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Attorneys for Scholars of the
LGBT Population

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, vs. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	Case No. 2:19-cv-00183-SAB MOTION FOR LEAVE TO FILE *AMICI CURIAE* BRIEF BY SCHOLARS OF THE LGBT POPULATION IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT November 7, 2019 With Oral Argument: 10:00 a.m.

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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 Plaintiff's Motion for Summary Judgment and in opposition to Defendants' Motion for Summary Judgment. Scholars' counsel conferred with the parties and they have each consented to its filing the accompanying brief.

I. DISTRICT HAVE DISCRETION TO PERMIT AMICUS BRIEFS

District courts have broad discretion to grant motions for leave to appear as amicus curiae. *See Hoptowit v. Ray*, 682 F.2d 1237, 1260 (9th Cir. 1982), *abrogated on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995); *accord Cmty. Ass'n for Restoration of the Env't. v. Cow Palace, LLC*, No. 13-CV-3016-TOR, 2015 WL 12868223, at *1 (E.D. Wash. Jan. 14, 2015). "An amicus brief should normally be allowed . . . when the amicus has unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide." *Cmty. Ass'n for Restoration of the Env't v. DeRuyter Bros. Dairy*, 54 F. Supp. 2d 974, 975 (E.D. Wash. 1999) (citing *Northern Sec. Co. v. United States*, 191 U.S. 555, 556, 24 S. Ct. 119 (1903). To "fulfill [its] role" an amicus curiae brief should "supplement and assist in cases of general public interest, supplement the efforts of counsel, and draw the court's attention to law that might otherwise escape consideration." *Id.* at 975 (citing *Miller-Wohl Co. v. Commissioner of*

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Labor & Indus., 694 F.2d 203, 204 (9th Cir. 1982)). Scholars of the LGBT Population's brief satisfies these criteria.

II. 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").

III. RELEVANCE OF SCHOLARS' AMICI CURIAE BRIEF

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,

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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).

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); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, passim (N.D. Cal. 2010).

IV. SCHOLARS AND THE WILLIAMS INSTITUTE ARE 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.

V. CONCLUSION

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

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DATED this 20th day of September, 2019.

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CERTIFICATE OF SERVICE

I, Nancy L. Isserlis, hereby certify that on the 20th day of September, 2019, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

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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

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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 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

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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 23,205, 23,215.

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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 in an arbitrary and capricious manner. 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 rejection and 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

[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)

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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.

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, which operates under a congressional charter and provides 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

("HRC Cmt."), Lambda Legal (72186) ("Lambda Cmt."); National Center for Lesbian Rights (69074) ("NCLR Cmt."); and National Center for Transgender Equality (71274) ("NCTE Cmt."). The above sources are attached hereto for the Court's convenience.

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> 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. In 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) (hereinafter "Mirza & Rooney"; cited in Lambda Cmt. at 11, 13). According to another 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 or family denied care must, at a minimum,

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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 provider; 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

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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. *See* Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, & Transgender Health* (hereinafter "ODPHP"; cited in Williams Cmt. at 10); IOM at 22-25.

Not only do health care refusals stand to worsen LGBT people's 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

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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)

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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 rejection and 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 in order 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

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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) (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. In *Conforti v. St. Joseph's Healthcare Sys.*, No. 2:17-cv-0050 (D.N.J., Jan. 5, 2017) (cited in Lambda Cmt. at 16), 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.

In addition to outright denials of care, anti-LGBT proselytizing and harassment is common in health care settings. According to the more than 13,000 comments and stories

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that the Human Rights Campaign 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 learned] that I slept with women and that I was a lesbian[, h]er 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 . . . 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."

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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 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

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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. Exec. Order No. 12,866 §§ 6-7, 58 Fed. Reg. 51,735 (Sept. 30, 1993); Exec. Order No. 13,563 § 1(c), 76 Fed. Reg. 3821 (Jan. 18, 2011). 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 an inconsistent evidentiary standards that allowed the agency to dismiss foreseeable harms while relying on speculative benefits. Because HHS

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"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. HHS brushed this evidence aside because "comment[ers] [did not] establish[] a causal relationship between this rule and how it would affect health care access, and [did not]

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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." 76 Fed. Reg. 3821, Exec. Order No. 13,563 § 1(c); *see also* 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 and has yet to go into effect. 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).

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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 such ideal circumstances, 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.[1]

That HHS discounted all of the evidence about potential harms to patients is even more arbitrary considering the agency's firm expectation that "as a result of this rule,

[1] *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 (excluding benefits agency deemed "too uncertain to support their explicit valuation" from cost-benefit analysis was arbitrary and capricious); *Gresham v. Azar*, 363 F. Supp. 3d 165, 177-78 (D.D.C. 2019) (agency failed to meaningfully grapple with losses commenters predicted).

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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 it 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 resulting from denials of health care to the costs borne by building and apartment owners having to "ensure that facilities are accessible to persons with disabilities" to comply with the civil rights laws. 84 Fed. Reg. 23,251. But unlike patients seeking care, such landlords are not innocent third parties; rather, it is their facilities and practices, even if unwittingly, that created barriers for people with disabilities and it is they who are obligated to comply with these civil rights statutes. Further, much more is at stake for patients here than mere inconvenience and expense. Being denied health care can be devastating, and being denied health care for discriminatory reasons compounds that harm and can result in avoidance of necessary care in the future. In turn, the minority stress associated with health care denials contributes to health disparities for the LGBT population. HHS's analogy is not merely

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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 vast 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 a pro-life medical association. *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

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provided on the harms the Rule stands to impose, 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) (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 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.

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

IV. CONCLUSION

We urge the court to hold that the Rule violates the APA.

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DATED this 20th day of September, 2019.

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CERTIFICATE OF SERVICE

I, Nancy L. Isserlis, hereby certify that on the 20th day of September, 2019, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following:

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APPENDIX

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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,

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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.

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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

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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)

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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.

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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.

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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.

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Williams Cmt.

The Williams Institute
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March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, D.C. 20201
Submitted through the Federal eRulemaking portal

RE: DEPARTMENT OF HEALTH AND HUMAN SERVICES; Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (83 Fed. Reg. 3800–3931) (**Docket: HHS-OCR-2018-00002**)

To Whom It May Concern:

Thank you for the opportunity to comment on the Notice of Proposed Rulemaking of the Office for Civil Rights ("OCR") of the U.S. Department of Health and Human Services ("HHS"), titled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority" ("Proposed Rule"). The undersigned are scholars at the Williams Institute, an academic research center at UCLA School of Law dedicated to conducting rigorous and independent research on sexual orientation and gender identity, including on health disparities and discrimination facing lesbian, gay, bisexual, and transgender (LGBT) people.

The mission of HHS and OCR is to protect and enhance the health and well-being of all Americans and eliminate discrimination in health care and health coverage. Indeed, the civil rights laws that OCR is charged with enforcing – including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act – require that health care entities avoid discriminating based on race, national origin, disability, age, and sex as a condition of their receipt of federal funds.

But that mission is undermined, and those civil rights laws potentially violated, if OCR authorizes refusals of care that go beyond the narrow terms permitted in the provider-conscience statutes. The Proposed Rule risks these consequences in numerous respects, as we explain below with respect to the Church, Coats-Snowe, and Weldon Amendments. We recognize that Congress drafted the provider-conscience laws to protect religious liberty, which is a core principle of our democracy, but drafted these laws narrowly in light of the importance of health care. As a result, any Final Rule and OCR's enforcement of it must strictly comply with the narrow refusals of care that Congress has authorized, and should minimize unauthorized denials of care or other barriers to care any Final Rule encourages.

In addition, because at least some, if not all, anti-LGBT prejudice in society (including discrimination in the provision of health care) is associated with some religious or faith-based beliefs, OCR must consider – including as part of a Regulatory Impact Analysis – how the Proposed Rule and any Final Rule will increase barriers for LGBT and other people to fully access vital programs, services, and activities, and will adversely impact the health and well-being of the LGBT population and other vulnerable populations in the United States.

I. To Pass Legal Muster, Any Final Rule Must Conform to the Underlying Statutes and be Consistent with the Mission of HHS and the Various Civil Rights Laws that OCR Enforces.

In the Church, Coats-Snowe, and Weldon Amendments, Congress insulated certain medical providers from being required – or being discriminated against for refusing – to perform abortions and certain specific other services that may violate their religious or moral beliefs. Each of these statutes was carefully and narrowly drafted, and each is different; as a result, each must be read separately and applied in careful compliance with Congressional intent. For the purposes of this comment, we accept the provider-conscience laws as written.

For example, the Weldon Amendment prohibits certain federal funding to federal, state, and local agencies and programs that "subject[] any institutional or individual health care entity to discrimination [for refusing to] provide, pay for, provide coverage for, or refer for abortions."[1] The Coats-Snowe Amendment prohibits the federal government, as well as state and local governments receiving federal funding, from discriminating against a "health care entity" that "refuses to undergo training in the performance of induced abortion, to require or provide such training, to perform such abortion, or to provide referrals for such training or such abortions,"[2] and certain other similar activities.[3] Neither the Weldon Amendment nor the Coats-Snowe Amendment mention on its face religious beliefs. However, OCR has determined that Congress intended the Weldon Amendment to apply only to health care entities that have objections to abortion based on religious or moral grounds; this limitation is necessary to comport the statute with clear Congressional intent.[4] Legislative history on the Coats-Snowe Amendment indicates it, too, should have such a limitation.[5]

In addition, the Church Amendments are largely focused on religious or moral objections to abortion and sterilization. The Church Amendments protect individual and entity recipients of "any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Services and Facilities Construction Act" from being required by "any court or any public official or other public

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[1] *See, e.g.*, *Consolidated Appropriations Act, 2018*, H.R. 1625, 115th Cong. § 507(d) (2018).

[2] 42 U.S.C. § 238n(a)(1).

[3] *Id.* §§ 238n(a)(2), (a)(3), (b).

[4] *See* U.S. Dep't of Health and Human Services, Opinion Letter from Office of Civil Rights Director re: OCR Transaction Numbers: 14-193604, 15-193782, & 15-195665, at 3-4 (June 21, 2016) (on file with agency); *see also* 83 Fed. Reg. 3886 (citing Letter from OCR Director to Complainants (June 21, 2016)).

[5] *See, e.g.*, 142 Cong. Rec. S2268-2276 (daily ed. Mar. 19, 1996) (statements of Senators Snowe, Coats, Boxer, Kennedy, Feinstein).

authority" to "perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions,"[6] among certain other similar protections related to abortion and sterilization.[7]

Thus, the primary purpose of the provider-conscience laws was to insulate certain providers from certain obligations related to abortion and, in the case of the Church Amendments, sterilization. Only the Church Amendments in any way go further. Subsection (d) of the Church Amendments provides that "[n]o individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[8] By its terms, this protection applies only to individuals, not entities such as hospitals. And unlike the Weldon and Coats-Snowe Amendments, only the Church Amendments explicitly allow providers to deny medical care based on "moral convictions."[9]

The limitations in the language and application of the statutes reflect Congress's intent to carefully circumscribe the occasions on which providers are authorized to refuse medical care. This is because it is clear that denials of care, even when based on religious or moral beliefs, impose harms on patients, undermine the mission of HHS to protect the health and well-being of all Americans, and can violate the terms of fundamental civil rights protection. Any Final Rule must strictly conform to these statutes and must make clear the limited circumstances in which each statute applies.

Any Final Rule must also make clear that the Weldon, Coats-Snowe, and Church Amendments are not absolute and are to be applied consistent with the obligations placed on health care entities by other laws. For example, nothing in the provider-conscience laws exempts hospitals from the requirement to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires all Medicaid- and Medicare-funded hospitals with an emergency department to screen, stabilize, and at times transfer patients with emergency medical concerns.[10] Not only does EMTALA not contain an exemption for religious or moral beliefs,[11]

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[6] 42 U.S.C. § 300a-7(b)(1).

[7] *Id.* § 300a-7(b)(2)-(c)

[8] *Id.* § 300a-7(d).

[9] *Id.* § 300a-7.

