit valuation"); *Gresham v. Azar*, 363 F. Supp. 3d 165, 177-78 (D.D.C. 2019) (agency acknowledge but failed to meaningful grapple with losses predicted by commenters).

care to the costs borne by building and apartment owners having to "ensure that facilities are accessible to persons with disabilities" to comply with civil rights laws. 84 Fed. Reg. 23,251. But unlike patients seeking care, such owners are not innocent third parties; rather, it is their facilities and practices that created barriers for people with disabilities and it is they who are obligated to comply with civil rights statutes. Further, much more is at stake for patients here than mere inconvenience and expense. Being denied health care for discriminatory reasons compounds the harm and can result in avoidance of necessary care. In turn, the minority stress associated with health care denials contributes to health disparities for the LGBT population. HHS's analogy is not merely inapt; it reveals an entire lack of concern for patients denied care and betrays HHS's mission "to enhance and protect the health and well-being of all Americans."

B. HHS Improperly Inflated the Benefits of the Rule

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

For example, in concluding that the Rule will have a positive impact on the recruitment and retention of health care professionals, HHS cited only two sources – a 2009 convenience-sample survey of members of the Christian Medical Association, and a letter from the American

Association of Pro-Life Obstetricians and Gynecologists. *See* 84 Fed. Reg. at 23,246-47. But it was arbitrary and capricious for HHS to elevate these sources over the wealth of data provided on the harms the Rule stands to impose on vulnerable patients, as well as over comments from the American Medical Association, among other professional associations, that the Rule "would undermine patients' access to medical care and information[.]" AMA Cmt. at 1. *See, e.g.*, *Gen. Chem. Corp. v. United States*, 817 F.2d 844, 857 (D.C. Cir. 1987) (conclusion arbitrary and capricious where supporting analysis was "internally inconsistent").

Even when HHS conceded that an asserted benefit could not be quantified, it still assigned that benefit a significant value – unlike its treatment of foreseeable harms to patients. *See, e.g.*, 84 Fed. Reg. at 23,249-50 (assigning benefits related to patient care where HHS was not "aware of data that provides a basis of quantifying these effects"); *id.* at 23,250 ("It is difficult to monetize the benefits of respect for conscience to the individual and society as a whole, but they are clearly significant."). HHS also made wholly unsupported assertions that should not be credited, such as some persons would not "take offense" or be "burden[ed] by – and may even "value" – a denial of service. *See id.* at 23,251, col. 2.

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

IV. CONCLUSION

For the foregoing reasons, we urge the court to grant Plaintiff's Motion for Summary Judgment, to hold that the Rule violates the APA, and to deny Defendants' Motion to Dismiss *or, in the alternative*, for Summary Judgment.

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Respectfully submitted,

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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.

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

4. **Jody L. Herman**, Ph.D., is a Scholar of Public Policy at the Williams Institute at UCLA School of Law. She holds a Ph.D. in Public Policy and Public Administration from The George Washington University. Her research focuses on measures of gender identity in survey research and the prevalence and impacts of discrimination based on gender identity or expression. At the Williams Institute, her work has included the development of trans-inclusive questions for population-based surveys and research on minority stress, health, and suicidality among transgender people, among other topics. Before joining the Williams Institute, Dr. Herman co-authored *Injustice at Every Turn*, based on the National Transgender Discrimination Survey. More recently, she served as Co-Principal Investigator for the 2015 U.S. Transgender Survey.

She currently serves as a Co-Investigator on the U.S. Transgender Population Health Survey ("TransPop"; NICHD R01HD090468; PI Ilan Meyer). She is a current awardee of the National Institutes of Health Loan Repayment Program through the National Institute on Minority Health and Health Disparities.

5. **Christy Mallory**, J.D., is the Director of State & Local Policy at the Williams Institute at UCLA School of Law. Her research focuses on sexual orientation and gender identity non-discrimination protections, laws limiting the practice of conversion therapy, laws banning the use of the gay and trans panic defenses, and other state and local level policies impacting LGBT people. Her work has been published in several media outlets, journals, and books including *When Mandates Work* (UC Press, 2013), *Loyola of Los Angeles Law Review*, *LGBTQ Policy Journal at the Harvard Kennedy School*, and *Albany Government Law Review*.

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

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

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

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

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