[10] 42 U.S.C. § 1395dd.

[11] *See id.*; *see also* U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid, *Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions*, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf; *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008) ("[I]t is far from clear whether the Weldon Amendment would prohibit California from enforcing its own version of the EMTALA in medical emergencies [which does exempt health care workers with religious objections to abortion from assisting in emergency or spontaneous abortions]."); *see generally In the matter of Baby "K"*, 16 F.3d 590, 598 (4th Cir. 1994) ("Congress rejected a case-by-case approach to determining what emergency medical treatment hospitals and physicians must provide and to whom they must provide it; instead, it required hospitals and physicians to provide stabilizing care to any individual

EMTALA was directed at stopping patient dumping by limiting hospitals' ability to refuse patients.[12]

Any Final Rule must not only conform to the underlying statutes and be construed consistently with other statutory obligations on health care providers, but must also adhere to HHS's mission "to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."[13] Likewise, one of the primary purposes of the Patient Protection and Affordable Care Act ("ACA") was to expand access to health care and health coverage.[14] And the ACA has, in fact, expanded health insurance coverage in the United States, including among LGBT people.[15] Any Final Rule should be consistent with this purpose of the ACA, as well.

Moreover, in some circumstances, religiously-motivated denials of care risk violating the core civil rights laws that OCR is charged with enforcing. In fact, in support of HHS's mission, OCR was established in response to a need to remove discriminatory barriers to HHS-funded programs.[16] Since its creation, OCR has been instrumental in enhancing access to health care and health coverage by enforcing civil rights laws that bar discrimination on the basis of race, color, national origin, disability, age, or sex in health care activities and programs that HHS conducts or funds.[17] Indeed, OCR's most recent civil rights statute, Section 1557, was passed as part of the ACA because Congress recognized that discriminatory barriers to health care and

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presenting an emergency medical condition."); *Bryan v. Rectors and Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) (holding, once stabilizing treatment has been provided for a patient who arrives with an emergency condition, "the patient's care becomes the legal responsibility of the hospital and the treating physicians" and is no longer governed by EMTALA).

[12] *See, e.g.*, G. Smith, II, The Elderly and Patient Dumping, Fla. B.J. 85 (Oct. 1999) ("Before COBRA and EMTALA limited a hospital's right to refuse medical treatment to patients, the common law's no-duty rule was restricted only by four exceptions: 1) once a hospital provides medical care, it must do so nonnegligently; 2) once a person gains "patient" status, the caregiver must aid and protect that patient; 3) where a person relies upon a caregiver's custom of providing emergency care, a duty to provide that care exists; and 4) true "emergency" cases obviate the no-duty rule.").

[13] U.S. Dep't of Health and Human Services, *Introduction: About HHS*, https://www.hhs.gov/about/strategic-plan/introduction/index.html.

[14] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); *see also* U.S. Dep't of Health and Human Services, Office for Civil Rights, *Nondiscrimination in Health Programs and Activities; Final Rule*, 81 Fed. Reg. 31376, 31444 ("One of the central aims of the ACA is to expand access to health care and health coverage for all individuals.").

[15] *See, e.g.*, M. Karpman et al., *QuickTake: Uninsurance Rate Nearly Halved for Lesbian, Gay, and Bisexual Adults since Mid-2013*, Health Reform Monitoring Survey (April 2015), http://hrms.urban.org/quicktakes/Uninsurance-Rate-Nearly-Halved-for-Lesbian-Gay-and-Bisexual-Adults-since-Mid-2013.html; G. Gonzales et al., *The Affordable Care Act and Health Insurance Coverage for Lesbian, Gay, and Bisexual Adults: Analysis of the Behavioral Risk Factor Surveillance System*, LGBT HEALTH 62-67 (2017).

[16] *See, e.g.*, U.S. Commission on Civil Rights, *Funding Federal Civil Rights Enforcement: 2000 and Beyond*, http://www.usccr.gov/pubs/crfund01/ch5.htm.

[17] *See* U.S. Dep't of Health and Human Services, *Office for Civil Rights (OCR)*, https://www.hhs.gov/ocr/index.html; U.S. Office of Health and Human Services, *Summaries of select case activities*, https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/index.html.

coverage remained and wanted to provide additional tools to limit discrimination against vulnerable communities.[18]

Thus, any Final Rule must protect OCR's ability to fully enforce the civil rights laws within its jurisdiction. For example, there is nothing in the provider-conscience laws that we believe would authorize providers to offer abortion services to Caucasian women but deny them to women of color, even were the providers to claim that doing so was consistent with religious belief. The Final Rule cannot impinge on basic civil rights protections.

For all of these reasons, the Final Rule must, at a minimum:

- **Make clear that the authorizations under subsection (d) of the Church Amendments apply only to individuals and not to health care entities**, as required by the plain language of the statute.

- **Make clear that the authorizations under subsections (b) and (c) of the Church Amendments apply only to abortion and sterilization in the limited circumstances provided for in the statute, and that these protections only apply where there are religious or moral objections**, as required by the plain language of the statute.

- **Make clear that the protections of the Coats-Snowe and Weldon Amendments apply only to particular abortion services in the limited circumstances provided for in the statutes,** as required by the plain language of the statutes, **and that these protections only apply where there are religious or moral objections** in order to be consistent with Congressional intent.

- **Identify when "moral" objections, as distinct from religious objections, will permit a provider to deny care, and define the limits of those objections.**

- **Make clear that these provider-conscience laws apply only to specific services and procedures, but nothing in the laws authorizes a denial of care based on the provider's rejection of persons because of their demographic characteristics or identity or status.** For example, any Final Rule should make clear that providers cannot deny cardiac care or setting of a broken leg to an individual based on the provider's disapproval or rejection of that individual's LGBT identity or status, if they provide these services to persons who are not LGBT, whatever the provider's religious or moral views are about that individual's LGBT status.

- **Ensure that definitions do not go beyond the meanings authorized under the relevant statute.** The Proposed Rule appears to broaden the definitions of several keys words in the provider-conscience laws, and any Final Rule should adhere to the narrower definitions found in the statutes.

[18] *See* U.S. Dep't of Health and Human Services, *Section 1557 of the Patient Protection and Affordable Care Act*, https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

- **Make clear that nothing in the rule authorizes hospitals or other providers to refuse care when EMTALA or other applicable law or duty of care requires them to provide it.**

- **Make clear that in its enforcement, OCR will balance the harm to patients from denials of medical care with the religious liberty interests of the provider denying the care.** As noted above, provisions of provider-conscience laws are not absolute. Balancing is necessary not only because health care is so critical, but also to avoid constructions of the laws that would violate the Establishment Clause.[19] Balancing would also be consistent with federal laws that weigh statutory religious liberty protections against other state interests.[20] Such balancing should take into account all relevant factors in a particular case, which may include the medical necessity of the service or procedure, the availability of alternative providers within the reasonable distance, and whether delay in care risks significant harm to the patient.

As a result of these points, it is clear that any Final Rule can permissibly have only limited, if any, impact on health care for LGBT individuals. There is nothing in the underlying statutes that would permit, *for example*, a cardiologist to deny cardiac care based on a patient's sexual orientation or gender identity. Similarly, whatever protections may attach to an individual health professional, there is nothing in the underlying statutes that would authorize a hospital or other institution to, *for example*, deny fertility treatment to same-sex couples, HIV treatment or prevention treatment to gay or bisexual men, or hormones for gender transition to a transgender patient.

Failure to clarify these points in any Final Rule risks impermissibly encouraging providers to deny care beyond the limited circumstances authorized by Congress, violating HHS and OCR's mission of enhancing health and well-being, and impermissibly elevating provider-conscience laws above the civil rights laws OCR enforces. Indeed, as currently drafted, the rule may improperly signal to providers that religious beliefs should be prioritized over medical standards or the health and care of patients, and could lead people to avoid seeking care as to which there can be no right to deny service just for fear of being turned away – all of which risk exacerbating barriers to care that vulnerable populations experience, as we discuss below.

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[19] U.S. CONST. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 714, 720 (2005) ("At some point, accommodation may devolve into an unlawful fostering of religion. . . . [Therefore, courts] must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries." (internal quotation marks and citations omitted)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).

[20] *See, e.g., Shelton v. University of Med. and Dentistry of N.J.*, 223 F.3d 220 (3d Cir. 2000) (holding, under Title II of the Civil Rights Act, hospital offered reasonable accommodation to transfer a nurse to a different unit when she refused on religious grounds to treat emergencies that she believed would result in abortions); Religious Freedom Restoration Act, 42 U.S.C. § 2000bb (1993) (establishing the federal government is permitted to substantially burden a person's exercise of religion in furtherance of a compelling government interest that is advanced in the least restrictive manner).

II. Any Final Rule Must Conform to the Underlying Statutes to Avoid Significant Harm to the Health and Well-Being of Vulnerable Populations; OCR Must Consider the Costs Related to Potential Harm to LGBT and Other Patients of the Proposed Rule, Including as Part of a Regulatory Impact Analysis

Under Executive Orders 12866 and 13563, OCR must conduct a Regulatory Impact Analysis ("RIA") that "analyzes the benefits, costs, and other impacts of" the Proposed Rule and any Final Rule.[21] A RIA is required here because the Proposed Rule and any Final Rule is likely to "impose costs, benefits, or transfers of $100 million or more in any given year"[22] and because the rule is significant for other reasons, as well.[23] As part of its RIA, OCR must consider the costs in terms of harm to patients that denials of health care and other barriers to care the Proposed Rule and any Final Rule are likely to cause.[24] Even if a RIA is not required, OCR should still consider these harms and make every effort to minimize them consistent with HHS's mission and the civil rights laws OCR enforces.

Denials of health care can result in several categories of harm, including:

- to the patient's physical and mental health when necessary medical services to treat particular medical conditions are denied;

- to the patient's health and well-being because refusals of service, independent of the underlying medical condition, result in dignitary harm to the individual; and

- to the community of which the patient is a member and the ability and willingness of others in that community to seek medical care.

Below we discuss these harms with respect to the LGBT population, which has been subject to persistent and pervasive stigma and discrimination and which, as a result, faces numerous health disparities. Because at least some anti-LGBT stigma and discrimination in society stems from or is otherwise related to certain religious or faith-based beliefs – regardless of moral intent – the Proposed Rule risks encouraging or excusing denials of care and other forms of discrimination against LGBT people in the health care context. Any Final Rule that does not strictly comply with the narrow circumstances permitted for denials of care in the underlying provider-conscience laws and does not minimize the potential for unauthorized denials of care risks

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[21] U.S. Dep't of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Guidelines for Regulatory Impact Analysis* 1 (2016), https://aspe.hhs.gov/system/files/pdf/242926/HHS_RIAGuidance.pdf, [hereinafter *HHS Guidelines for Regulatory Impact Analysis*].

[22] Exec. Order No. 12866, §§ 1(a), 3(f)(1); *HHS Guidelines for Regulatory Impact Analysis* at 2-3.

[23] *HHS Guidelines for Regulatory Impact Analysis*,at 3.

[24] Exec. Order No. 12866 § 1(a), 58 Fed. Reg. 51735 (Oct. 4, 1993); Exec. Order No. 13563 §§ 1(b), 1(c), 76 Fed. Reg. 3821 (Jan. 21, 2011) ("In applying these [regulatory impact and review] principles, each agency is directed to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible. Where appropriate and permitted by law, each agency must consider (and discuss qualitatively) values that are difficult or impossible to quantify, *including equity, human dignity, fairness, and distributive impacts*." (emphasis added)).

impermissibly perpetuating these harms in violation of HHS's and OCR's mission, the purpose of the ACA, and laws that prohibit race, sex, and other forms of discrimination in health care.

Despite recent advances in the legal and social acceptance of LGBT people, research finds that LGBT people continue to experience persistent and pervasive discrimination as well as widespread stigma, prejudice, and violence.[25] The existence of this discrimination and stigma in health care, as well as other barriers to care and well-being for LGBT people, is well-documented.[26] According to the Institute of Medicine, "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."[27]

Denials of, or other forms of discrimination in, health care have repercussions for an LGBT people's dignity, health, and well-being. As is explained in detail in the attached amici brief that scholars, including the undersigned, recently filed with the U.S. Supreme Court in *Masterpiece Cakeshop v. Colorado Human Rights Commission*,[28] refusals of service based on

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[25] *See e.g.*, INSTITUTE OF MEDICINE, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING, 5, 13 (2011); Ilan H. Meyer, The Elusive Promise of LGBT Equality, 106:8 AM. J. PUB. HEALTH 1356 (2016).

[26] *See, e.g.*, INSTITUTE OF MEDICINE, *supra*, at 212-14 (discussing evidence of stigma, discrimination, and violence against LGBT people because of their sexual orientation or gender identities), Ilan H. Meyer et al., Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014, 107 AM. J. PUB. HEALTH 582 (2017). LGBT people can face discrimination and stigma in a wide variety of settings and from many sources in addition to health care, such as employment, housing, and family life. *See, e.g.*, Jennifer Pizer et al., Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People: The Need for Federal Legislation Prohibiting Discrimination and Providing Equal Employment Benefits, 45 LOY. L.A. L. REV. 715, 720-42 (2012). In turn, such discrimination can have negative consequences for the health and well-being of LGBT individuals. *See, e.g.*, INSTITUTE OF MEDICINE, *supra*, at 734-42 (discussing research documenting that workplace discrimination negatively affects the income and health of LGBT people). Moreover, contrary to popular stereotypes about the affluence of the LGBT community, research demonstrates the economic diversity of LGBT people, including higher rates of poverty and food insecurity for LGBT people nationally compared to non-LGBT people. *See, e.g.*, M.V. Lee Badgett et al., Williams Institute, *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community* (2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf; Taylor N.T. Brown et al., Williams Institute, *Food Insecurity and SNAP Participation in the LGBT Community* (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-and-SNAP-Participation-in-the-LGBT-Community.pdf; Gary J. Gates & Frank Newport, Gallup, *Special Report: 3.4% of U.S. Adults Identify as LGBT* (2013), http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx; Sandy E. James et al., *The Report of the U.S. Transgender Survey* (2016), www.ustranssurvey.org/report. Given poverty, homelessness, and other evidence of economic and social vulnerability among LGBT people—including in child welfare contexts—it is crucial that HHS ensure not only that health programs and activities but also the various human services it funds and regulates are available to all in a non-discriminatory manner.

[27] INSTITUTE OF MEDICINE, *supra*, at 62.

[28] Amici Brief of Ilan H. Meyer, PhD, and Other Social Scientists and Legal Scholars Who Study the LGB Population in Support of Respondents, *Masterpiece Cakeshop Ltd. v. Colorado Human Rights Commission*, No. 16-111 (filed Oct. 30, 2017), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Williams-Masterpiece-Cakeshop-Amici-Brief.pdf.

sexual orientation or gender identity are "minority stressors" that can profoundly harm the health and well-being of LGBT people who are directly subject to these refusals of service.

When a health care provider denies care or provides lesser care to a LGBT person because of their sexual orientation or gender identity – regardless of the intent behind the discrimination – it is a prejudice event, a type of minority stress, which has both tangible and symbolic impacts on the LGBT patient. If a provider denies care to an individual patient, that denial creates harmful repercussions for the patient: An individual who is denied care must, at a minimum, experience the inconvenience of seeking alternative providers for the service. This can be especially critical for individuals who live in communities where no such alternatives are available or where reaching an alternative care provider can only be done with great cost and effort. Where delay in obtaining care has consequences for physical or mental health, those damaging repercussions are further exacerbated and could, in emergency cases, result in disability or death.

Prejudice events, such as health care denials, also carry a strong symbolic message of disapprobation. This symbolic message makes a prejudice event more damaging to the victim's psychological health than a similar event not motivated by prejudice. Research also indicates that "[f]ear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care."[29] Such expectations of discrimination generate a state of extra vigilance in LGBT people that is also stressful and could lead to people not finding care when it is needed.

Stress related to being part of a group that is systematically stigmatized and discriminated against, due to religious or cultural belief systems, affects overall health, which HHS has recognized with respect to LGBT people. For example, in stating that the LGBT population requires special public-health attention, HHS explained that "[p]ersonal, family and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals."[30] Indeed, according to HHS, "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination."[31] Similarly, the Centers for Disease Control and Prevention ("CDC") reports that homophobia, stigma, and discrimination can negatively affect the physical and mental health of gay and bisexual men, as well as the quality of the healthcare they receive.[32] HHS's Office of Women's Health has recognized that discrimination and stigma may lead lesbians and bisexual women to have higher rates of depression and anxiety than other women, as well as to be less likely than other women to get routine mammograms and clinical breast exams.[33] The CDC also reports that

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[29] *Id.* (discussing "felt stigma"); *see also id.* at 63-64 (discussing "internalized stigma" and other personal barriers to care).

[30] *Id.*

[31] *Id.*

[32] U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, Gay and Bisexual Men's Health, Stigma and Discrimination, http://www.cdc.gov/msmhealth/stigma-and-discrimination.htm.

[33] U.S. Department of Health and Human Services, Office of Women's Health, Lesbian and Bisexual Health, https://www.womenshealth.gov/a-z-topics/lesbian-and-bisexual-health (last visited Nov. 20, 2017) (an archive of this webpage is available at https://web.archive.org/web/20170919061935/https://www.womenshealth.gov/a-z-topics/lesbian-and-bisexual-health).

discrimination and social stigma may help explain the high risk for HIV infection among transgender women,[34] among other health concerns facing transgender people. With respect to LGBT youth, the Institute of Medicine (now called the National Academies of Sciences, Engineering, and Medicine), which operates under a congressional charter and provides independent, objective analysis of scientific research, has observed that "the disparities in both mental and physical health that are seen between LGBT and heterosexual and non-gender-variant youth are influenced largely by their experiences of stigma and discrimination during the development of their sexual orientation and gender identity and throughout the life course."[35]

The disparities between health outcomes for LGBT and non-LGBT people have been well-documented. For example, in Healthy People 2010 and Healthy People 2020, which set health priorities for the country,[36] HHS found that LGBT people face these health disparities:

- LGBT youth are 2 to 3 times more likely to attempt suicide;
- LGBT youth are more likely to be homeless;
- Lesbians are less likely to get preventive services for cancer;
- Gay men are at higher risk of HIV and other STDs, especially among communities of color;
- Lesbians and bisexual females are more likely to be overweight or obese;
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals;
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers;
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.[37]

The discrimination and related health disparities facing the LGBT population stand to worsen if health care providers are authorized to refuse to serve LGBT people. In light of the importance of health care to the public's health, the provider-conscience laws must carefully and narrowly delineate those circumstances where denials of care are authorized, and any Final Rule must adhere to those limitations. Any Final Rule must also make the explicit point that hospitals and other entities are not permitted to turn away a LGBT or any other person because of rejection of the class of people they belong to or appear to belong to. Any Final Rule must make these points clear so as to avoid unauthorized denials and improperly chilling patients in accessing care.

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[34] U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, HIV Among Transgender People, http://www.cdc.gov/hiv/group/gender/transgender/index.html.

[35] INSTITUTE OF MEDICINE, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING 142 (2011), https://www.ncbi.nlm.nih.gov/books/NBK64806/pdf/Bookshelf_NBK64806.pdf.

[36] U.S. Dep't of Health & Human Services, Office of Disease Prevention and Health Promotion, Healthy People, Lesbian, Gay, Bisexual, and Transgender Health, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25.

[37] *Id.*

III. OCR Must Continue To Devote Sufficient Resources To Its HIPAA and Civil Rights Functions.

We are concerned that any Final Rule – along with OCR's concomitant decision to create a separate Conscience and Religious Freedom Division – will result in the allocation of an enhanced portion of OCR's resources to defending refusals of medical care. That reallocation of resources will come at the expense of OCR's other critical enforcement responsibilities and will undermine the protections of both fundamental civil rights laws and the Health Insurance Portability and Accountability Act (HIPAA).

"In FY 2017, OCR received approximately 30,166 complaints, a 23 percent increase over the 24,523 complaints received in FY 2016" and its "[c]ase receipts are expected to further rise in FY 2019."[38] The lion's share of complaints received by OCR are for alleged HIPAA violations, but OCR also receives thousands of civil rights complaints each year.

By comparison, "[s]ince the designation of OCR as the agency with authority to enforce Federal health care conscience laws in 2008…. OCR has received on average, only about 1.25 [conscience] complaints per year from the [timeframe of] 2008 until November 2016."[39] OCR has reportedly received 300 provider-conscience complaints recently, but the number of such complaints OCR has ever received still represents a very small fraction of OCR's overall workload.[40] In light of these statistics and HHS's mission, it is crucial that OCR continue to devote sufficient resources to its HIPAA and civil rights functions.

Nor is there any reason to believe that OCR was not already devoting sufficient resources to enforcing provider-conscience laws. In the last ten years, OCR has resolved three sets of complaints filed under provider-conscience laws with written agreements or letters of finding.[41] In one of these instances, a private hospital adopted new policies in response to a complaint alleging that a nurse was forced to participate in an abortion despite her conscience objections;[42] similarly, Vanderbilt University took corrective action when it was alleged that it had coerced applicants for its nurse residency program to agree to assist in abortion procedures.[43] In each of these instances, OCR appropriately investigated and reached resolutions to ensure that the entities took corrective action.[44] Although there has been one instance in which HHS was

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[38] U.S. Dep't of Health and Human Services, *Budget In Brief*, 124 (Feb. 19, 2018), https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf.

[39] *See* 83 Fed. Reg. 3886 (stating that since 2008 OCR has received a total of forty-four complaints, and that prior to the 2016 presidential election, OCR had only received 10 such complaints); *but,* Jesse Hellman, *New HHS office that enforces health workers' religious rights received 300 complaints in a month*, The Hill (Feb. 20, 2018), http://thehill.com/policy/healthcare/374725-hhs-new-office-that-enforces-religious-moral-rights-of-health-workers.

[40] *Id.*

[41] *See* 83 Fed. Reg. 3886 (*citing* OCR Complaint No. 10–109676; OCR Complaint No. 11–122388; OCR Complaint No. 11–122387).

[42] OCR Complaint No. 10–109676.

[43] OCR Complaint No. 11–122388; OCR Complaint No. 11–122387.

[44] *See* 83 Fed. Reg. 3886.

accused of improperly handling conscience protection claims,[45] there is no evidence that those claims, if in fact they were improperly processed, could not be handled under the current regulations governing the provider-conscience laws and without creation of a new division.

We are additionally concerned about the allocation of resources at OCR in light of a future decrease in OCR's budget. In FY 2016, OCR's budget was approximately $38 million. That same year, only 35 percent of "civil rights complaints requiring formal investigation [were] resolved within 365 days."[46] We appreciate that OCR, in response, requested a budget of nearly $43 million dollars for FY 2017, because it expected "complex cases that involve novel issues of law and complicated facts [to] dramatically increase" and that an increased budget would be needed to increase its capacity to handle such.[47] However, under the Consolidated Appropriations Act, 2018, OCR's FY 2018 budget is approximately $39 million.[48] And for FY 2019, HHS is requesting only $31 million for OCR.[49]

As a result, it appears OCR will have to divert substantial resources away from its HIPAA and/or civil rights functions to meet any enhanced budget for enforcing the provider-conscience laws. Moreover, given OCR's ability to appropriately resolve conscience complaints in the past and the agency's budget realities, the economic expenditures associated with this new rule and the creation of OCR's new division appear unjustified. OCR must continue to devote sufficient resources to its core civil rights and HIPAA functions.

IV. Conclusion

For the foregoing reasons, should OCR choose to issue a Final Rule, we urge OCR to limit it as discussed above, conduct a RIA or otherwise accounts for the impact of the Proposed Rule and any Final Rule has on patients, and to continue to devote sufficient resources to its HIPAA and civil rights functions.

Respectfully Submitted,

[Signatures on next page.]

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[45] *See id.*

[46] *See* U.S. Dep't of Health and Human Services, *Fiscal Year 2017 Office of Civil Rights Justification of Estimates for Appropriations Committee* 9, https://www.hhs.gov/sites/default/files/fy2017-budget-justification-ocr_1.pdf.

[47] *Id.* at 7.

[48] *Consolidated Appropriations Act, 2018*, H.R. 1625, 115th Cong., 919 (2018), https://www.congress.gov/115/bills/hr1625/BILLS-115hr1625eah.pdf.

[49] U.S. Dep't of Health and Human Services, *Budget in Brief*, 124 (Feb. 19, 2018) ("The fiscal year (FY) 2019 Budget request for the Office for Civil Rights (OCR) is $31 million, $8 million below the 2018 Continuing Resolution level"), https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf

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No. 16-111

In The Supreme Court of the United States

MASTERPIECE CAKESHOP, LTD.; AND
JACK C. PHILLIPS,

Petitioners,

v.

COLORADO CIVIL RIGHTS COMMISSION; CHARLIE
CRAIG; AND DAVID MULLINS.

Respondents.

ON WRIT OF CERTIORARI TO THE
COLORADO COURT OF APPEALS

BRIEF OF *AMICI CURIAE* ILAN H. MEYER, PHD, AND OTHER SOCIAL SCIENTISTS AND LEGAL SCHOLARS WHO STUDY THE LGB POPULATION IN SUPPORT OF RESPONDENTS

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I. INTEREST OF AMICI CURIAE[1]

Amici include scholars in public health and social sciences who are recognized experts on the health and well-being of sexual minorities, including lesbians, gay men, and bisexuals ("LGB"). Many of the *amici* have conducted extensive research and authored publications in peer-reviewed academic journals on the effects of discrimination on LGB people. *Amici* also include legal scholars who are recognized experts on law and policy affecting LGB people's health and well-being. The Appendix identifies the individual *amici*.

This Court and other courts have expressly relied on the research of many of the *amici*, and several of the *amici* have served as expert witnesses. *See, e.g.*, *Obergefell v. Hodges*, 135 S. Ct. 2584, 2600 (2015) (citing Brief of Gary J. Gates as *Amicus Curiae*); *Baskin v. Bogan*, 766 F.3d 648, 663, 668 (7th Cir. 2014); *Nungesser v. Columbia Univ.*, 169 F. Supp. 3d 353, 365 n.8 (S.D.N.Y. 2016); *Roberts v. United Parcel Serv. Inc.*, 115 F. Supp. 3d 344, *passim* (E.D.N.Y. 2015); *Stawser v. Strange*, 307 F.R.D. 604, 609 (S.D. Ala. 2015); *Campaign for S. Equality v. Bryant*, 64 F. Supp. 3d 906, 943 n.42 (S.D. Miss.

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[1] As required by Rule 37 of the Rules of this Court, *amici curiae* obtained consent of counsel of record for all parties to file this brief. Blanket permission from petitioners and the Colorado Civil Rights Commission have been filed with the Court. Respondents, Charlie Craig and David Mullins, emailed their permission to *amici*. A copy of which was included with the filing of this brief. *Amici curiae* also represent that no counsel for a party authored this brief in whole or in part, and that no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief.

2014); *DeBoer v. Snyder*, 973 F. Supp. 2d 757, 763-64 (E.D. Mich.), *rev'd*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom.*, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015); *Bassett v. Snyder*, 951 F. Supp. 2d 939, 967 (E.D. Mich. 2013); *Dragovich v. U.S. Dep't of Treasury*, 872 F. Supp. 2d 944, *passim* (N.D. Cal. 2012); *Log Cabin Republicans v. United States*, 716 F. Supp. 2d 884, 917 (C.D. Cal. 2010); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921, *passim* (N.D. Cal. 2010).

As scholars who specialize in issues related to LGB people, *amici* have a substantial interest in this matter. In this brief, *amici* present public health and social science research relevant to the legal questions before this Court. In particular, *amici* describe the harmful effects on LGB people of stigma- and prejudice-related stress (referred to as "minority stress") when a business or other place of public accommodation discriminates against them on the basis of sexual orientation.[2] Eliminating discrimination against LGB people, and the harms of minority stress to LGB people's health and well-being, are compelling government interests, especially in light of the long history of invidious discrimination that this population has suffered.

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[2] Stigma and prejudice against transgender people leads to minority stress that adversely impacts this population's health and well-being, as well. *See, e.g.*, Bockting *et al.*, *Adult Development and Quality of Life of Transgender and Gender Nonconformity People*, 23 Current Op. Endocrinology, Diabetes & Obesity 188 (Apr. 2016). Because this case concerns sexual orientation discrimination, we do not address the transgender population.

II. SUMMARY OF ARGUMENT

When a place of public accommodation refuses to serve, or provides lesser services to, LGB people because of their sexual orientation, that experience can have powerful tangible and symbolic effects on them—just as the denial of equal service can adversely impact other minorities. A discriminatory experience can be humiliating and result in harm to health, well-being, and dignity.

After Petitioners rejected the request of Charlie Craig and David Mullins to purchase a wedding cake, Charlie left the bakery shaking, crying, embarrassed, and feeling like a failure before his mother, who witnessed the incident.[3] The symbolic power of such incidents affects not only the LGB person treated unequally but also the larger LGB community, as it becomes aware of the discrimination and fears future such experiences. This Court has recognized that public accommodation antidiscrimination laws protect against these types of harms and, in doing so, "plainly serve[] compelling state interests of the highest order." *Roberts v. United States Jaycees*, 468 U.S. 609, 624 (1984).

The denial of equal service by a bakery or other business to a LGB person because of his or her sexual orientation is an example of what research identifies as a "minority stressor." While everyone has the potential to experience "general stressors"—such as losing a job—LGB people also face minority stressors that stem from anti-LGB stigma and prejudice. A

[3] Munn, *How It Feels When Someone Refuses to Make Your Son a Wedding Cake*, Time (2017), http://time.com/4991839/masterpiece-cakeshop-supreme-court-gay-discrimination/.

large body of research has shown that LGB people, as a group, experience more stress than heterosexuals, and that this excess exposure to stress is caused by anti-LGB stigma and prejudice.[4]

Another minority stressor facing LGB people relates to *expectations* of rejection and discrimination. Because LGB people learn that they may be rejected and discriminated against in society, they come to expect or fear such occurrences in day-to-day social interactions. The expectation of discrimination causes LGB people to be vigilant as they go through life. For example, a same-sex couple walking down the street may reasonably fear that they will be shouted at with homophobic slurs or even assaulted; as a result, the couple may attempt to conceal their LGB identity (such as by not holding hands). This state of vigilance is stressful and can be damaging to LGB people.[5]

Furthermore, if businesses are allowed to discriminate against people because of their sexual orientation, LGB people may reasonably expect discrimination by other businesses and modify their behavior accordingly. This expectation of discrimination can inhibit LGB people's ability to fully participate in the public marketplace. *See, e.g.*, *Washington v. Arlene's Flower's, Inc.*, 389 P.3d 543, 548-49 (Wash. 2017) (same-sex couple abandoned

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[4] *See, e.g.*, Meyer *et al.*, *Social Patterning of Stress and Coping: Does Disadvantaged Social Statuses Confer More Stress and Fewer Coping Resources?*, 3 Soc. Sci. Med. 67 (2008).

[5] *See, e.g.*, Sawyer *et al.*, *Discrimination and the Stress Response: Psychological and Physiological Consequences of Anticipating Prejudice in Interethnic Interactions*, 102 Am. J. Pub. Health 1020 (2012).

plans for a large wedding after being discriminated against by a florist, citing the "emotional toll" of the discrimination and fear of additional discrimination by other vendors, and instead married at home before a small group of people). Antidiscrimination laws exist in part to prevent such market distortions.

Stigma-related minority stress experienced by LGB people has been linked to a 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 minorities than the heterosexual majority.[6] Minority stress may also adversely impact same-sex couples' relationship quality and stability, thereby undercutting one of the advantages of marriage this Court recognized in *Obergefell*, 135 S. Ct. at 2600-01.

Research also has shown that LGB people fare better in regions where social and legal conditions are more hospitable to them.[7] These studies suggest that antidiscrimination laws that prohibit public accommodations from discriminating against LGB people help reduce minority stress and resultant health disparities.

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[6] *See, e.g.*, Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Nat'l Acads. Press 2011).

[7] Hatzenbuehler *et al.*, *State Level Policies and Psychiatric Morbidity in Lesbian, Gay, and Bisexual Populations*, 99 Am. J. Pub. Health 2275 (2009); Hatzenbuehler *et al.*, *The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study*, 100 Am. J. Pub. Health 452 (2010).

Ultimately, *Amici* conclude that the minority stress literature supports a finding that Colorado has a compelling interest in barring public accommodations from discriminating against LGB people. Indeed, this case is not just about a wedding cake. Something much larger is at stake for LGB people: their health, well-being, and dignity. Allowing businesses to avoid their obligations to serve LGB people equally would undercut the "equal dignity" of same-sex couples that this Court has protected. *Obergefell*, 135 S. Ct. at 2608; *see also United States v. Windsor*, 133 S. Ct. 2675, 2692, 2694 (2013); *Lawrence v. Texas*, 539 U.S. 558, 567, 574-75 (2003). Should the Court agree with Petitioners here, LGB people would likely face increased discrimination in a variety of settings, which antidiscrimination laws would not be able to prevent or remedy.

One of Petitioners' *amici* has alleged that the minority stress literature does not apply here, and that the particular incident in question was not stressful. *See* Brief of Amici Curiae Mark Regnerus et al. in Support of Petitioners, *Masterpiece Cakeshop, LTD v. Colorado Civil Rights Commission*, No. 16-111 (filed Sept. 7, 2017) (hereinafter "the Regnerus Brief"). None of the Regnerus Brief's arguments undermines our conclusions in this brief, as we explain below.

III. ARGUMENT

As Respondents demonstrate, this case involves a discriminatory denial of service; it does not involve any targeting of speech, compelled speech, or regulation of expressive conduct. Respondent Colorado Civil Rights Commission Br. 20-27, 32-44;

Respondents Craig and Mullins Br. 15-28; *R.A.V. v. City of St. Paul,* 505 U.S. 377, 390 (1992) ("acts are not shielded from regulation merely because they express a discriminatory idea or philosophy"); *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 62 (2006) (regulation forbidding discrimination against military recruiters did not compel speech endorsing military policy). Even if the Colorado law were deemed to regulate protected expressive conduct, Petitioners' free-speech challenge must fail if the law furthers "an important or substantial governmental interest" that "is unrelated to the suppression of free expression," and "if the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." *United States v. O'Brien*, 391 U.S. 367, 377 (1968). Nor can Petitioners object to a neutral law of general applicability on free-exercise grounds if the law is rationally related to a legitimate government interest. *Church of Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 531 (1993).

Regardless of whether the governmental interest need be legitimate, substantial, or compelling, that requirement is clearly met by the Colorado law. Protecting the dignity of, and eradicating discrimination against, LGB people is a compelling state interest, for "eliminating discrimination and assuring its citizens equal access to publicly available goods and services . . . , which is unrelated to the suppression of expression, plainly serves compelling state interests of the highest order." *Roberts*, 468 U.S. at 624; *see also Bd. of Dirs. of Rotary Int'l v. Rotary Club*, 481 U.S. 537, 549 (1987). In a similar

vein, this Court, in upholding the public accommodations provision of the 1964 Civil Rights Act, recognized Congress's power to "vindicate the deprivation of personal dignity that surely accompanies denials of equal access to public establishments." *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 250 (1964) (internal quotation marks omitted); *see also id.* at 291-92 (Goldberg, J., concurring); *Bob Jones Univ. v. United States*, 461 U.S. 574, 604 (1983) (government's compelling interest in eradicating race discrimination in education overrode burden on religious exercise).

Consistent with this line of cases, this Court has repeatedly made clear that our Constitution protects and ensures the "equal dignity" of individuals in same-sex couples and LGB people more broadly. *Obergefell*, 135 S. Ct. at 2608; *see also Windsor*, 133 S. Ct. at 2692, 2694; *Lawrence*, 539 U.S. at 567, 574-75; *Romer v. Evans*, 517 U.S. 620, 634-35 (1996).

Just as this Court's jurisprudence protects same-sex couples and LGB people from discriminatory state action, Colorado prohibits its places of public accommodation from discriminating based on sexual orientation, among other personal characteristics. Colorado Rev. Stat. § 24-34-601(2)(a) (2017). The purpose of Colorado's antidiscrimination law is to "eradicate the underlying causes of discrimination and halt discriminatory practices" that stigmatize and make second-class citizens of many Coloradans. *Red Seal Potato Chip Co. v. Colo. Civil Rights Comm'n*, 618 P.2d 697, 700 (Colo. Ct. App. 1980). *See generally* Sepper, *The Role of Religion in State Public Accommodation Laws*, 60 St. Louis Univ. L.J. 631, 663-67 (2016) (public accommodation anti-

discrimination laws "vindicate individual and societal interests in material, dignitary, and expressive terms").

Although this Court has already stated that prevention of exclusion and stigmatization is a compelling interest in the public accommodations context, *amici* write to provide the Court with relevant research that finds that LGB people are subject to "minority stress" due to anti-LGB stigma and prejudice. *Amici* describe how being refused service by a business due to stigma and prejudice against LGB people is a minority stressor. Thus, public-accommodation discrimination leads to dignitary harm and can cause adverse outcomes for health and well-being for LGB people. In addition, should this Court accept Petitioners' claims, widespread discrimination could ensue, leading LGB people to reasonably expect discrimination, which, in turn, increases the risk that they will not fully participate in the marketplace. Minority stress may also negatively impact same-sex couples' relationship quality and stability. In contrast, research shows that where social and legal conditions are more hospitable to LGB people, the health of sexual minorities improves, and health disparities between LGB people and heterosexuals are reduced.

A. LGB People Face Discrimination and Other Minority Stressors Stemming From Anti-LGB Stigma

1. LGB people have long endured discrimination.

LGB people have faced a long, painful history of public and private discrimination in the United States. In *Obergefell*, this Court observed that gays and lesbians have been "prohibited from most government employment, barred from military services, excluded under immigration laws, targeted by police, and burdened in their rights to associate." 135 S. Ct. at 2596; *see also Windsor*, 133 S. Ct. at 2693 ("The avowed purpose and practical effect of the law here in question are to impose a disadvantage, a separate status, and so a stigma upon all who enter into same-sex marriages made lawful by the unquestioned authority of the States."); *Lawrence*, 539 U.S. at 575 (discussing stigmatization from criminal sodomy statutes); *Romer*, 517 U.S. at 632 (discussing animus in anti-LGB legislation). Speaking to both public and private discrimination, the Seventh Circuit has explained that "homosexuals are among the most stigmatized, misunderstood, and discriminated-against minorities in the history of the world, the disparagement of their sexual orientation, implicit in the denial of marriage rights to same-sex couples, is a source of continuing pain to the homosexual community." *Baskin v. Bogan*, 766 F.3d 648, 658, 663 (7th Cir. 2014); *accord Windsor v. United States*, 699 F.3d 169, 182 (2d Cir. 2012) ("It is easy to conclude that homosexuals have suffered a

history of discrimination."), *aff'd*, 133 S. Ct. 2675 (2013).

Despite advances that LGB people have made to protect their autonomy and equality under the Constitution and some state and local laws, research finds evidence of persistent and pervasive discrimination against LGB people in employment,[8] education,[9] housing,[10] and public accommodations,[11] as well as widespread stigma, prejudice, and

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[8] *See, e.g.*, Pizer *et al.*, *Evidence of Persistent and Pervasive Workplace Discrimination Against LGBT People*, 45 Loy. L.A. L. Rev. 715, 721-728 (2012); Tilcsik, *Pride and Prejudice: Employment Discrimination Against Openly Gay Men in the United States*, 117 Am. J. Sociology 586, 586-626 (2011).

[9] *See, e.g.*, Kosciw *et al.*, GLSEN, *The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools* (2016); Wolff *et al.*, *Sexual Minority Students in Non-Affirming Religious Higher Education: Mental Health, Outness, and Identity*, 3 Psychol. Sexual Orientation & Gender Diversity 201 (2016).

[10] *See, e.g.*, Levy *et al.*, Urban Institute, *A Paired-Tested Pilot Study of Housing Discrimination Against Same-Sex Couples and Transgender Individuals* (2017).

[11] *See, e.g.*, Badgett *et al.*, Williams Institute, *Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination* 19-20 (2007); Mallory *et al.*, Williams Institute, *The Impact of Stigma and Discrimination against LGBT People in Florida* 30-32 (2017); Mallory *et al.*, Williams Institute, *The Impact of Stigma and Discrimination Against LGBT People in Georgia* 27-28 (2017); Mallory *et al.*, Williams Institute, *The Impact of Stigma and Discrimination Against LGBT People in Texas* 29-31(2017); Mallory & Sears, Williams Institute, *Evidence of Discrimination in Public Accommodations Based on Sexual Orientation and Gender Identity: An Analysis of Complaints Filed with State Enforcement Agencies, 2008-2014* (2016).

violence.[12] With respect to public accommodations specifically, 31% of gay men, 29% of lesbians, and 15% of bisexual men and women respondents to a national survey conducted by the Pew Research Center in 2013 reported that they had "received poor service at a restaurant, hotel, or other place of business."[13]

2. LGB People Face Minority Stressors Stemming from Anti-LGB Stigma and Prejudice

Experiences of discrimination are among other significant minority stressors that adversely impact LGB people's health and well-being. Stress is "any condition having the potential to arouse the adaptive machinery of the individual."[14] Using engineering analysis, stress can be described as the load relative to supportive surface.[15] Like a surface that may break when load weight exceeds its capacity to withstand the load, so too has stress been described as reaching a breaking point beyond which an organism may reach "exhaustion" and even death.[16] Stress is

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[12] *See, e.g.*, *infra* nn. 65-68 and accompanying text.

[13] Pew Research Center, *A Survey of LGBT Americans: Attitudes, Experiences and Values in Changing Times* 41 (2013).

[14] Pearlin *et al.*, *Stress and Mental Health: A Conceptual Overview, in A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* 161, 175 (Cambridge Univ. Press 1999).

[15] Wheaton *et al.*, *The Nature of Stressors, in A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* 176-97 (Cambridge Univ. Press 1999)

[16] Selye, *History and Present Status of the Stress Concept, in Handbook of Stress: Theoretical and Clinical Aspect* 7-17 (Goldbeger & Breznitz eds., Free Press 2nd ed. 1993).

detrimental because it requires an adaptation effort by the individual exposed to stress.[17] Research over more than 40 years has shown that stress causes mental and physical disorders.[18]

LGB people are exposed to stressors that researchers refer to as "minority stressors" that stem from anti-LGB stigma and prejudice.[19] In addition, all people (including LGB people) are exposed to "general stressors," which do not stem from stigma and prejudice.[20]

Exposure to minority stress is chronic, in that it is attached to persistent social processes characterized by anti-LGB stigma and prejudice. Similarly, because it relates to stigma and prejudice against LGB people, minority stress refers to *excess* exposure of LGB people to stress as compared with heterosexuals.[21] Thus, minority stress requires

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[17] *Id.*; Pearlin *et al.* (1999), *supra.*

[18] Thoits, *Stress and Health: Major Findings and Policy Implications*, 51(S) J. Health & Soc. Behav. S41 (2010).

[19] Stigma is "a function of having an attribute that conveys a devalued social identity in a particular context." Crocker *et al.*, *Social Stigma, in* 4 *The Handbook of Social Psychology* 506 (Gilbert *et al.*, eds., McGraw-Hill 1998).

[20] Meyer, *Minority Stress and Mental Health in Gay Men*, 36:1 J. Health & Behav. 38 (1995); Meyer, *Prejudice, Social Stress and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129:5 Psychol. Bull. 674-697 (2003); Meyer *et al.* (2008), *supra.*

[21] Meyer *et al.* (2008), *supra*; Herek, *Sexual Stigma and Sexual Prejudice in the United States: A Conceptual Framework, in Contemporary Perspectives on Lesbian, Gay, and Bisexual Identities* 65-111 (D. A. Hope ed., 2009); Springer & Herek, *Hate Crimes and Stigma-Related Experiences Among Sexual Minority Adults in the United States: Prevalence Estimates from a*

special adaptation by LGB individuals but not by non-LGB individuals.[22] Because stress can cause mental and physical disorders, the excess exposure to minority stress among LGB people, as compared with heterosexuals, confers an excess risk for diseases that are caused by stress.[23]

Minority stress is defined by specific stress processes, including "prejudice events" and "expectations of rejection and discrimination," among others.[24] "Prejudice events" refers to events that stem from societal anti-LGB stigma and prejudice. Thus, being fired from a job is a general stressor that could affect any person, but it is classified as a prejudice event—a minority stressor—when it is motivated by discrimination against LGB people.

Structural exclusion from resources and advantages available to heterosexuals—such as (1) the historical exclusion of LGB people from the institution of marriage prior to *Obergefell*, (2) the historical exclusion of gay men and lesbians from federal civilian and military employment, and (3) and the current omission of express protections against sexual orientation discrimination in Titles II and VII of 1964 Civil Rights Act, among other federal antidiscrimination laws—leads to prejudice events. Prejudice events also include interpersonal events, perpetrated by individuals acting either in violation

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National Probability Sample, 24:1 J. Interpersonal Violence 54-74 (2009); Meyer (2003), *supra.*

[22] Frost & Meyer, *Internalized Homophobia and Relationship Quality Among Lesbians, Gay Men, and Bisexuals*, 59 J. Counseling Psychol. 97-109 (2009).

[23] Meyer *et al.* (2008), *supra.*

[24] Meyer (2003), *supra.*

of the law (e.g., hate crimes) or within the law (e.g., lawful but discriminatory employment practices).

A prejudice event may be perpetrated by one person, but it carries a symbolic message of social disapprobation. The added symbolic value makes a prejudice event more damaging to the victim's psychological health than a similar event not motivated by prejudice.[25] This exemplifies an important quality of minority stress: Prejudice events have a powerful impact because they convey deep cultural meaning.[26] Even "a seemingly minor event, such as a slur directed at a gay man, may evoke deep feelings of rejection and fears of violence [seemingly] disproportionate to the event that precipitated them."[27] Therefore, assessment of stressors related to stigma and prejudice must consider not only the tangible impact of stress—typically defined as the amount of adaptation required by the event—but also the symbolic meaning within the social context.

In sum, stressors are ubiquitous in our society and experienced by LGB and heterosexual people alike. But the quality of stressors the two populations experience differ in that LGB people are uniquely exposed to minority stressors that stem from stigma and prejudice toward them. This added source of stress experiences exposes LGB people to excess stress compared with heterosexuals and leads to

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[25] Frost *et al., Minority Stress and Physical Health Among Sexual Minority Individuals*, 38 J. Behav. Med. 1 (2015); Herek *et al., Psychological Sequelae of Hate-Crime Victimization Among Lesbian, Gay, and Bisexual Adults*, 57:6 J. Consult. & Clin. Psychol. 945 (1999).

[26] Meyer (1995), *supra.*

[27] *Id.*

excess adverse health outcomes in LGB as compared with heterosexual populations. *See infra* Part III.C.

B. Exclusion From a Public Accommodation is a Prejudice Event and Increases Expectations of Rejection and Discrimination

Based on the large body of research on minority stress, *amici* conclude that when a baker refuses to sell a wedding cake to a LGB person, it is a prejudice event, a type of minority stress, which has both tangible and symbolic impacts on the LGB customer. From a practical perspective, the rejected customer is faced with an additional adaptational task—a concrete problem to resolve: finding a replacement for the needed service or good (here, a wedding cake). This demonstrates the basic premise of minority stress as an *excess* stress: the extra burden of finding an alternative provider adds to the stress of planning a wedding compared with heterosexual couples not affected by such discrimination. This added burden is unique to the class of customers who are shunned by the baker because of their same-sex fiancés.

While the couple here was able to procure another cake, the rejected customer may not always have the ability or time to find a replacement because an alternative business may not be available or because of the immediacy of the need. *See, e.g.*, First Amended Complaint, *Zawadski v. Brewer Funeral Services, Inc.*, No. 55CI1:17-cv-00019-CM (Miss. Cir. Ct., filed Mar. 7, 2017) (widow alleging funeral home refused to transport and cremate deceased same-sex spouse because of their sexual orientation, leaving the decedent's body without proper storage for hours and

the family scrambling to find alternative funeral services).

In addition to such tangible challenges, being rejected by a business for one's sexual orientation underscores the stigmatization that LGB people face. Here, the baker's rejection of a same-sex couple amplifies social rejection and reiterates decades-old stigma and prejudice. In the context of marriage, this is an especially powerful rejection because it relates to the couple's relationship, which inherently embodies their sexual orientation. *See also Obergefell*, 135 S. Ct. at 2600 ("'[W]hen sexuality finds overt expression in intimate conduct with another person, the conduct can be but one element in a personal bond that is more enduring.'" (quoting *Lawrence*, 539 U.S. at 567)). Being rejected by a business is a stark reminder to same-sex couples that even after this Court concluded that their relationships and dignity are protected by the U.S. Constitution, *Obergefell*, 135 S. Ct. at 2608; *Windsor*, 133 S. Ct. at 2692, 2694; *Lawrence*, 539 U.S. at 567, 574-75, they may continue to experience rejection and discrimination in the public marketplace.

Being rejected—and even the threat of rejection—in public accommodations will also increase expectations of future rejection and discrimination among LGB people. This is another form of minority stress.[28] An expectation of rejection and discrimination is a stressor because it requires vigilance by members of minority groups to defend themselves against potential rejection,

[28] Meyer (2003), *supra.*

discrimination, or violence.[29] Unlike prejudice events, which entail concrete events, expectations of rejection and discrimination are stressful even in the absence of a specific prejudice event because the expectation is based on what has been learned from repeated exposure to a stigmatizing social environment.[30] For example, gay couples must remain vigilant when walking in a public space, especially if they demonstrate affection, such as by holding hands, for fear of harassment or violence. The vigilance required in such a state is similar to the classic example of stress experienced by a person in a flight-or-fight stress response, which brings about biophysiological changes that can be harmful to one's health.[31]

Furthermore, it is reasonable to conclude that rejection by a baker or other business will reproduce expectations of rejection and may lead LGB people not to fully participate in the marketplace. For example, in *Washington v. Arlene's Flowers*, the Washington Supreme Court observed that after a florist turned the same-sex couple away, the couple abandoned plans for a large, 100-guest wedding. 389 P.3d at 548. The "emotional toll" of the incident and fear being of denied service by other vendors prompted the couple to forego their plans and marry at home in front of 11 guests. *Id.* at 549.

Should this Court conclude that the First Amendment protects Petitioners' actions here, an

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[29] *Id.*

[30] Crocker, *Social Stigma and Self-Esteem: Situational Construction of Self-Worth*, 35:1 J. Experimental Soc. Psychol. 89-107 (1999).

[31] Selye, *The General Adaptation Syndrome and the Diseases of Adaptation*, 6:2 J. Clin. Endocrinology 117 (1946).

untold number of businesses may turn away LGB people. As a result, in order to ensure they will not be refused service when they need it, LGB customers would experience an additional burden of having to come out as LGB in advance of seeking services or goods, or face the risk of being turned away too late. If a same-sex couple getting married doesn't come out to, for example, an event space where they are planning their wedding party, they may find out at the last minute that the event space will not host them. Or, if planning a honeymoon at an inn, LGB customers would have to inquire in advance whether the inn-keeper would accommodate them, lest they arrive only to find out too late that they are not welcome. If the business rejects the LGB customer when he or she comes out, the LGB person must undertake the additional burden of trying to find an alternative provider, if such an alternative provider even exists or is available in the locale.

These experiences inflict dignitary harms on LGB people and are stressful, as they require LGB people to expend greater effort and expense to arrive at the same services or goods provided to non-LGB people with less effort and expense.[32] Moreover, the possibility of public rejection from services and goods creates a stigmatizing social environment. As we discuss next, a stigmatizing social environment and

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[32] Comparisons of LGB and heterosexual people throughout our analysis assume everything else being equal in terms of other sources of potential discrimination, such as minority racial/ethnic identity. Of course, other forms of discrimination would similarly apply to LGB people and heterosexuals. Thus racist discrimination would apply equally to Black heterosexual and LGB people, but only the LGB people would experience the additional anti-LGB discrimination.

minority stress adversely impact LGB people's health and well-being.

C. Minority Stress Adversely Affects the Health and Well-Being of LGB People and May Impact Relationship Quality and Stability

1. Minority Stress Negatively Impacts the Health and Well-Being of the LGB People

Stigma is a "fundamental social cause" of disease, in that it influences multiple disease outcomes through multiple risk factors across a widespread population.[33] This makes stigma "a central driver of morbidity and mortality at a population level."[34] Stigma leads to poor health outcomes by blocking resources "of money, knowledge, power, prestige, and beneficial social connections," increasing social isolation and limiting social support, and increasing stress.[35]

To date, hundreds of peer-reviewed research articles have reported on studies using the minority stress framework. By and large, this body of work shows that exposure to minority stress has a negative impact on the health and well-being of LGB people. This has led the Institute of Medicine (now called The National Academies of Sciences, Engineering, and Medicine), which operates under a congressional

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[33] Hatzenbuehler *et al.*, *Stigma As a Fundamental Cause of Population Health Inequalities*, 103:5 Am. J. Pub. Health 813, 813 (2013).

[34] *Id.* at 813.

[35] *Id.* at 814.

charter and provides independent, objective analysis of scientific research, to determine that minority stress is a core perspective for understanding LGB health and disparities in health between LGB and heterosexual people.[36]

Other leading public-health authorities have also recognized health disparities of LGB as compared with heterosexual populations. In Healthy People 2010 and Healthy People 2020, which set health priorities for the United States, the Department of Health and Human Services (HHS) identified the LGB population as having disparities in health outcomes, faring worse than heterosexuals.[37] In explaining why the LGB population required special public-health attention, HHS provided a minority stress explanation, noting that "[p]ersonal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals."[38]

This burden has most clearly been articulated in the minority stress literature.[39] Studies have concluded that minority stress processes are related to an array of mental health problems, including depressive symptoms, substance use, and suicide

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[36] Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Nat'l Acads. Press 2011).

[37] *See* United States Dep't of Health & Human Services, Office of Disease Prevention and Health Promotion, Healthy People, *Lesbian, Gay, Bisexual, and Transgender Health*, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health

[38] *Id.* (citing Healthy People 2010).

[39] Institute of Medicine (2011), *supra*.

ideation and attempts.[40] LGB individuals also have lower levels of social well-being, which reflects a person's acceptance by his or her social environment,[41] than heterosexual people because of exposure to minority stress.[42]

Minority stress is also associated with a higher incidence of reported suicide attempts among LGB individuals than heterosexuals (especially in youth, when sexual identity is first disclosed to friends and family).[43] The higher prevalence of suicide attempts

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[40] Mays & Cochran, *Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States*, 91:11 Am. J. Pub. Health 1869-76 (2001); Herek *et al.*, *Sexual Orientation and Mental Health*, Ann. Rev. Clin. Psychol. 3 (2007); King *et al.*, *A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People*, 70 BMC Psychiatry 8 (2008); Meyer (2003), *supra*; Cochran & Mays, *Sexual Orientation and Mental Health, in Handbook of Psychology and Sexual Orientation*, 204-22 (Oxford Univ. Press 2013).

[41] Kertzner *et al.*, *Social and Psychological Well-Being in Lesbians, Gay Men, and Bisexuals: The Effects of Race, Gender, Age, and Sexual Identity*, 79:4 Am. J. Orthopsychiatry 500 (2009).

[42] Kertzner *et al.*, *Psychological Well-Being in Midlife and Older Gay Men, Gay and Lesbian Aging: Research and Future Directions* 97-115 (2004); Riggle *et al.*, *LGB Identity and Eudaimonic Well Being in Midlife*, 56:6 J. Homosexuality 786 (2009).

[43] *E.g.*, Cochran & Mays, *Lifetime Prevalence of Suicide Symptoms and Affective Disorders Among Men Reporting Same-Sex Sexual Partners: Results From NHANES III*, 90:4 Am. J. Pub. Health 573 (2000); Gilman *et al.*, *Risk of Psychiatric Disorders Among Individuals Reporting Same-Sex Sexual Partners in the National Comorbidity Survey*, 91:6 Am. J. Pub. Health 933 (2001); Herrell *et al.*, *Sexual Orientation and Suicidality: A Co-Twin Control Study in Adult Men*, 56:10 Arch. Gen. Psychiatry 867 (1999); Friedman *et al.*, *A Meta-Analysis of*

among LGB youth is influenced by minority stress encountered by youths, for example, experiencing rejection by their family.[44]

Minority stressors stemming from social structural discrimination have serious negative consequences on mental health. For example, LGB people who live in states without laws that extend protections to sexual minorities (e.g., job discrimination or hate crimes) demonstrate higher levels of mental health problems compared to those living in states with laws that provide such protections.[45] Furthermore, the denial of marriage rights for same-sex couples had a demonstrated negative effect on the mental health of lesbians and gay men, regardless of their relationship status.[46]

Several studies have also demonstrated links between minority stress factors and some physical

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Disparities in Childhood Sexual Abuse, Parental Physical Abuse, and Peer Victimization Among Sexual Minority and Sexual Nonminority Individuals, 8 Am. J. Pub. Health 101 (2011); Meyer *et al.*, *Lifetime Prevalence of Mental Disorders and Suicide Attempts in Diverse Lesbian, Gay, and Bisexual Populations,* 6 Am. J. Pub. Health 98 (2008); Safren & Heimberg, *Depression, Hopelessness, Suicidality, and Related Factors in Sexual Minority and Heterosexual Adolescents*, 67:6 J. Consult. Clin. Psychol. 859 (1999).

[44] Ryan *et al.*, *Family Rejection As a Predictor of Negative Health Outcomes, in White and Latino Lesbian, Gay, and Bisexual Young Adults*, 1 Pediatrics 123 (2009).

[45] Hatzenbuehler *et al.* (2009), *supra.*

[46] Riggle *et al.*, *Psychological Distress, Well-Being, and Legal Recognition in Same-Sex Couple Relationships*, 1 J. Fam. Psychol. 24 (2010); Rostosky *et al.*, *Marriage Amendments and Psychological Distress in Lesbian, Gay, and Bisexual (LGB) Adults*, 1 J. Counseling Psychol. 56 (2009); Hatzenbuehler *et al.* (2010), *supra.*

health problems. For example, one study found that LGB people who had experienced a prejudice-related stressful life event were about three times more likely than those who did not experience a prejudice-related life event to have suffered a serious physical health problem over a one-year period.[47] This effect remained statistically significant, even after controlling for the experience of other non-prejudicial stress events and other factors known to affect physical health. Thus, prejudice-related stressful life events were more damaging to the physical health of LGB people than general stressful life events that did not involve prejudice. In another study, exposure to discrimination at work was related to an increased number of sick days and physician visits among LGB people.[48]

2. Minority Stress May Adversely Impact Same-Sex Couples' Relationship Quality and Stability

LGB people have the same aspirations for achieving intimate relationships as heterosexuals, but they face greater social barriers to maintaining long-term relationships.[49] This Court's decisions in *Lawrence*, *Windsor*, and *Obergefell* have helped remove some major barriers. Indeed, emerging evidence suggests "that legal relationship recognition

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[47] Frost *et al.* (2015), *supra.*

[48] Huebner & Davis, *Perceived Antigay Discrimination and Physical Health Outcomes*, 5 Health Psychol. 26 (2007);

[49] Frost, *Similarities and Differences in the Pursuit of Intimacy Among Sexual Minority and Heterosexual Individuals: A Personal Projects Analysis*, 67:2 J. Soc. Issues 282 (2011).

and parenting may act as stabilizing factors for [both same-sex and different-sex] couples."[50]

But minority stress remains a burden for same-sex partners.[51] Some studies indicate that minority stress in LGB people's lives may negatively affect couples' relationship quality and stability.[52] Consistently, some findings suggest that social approval and support appears to be important to couple stability.[53]

While different-sex and same-sex couples all experience general stressors—such as stresses related to finances or household chores—same-sex couples experience additional minority stressors that stem from the stigmatization of same-sex

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[50] Rostosky & Riggle, *What Makes Same-Sex Relationships Endure? in LGBTQ Divorce and Relationship Dissolution: Psychological and Legal Perspectives and Implications for Practice* (Goldberg & Romero, eds., Oxford Univ. Press forthcoming 2018) (on file with counsel).

[51] Clark *et al.*, *Windsor and Perry: Reactions of Siblings in Same-Sex and Heterosexual Couples*, 62:8 J. Homosexuality 993 (2015).

[52] Doyle & Molix, *Social Stigma and Sexual Minorities' Romantic Relationship Functioning: A Meta-Analytic Review*, 41:10 Pers. Soc. Psychol. Bull. 1363 (2015); Rostosky & Riggle, *Same-Sex Relationships and Minority Stress*, 13 Current Opinion Psychol. 29 (2017); Frost & LeBlanc, *Stress in the Lives of Same-Sex Couples: Implications for Relationship Dissolution and Divorce*, *in LGBTQ Divorce and Relationship Dissolution: Psychological and Legal Perspectives and Implications for Practice* (Goldberg & Romero, eds., Oxford Univ. Press, forthcoming 2018) (on file with counsel).

[53] Lehmiller & Agnew, *Perceived Marginalization and the Prediction of Romantic Relationship Stability*, 69:4 J. Marriage & Family 1036 (2007).

relationships.[54] Societal stigma surrounding same-sex relationships can also be uniquely internalized, contributing to feelings of internalized homophobia among people in same-sex relationships,[55] which has been shown to be detrimental to relationship quality among sexual minority individuals.[56] Moreover, societal stigma of same-sex relationships can lead to adverse mental health effects among LGB individuals, which create the potential for mental health problems in the couple (e.g., depression) that jeopardize the relationship.[57]

D. Better Social and Legal Conditions are Associated with Fewer Adverse Effects of Minority Stress

Research has shown that in U.S. regions where LGB people have better social and legal conditions, they also have better health and lesser health disparities compared with heterosexuals.[58] Because minority stress stems from societal stigma, its root

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[54] Frost, *Stigma and Intimacy in Same-Sex Relationships: A Narrative Approach*, 25:1 J. Fam. Psychol. 1 (2011); Frost & LeBlanc (forthcoming 2018), *supra*; LeBlanc *et al.*, *Similar Others in Same-Sex Couples' Social Networks*, 62:11 J. Homosexuality 1599 (2015); Meyer (2003), *supra*.

[55] Frost & Meyer (2009), *supra*.

[56] Balsam & Szymanski, *Relationship Quality and Domestic Violence in Women's Same-Sex Relationships: The Role of Minority Stress,* 29:3 Psychol. Women Q. 258 (2005); Edwards *et al.*, *The Perpetration of Intimate Partner Violence Among LGBTQ College Youth: The Role of Minority Stress*, 42:11 J. of Youth & Adolescence 1721 (2013).

[57] Rostosky & Riggle (forthcoming 2018), *supra*; Frost & LeBlanc (forthcoming 2018), *supra.*

[58] Hatzenbuehler *et al.* (2009), *supra*; Hatzenbuehler *et al.* (2010), *supra.*

can only be eliminated through social and structural intervention.[59] Antidiscrimination laws that prohibit public accommodations from discriminating against LGB people would propel improved social and legal conditions. Indeed, as this Court has recognized, public accommodations laws "protect[] the State's citizenry from a number of serious social and personal harms" by ensuring that members of historically disadvantaged groups can participate as full members of civic society. *Roberts*, 468 U.S. at 625.

But just as laws can help eradicate and dismantle stigma and enhance a nation's health, laws can "be a part of the problem by enforcing stigma."[60] Indeed, the role of law in shaping stigma is so clear to public health professionals that they explicitly debate the ethics of using law to promote stigma, for example, related to smoking, even when such laws have undeniable benefits to the public's health by preventing morbidity and mortality.[61]

If this Court accepts Petitioners' arguments here, then future denial of service to LGB customers would be enshrined in the authority of the U.S. Constitution—leading to greater stigmatization of LGB people and same-sex relationships. At the same time, LGB people would feel less protected by the

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[59] Meyer & Frost, *Minority Stress and the Health of Sexual Minorities, in Handbook of Psychology and Sexual Orientation* 252-66 (Oxford Univ. Press 2013).

[60] Burris, *Stigma and the Law*, 367 Lancet 529 (2006); Link & Hatzenbuehler, *Stigma as an Unrecognized Determinant of Population Health: Research and Policy Implications*, 41 J. Health Politics, Policy, & Law 653 (2016).

[61] Bayer, *Stigma and the Ethics of Public Health: Not Can We But Should We*, 67:3 Soc. Sci. & Med. 463 (2008).

state than their heterosexual counterparts, and would need to be increasingly vigilant to secure their families' well-being.

E. Regnerus *Amici* Brief Does Not Undermine the Significance of the Minority Stress Literature to this Case

One of Petitioners' *amici* briefs (the "Regnerus Brief," *supra*) asserts a variety of arguments that purport to undermine the significance of minority stress to the issues before the Court. Contrary to the claims made by the Regnerus Brief, none of the arguments therein undermines our arguments and conclusions here.

The Regnerus Brief asserts some methodological objections to studies on minority stress. But these methodological challenges are not unique to the minority stress literature and are routinely handled by scientists, who are trained to discern the implications of these challenges.

In generating knowledge, scientists generally rely on theory, hypotheses posed based on theory, and empirical evidence that enables them to assess these hypotheses using quantitative and qualitative methods. To collect and assess evidence, scientists use conventions and rules about causal inference developed over decades of methodological writings. These are the same processes that were used by scientists studying the incidence and impact of minority stress, and their conclusions are no less worthy of respect than scientific conclusions drawn in other contexts.

Moreover, in all fields of inquiry, no one research article is determinative, and all studies have methodological limitations. Indeed, a good scientific article provides the reader with a thorough review of the study's limitations, as well as suggestions for further study that may address limitations. The mere existence of methodological limitations in any one study, or even in a group of studies, does not by itself discredit the study or area of investigation. Relying on conventions of scientific research methodology and causal inference, a scientist uses his or her expertise and judgment about the significance and potential impact of the limitations in any particular study or group of studies to form conclusions about the questions under study.

First, the Regnerus Brief raises a host of alleged methodological limitations that the authors erroneously claim invalidate minority stress research and conclusions. But none of these alone or together invalidate minority stress research and conclusions, or disqualify the weight of scientific findings we discuss. For example, contrary to the Regnerus Brief, the fact that research evidence on minority stress stems from hundreds of independent research studies, done with varying methodologies, and using a variety of measures is a *strength* of this body of work. Indeed, an established method to assess the validity of scientific findings relies on the assessment of *convergences* of results across *divergent* methods. To the extent that convergences are shown from different studies leading to the same conclusions, this provides evidence that the findings are not

singularly, and spuriously, confounded by a particular method or measure.[62]

Second, the Regnerus Brief alleges that the literature conflates causation and association, but discusses only one study to demonstrate this, and, even then, does not actually describe the purported error of this study's causal inference. Instead, the Regnerus Brief addresses some limitations that do not go to causality. In fact, the one study mentioned is perfectly suited for testing causal relationships in that it is longitudinal and carefully measured and tracked instances of the minority stressor as a cause and its health effect.[63]

In any event, this Court has never required in public accommodations cases that the government must prove that a specific exclusion *caused* the various harms that antidiscrimination laws aim to ameliorate, contrary to the Regnerus Brief's assertion. Regnerus Br. at 1 & 15 (citing *Brown* v. *Entertainment Merchants Ass'n*, 564 U.S. 786 (2011)). Rather, in *Roberts*, for example, it was nothing less than obvious to the Court that discrimination by public accommodations causes dignitary, economic, and other harms. 468 U.S. at 625. Furthermore, this is not a case like *Brown*, cited by the Regnerus Brief, in which the government was attempting to ban protected speech because of harms caused by the speech.

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[62] Campbell & Fiske, *Convergent and Discriminant Validation by the Multitrait-Multimethod Matrix*, 56 Psychol. Bull. 81 (1959).

[63] Frost *et al*. (2015), *supra*.

Third, the Regnerus Brief critiques some studies assessing minority stress that use non-probability, or non-random, samples. But the Regnerus Brief's blanket statement that "[t]hat is not how research on populations ought to be conducted," Regnerus Br. 23, is wrong and contrary to scientific method. Clearly, studies that use non-probability samples differ from studies that use probability (representative) samples, but both types of studies are appropriately utilized by scientists.[64] Probability samples are required to make unbiased population estimates about statistics, such as prevalence of a disorder in a population. But non-probability samples provide insight into studied phenomena and often are preferred for assessing causal relationships. Indeed, one of the definitive textbooks on scientific causal inference describes numerous considerations for causal inference that do not rely on probability samples.[65]

Fourth, the Regnerus Brief argues that some of the data on minority stress are too old to be relevant today because of "recent changes in societal norms and increasing acceptance of LGB persons." Regnerus Br. 4. But evidence from recent studies suggests that improvements in societal norms have not been far-reaching enough to weaken our arguments here. For example, recent data on youth in U.S. high schools—perhaps the population most likely to have adopted more-accepting norms—shows that LGB youth continue to be disproportionally targeted for harassment. The survey of high school students

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[64] Meyer & Wilson, *Sampling Lesbian, Gay, and Bisexual Populations*, 56:1 J. Counseling Psychol. 23, 23-31 (2009).

[65] Shadis *et al.*, *Experimental and Quasi-Experimental Designs for Generalized Causal Inference.* (Houghton Mifflin Co. 2002).

conducted in 2015 by the Centers for Disease Control and Prevention (CDC) uses a national probability sample of youth in high schools and therefore is representative of all U.S. youth in high schools. As reported by the CDC, results of the survey showed, among other findings, that 10% of LGB students, compared with 5% of heterosexual students, reported being threatened or injured with a weapon on school property, and 34% of LGB students, compared with 19% of heterosexual students, reported being bullied on school property.[66] And consistent with minority stress explanations, the LGB students were more likely to report being sad or hopeless (60% of LGB versus 26% of heterosexual students), seriously considered attempting suicide (43% of LGB versus 15% of heterosexual students), and actually attempted suicide (29% of LGB versus 6% of heterosexual students).[67] Similarly, the number of anti-LGB bias crimes reported to the FBI in the country has been steady for the past decade. For example, in 2005, 1,213 victims of crimes stemming from sexual-orientation bias were reported to the FBI; in 2015, 1,263 victims of these crimes were reported to the FBI.[68]

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[66] Kann *et al.*, *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12—United States and Selected Sites, 2015*, 65 Morbidity & Mortality Weekly Report 1 (Aug. 12, 2016).

[67] *Id.*

[68] United States Dep't of Justice, Federal Bureau of Investigation, *Hate Crime Statistics 2005*, *Victims*, https://www2.fbi.gov/ucr/hc2005/victims.htm; United States Dep't of Justice, Federal Bureau of Investigation, Criminal Justice Information Services Division, *2015 Hate Crime Statistics*, *Victims*, https://ucr.fbi.gov/hate-crime/2015/topic-

Thus, contrary to the Regnerus Brief, despite the increase in social acceptance of LGB people in today's society, stigma, prejudice, and discrimination persist.[69] *See supra* Part III.A.1.

Fifth, the Regnerus Brief notes that minority stress research describes some LGB people as resilient in the face of adversity. Regnerus Br. 9. While research has found that some LGB people are resilient in the face of adversity, others succumb to adverse health effects of minority stress. And, that some people may be able to rebound from adversity does not justify placing adversity in their path. In fact, one of the purposes of antidiscrimination law is to clear discriminatory obstacles in people's paths.

The Regnerus Brief suggests that the issue at stake here is a minor experience that could be "waved off by the plaintiffs as 'Oh well, we realize some people aren't on board with same-sex marriage.'" (Br. 10). The Regnerus Brief misconstrues minority stress writings to claim that this experience does not represent minority stress because the actions of Petitioners were not chronic or acute. In fact, minority stress is chronic not because each stressful event is chronic, but because LGB people repeatedly encounter such events. As we have explained here, the issue at stake is greater than the one-time interaction of the parties to this case. If this Court

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pages/victims_final; *see also* Park & Mykhyalyshyn, *L.G.B.T. People Are More Likely Targets of Hate Crimes Than Any Other Minority Group*, N.Y. Times, June 16, 2016, https://www.nytimes.com/interactive /2016/06/16/us/hate-crimes-against-lgbt.html?_r=0.

[69] Meyer, *The Elusive Promise of LGBT Equality*, 106:8 Am. J. Pub. Health 1356 (2016).

accepts Petitioners' arguments and allows for exemptions to antidiscrimination laws, it would change the social environment of LGB people for the worse, leading to repeated and acute experiences of being rejected from businesses and to expectations of such rejection and discrimination in LGB people's daily interactions within the public marketplace.

Finally, we are compelled to address the Regnerus Brief's false claim that "politics have crowded out sound scientific methodology" in research on minority stress. (Br. 21.). The studies we rely on herein—and many others in this body of research that we do not have room to cite—meet established standards for scientific rigor, as evidenced by their publication in demanding peer-reviewed journals. Furthermore, the Regnerus Brief's assertion about politics is incredible given that a federal court has already found that Mark Regnerus himself conducted results-oriented research in order to "oblige" a politically-driven funder. *DeBoer v. Snyder,* 973 F. Supp. 2d 757, 766 (E.D. Mich.), *rev'd*, 772 F.3d 388 (6th Cir. 2014), *rev'd sub nom.*, *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).[70]

In the end, the Regnerus Brief does not successfully dispute that a stigmatizing social

[70] Indeed, the court concluded that Regnerus's testimony was "entirely unbelievable and not worthy of serious consideration." *DeBoer*, 973 F. Supp. 2d at 766. The court also concluded that Regnerus had "fringe viewpoints," *id.* at 768, which is underscored by the fact that Regnerus's own academic colleagues at his university took the extraordinary step of publicly distancing themselves from his findings. *Id.* at 766; UT Austin College of Liberal Arts, *Statement Regarding Sociology Professor Mark Regnerus* (2014), https://liberalarts.utexas.edu/public-affairs/news/7531.

environment damages the health of LGB people by bringing about life events and other conditions that are stressful. It is an environment that demands vigilance of its LGB citizens as they watch to protect themselves from potential discrimination and violence. It is an environment where, in an attempt to protect themselves from the stress of anti-LGB stigma, LGB people are moved to conceal their sexual identity. And it is an environment where stigma and stereotypes are internalized by both heterosexual and LGB people. Each of these stressors causes serious injury in the form of psychological distress, physical and mental health problems, suicide, and lowered sense of well-being. These stressors also negatively impact same-sex couples' relationship quality and stability.

IV. CONCLUSION

The minority stress literature converges on one conclusion: that when a place of public accommodation refuses to serve, or provides lesser services to, LGB people because of their sexual orientation, that experience can have powerful tangible and symbolic effects on LGB people, which adversely impact their health and well-being. Because of the power of law, if this Court countenances such discrimination, our Constitution will be a source of stigma rather than dignity for LGB people. For the foregoing reasons, the Court should affirm.

Respectfully submitted,

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APPENDIX

APPENDIX: LIST OF *AMICI* SCHOLARS

1. **Ilan H. Meyer**, Ph.D., is Distinguished Senior Scholar for Public Policy at the Williams Institute, UCLA School of Law, and Professor Emeritus of Sociomedical Sciences at Columbia University. Dr. Meyer 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, Dr. Meyer 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, Dr. Meyer 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. Dr. Meyer has served as an expert in several court cases and hearings, including *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010); United States Commission on Civil Rights briefing on peer-to-peer violence and bullying in K-12 public schools (2011); *Garden State Equality v. Doe* (N.J. Sup. Ct. 2013);

Bayev v. Russia (European Court of Human Rights 2014); and *Sexual Minorities Uganda v. Scott Lively* (D. Mass. 2016). Dr. Meyer has been a principal investigator for over 20 research projects and is currently the principal investigator of two important National Institutes of Health funded studies, the *Generations Study*, a study of stress, identity, health, and health care utilization across three cohorts of lesbians, gay men, and bisexuals; and the TransPoP study, the first national probability sample of transgender individuals, both in the United States.

2. **M. V. Lee Badgett**, Ph.D., is a Professor of Economics at the University of Massachusetts Amherst and a Williams Distinguished Scholar at the Williams Institute, UCLA School of Law. Her current research focuses on poverty in the LGBT community, employment discrimination against LGBT people in the U.S., and the cost of homophobia and transphobia in global economies. Dr. Badgett's latest book is *The Public Professor: How to Use Your Research to Change the World*. Her book, *When Gay People Get Married: What Happens When Societies Legalize Same-Sex Marriage*, analyzes the positive U.S. and European experiences with marriage equality for gay couples. Her first book, *Money, Myths, and Change: The Economic Lives of Lesbians and Gay Men*, presented her groundbreaking work debunking the myth of gay affluence. Dr. Badgett's work includes testifying as an expert witness in legislative matters and litigation (including as an expert witness in California's Prop 8 case), consulting with development agencies (World Bank and UNDP), analyzing public policies, consulting with regulatory

bodies, briefing policymakers, writing op-ed pieces, speaking with journalists, and advising businesses.

3. **Juan Battle**, Ph.D., is a Professor of Sociology, Public Health, & Urban Education and the Coordinator of the Africana Studies Certificate Program at the Graduate Center of the City University of New York (CUNY). His research focuses on race, sexuality, and social justice. Dr. Battle has over 75 grants and publications, including books, book chapters, academic articles, and encyclopedia entries. In addition to having delivered lectures at a multitude of academic institutions, community-based organizations, and funding agencies throughout the world, Dr. Battle's scholarship has included work throughout North America, South America, Africa, Asia, and Europe. Among his current projects, he is heading the Social Justice Sexuality initiative—a project exploring the lived experiences of Black, Latina/o, and Asian lesbian, gay, bisexual, and transgender (LGBT) people in the United States and Puerto Rico. He is also heading a project examining LGBT poverty in New York City. Dr. Battle is a Fulbright Senior Specialist and was the Fulbright Distinguished Chair of Gender Studies at the University of Klagenfurt, Austria and was an Affiliate Faculty of the Institute for Gender and Development Studies (IGDS), The University of the West Indies, St. Augustine, Trinidad and Tobago.

4. **Stuart Biegel**, J.D., has been a longtime member of the faculty at both the UCLA School of Law and the UCLA Graduate School of Education and Information Studies. He has served as Director of Teacher Education at UCLA, Special Counsel for the California Department of Education, and the Consent

Decree Monitor for the federal court in the San Francisco school desegregation case. Professor Biegel is the original author of the West casebook *Education and the Law* (4th ed. 2016), which focuses on both K-12 and higher education communities, and also includes major coverage of technology issues, privacy law issues, and disability rights. Among many other publications, his scholarship includes *The Right to Be Out: Sexual Orientation and Gender Identity in America's Public Schools* (University of Minnesota Press, 2d ed. forthcoming 2018) and *Unfinished Business: The Employment Non-Discrimination Act (ENDA) and the K-12 Education Community,* 14 *NYU Journal of Legislation & Public Policy* 357 (2011). He has also consulted with the National Education Association and the U.S. Commission on Civil Rights on issues relating to marginalized and disenfranchised youth.

5. **Susan D. Cochran**, Ph.D, M.S., is a Professor of Epidemiology at the UCLA Fielding School of Public Health and a Professor of Statistics, UCLA. Her research focuses on the mechanisms by which social adversity affects health. She has received numerous awards for her research and professional activities including the prestigious 2001 Award for Distinguished Contributions to Research in Public Policy from the American Psychological Association. In 2010, she was a member of the APA Presidential Task Force on "Reducing and preventing discrimination against and enhancing benefits of inclusion of people whose social identities are marginalized in society." Using funding from the National Institute on Drug Abuse, she conducted three large-scale population-based studies of mental

health and substance use concerns among lesbian, gay, and bisexual individuals in California. She is also a member of the World Health Organization ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health. She has served as *Amicus curiae* (*Baehr v. Lewin*, Circuit Court, State of Hawaii, October, 1996; *Baehr v. Lewin*, Appeals Court, State of Hawaii, July, 1997) and provided expert testimony (*Howard v. Arkansas Department of Human Services*, 2004; *Doe v. Doe, Miami-Dade County*, 2008; and *Cole v. Arkansas*, 2010) for LGB-related matters.

6. **Kerith Conron**, Sc.D., M.P.H., is the Blachford-Cooper Distinguished Scholar and Research Director at the Williams Institute, UCLA School of Law. Dr. Conron earned her doctorate from the Harvard School of Public Health and MPH from the Boston University School of Public Health. She is a social and psychiatric epidemiologist whose work focuses on documenting and reducing health inequities that impact sexual and gender minority populations. Dr. Conron is committed to altering the landscape of adversity and opportunity for the most marginalized lesbian, gay, bisexual, and transgender (LGBT) communities through collaborative activities that impact the social determinants of health. She has been supported by the National Institutes of Health to conduct community-based participatory research with LGBT youth of color and to train scholars in LGBT population health research. Dr. Conron has been active in LGBT health for over 15 years, serving on the first Steering Committee of the National Coalition for LGBT Health and as the first coordinator of the Office of LGBT Health for the City

of Boston. Her current research focuses on socioeconomic status and strategies to reduce poverty and to promote health. Her publications appear in the American Journal of Public Health, Archives of Pediatrics and Adolescent Medicine, and Psychological Medicine. Her expertise and commentary have been featured by major media outlets including the New York Times, the Associated Press, and National Public Radio.

7. **Brian de Vries**, Ph.D., is a (retired) professor of Gerontology at San Francisco State University, with adjunct appointments at both Simon Fraser University (in Vancouver) and the University of Alberta (in Edmonton). Dr. de Vries has been instrumental in guiding his professional associations through his role as fellow of the Gerontological Society of America (GSA), past Board member of the American Society on Aging (ASA), and former co-Chair of the LGBT Aging Issues Network constituent group. Similarly, Dr. de Vries was appointed to the Institute of Medicine's Board on the Health of Select Populations Committee which authored the influential book: *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*. Dr. de Vries has co-edited several professional journals and acclaimed academic books as well as authored or co-authored approximately 100 journal articles and book chapters, and has given over 150 presentations to local, national, and international professional audiences on the social and psychological well-being of midlife and older LGBT persons, among other topics.

8. **Brian Dodge**, Ph.D., is an Associate Professor in the Department of Applied Health Science and Associate Director of the Center for Sexual Health Promotion at the Indiana University School of Public Health-Bloomington. A nationally recognized expert on bisexual health, he is a co-director of the Bisexual Research Collaborative on Health (BiRCH), a partnership of Indiana University, University of Illinois at Chicago, and The Fenway Institute. His research focuses on understanding social and behavioral aspects of sexual health and other aspects of well-being among a variety of understudied and underserved sexual minority communities, with a specific emphasis on the impact of stigma and minority stress on health among bisexual individuals. His work includes some of the first National Institutes of Health-funded studies on health among bisexual men and women, relative to their exclusively heterosexual and homosexual counterparts. He also collaborates on assessments of health among probability samples of sexual minority individuals in the U.S., including as a co-investigator of the ongoing nationally representative National Survey of Sexual Health & Behavior. Dr. Dodge has provided expert legal consultation on bisexuality-related cases for the Maricopa County, Phoenix, Arizona Public Defenders' Office and the U.S. Military.

9. **Jessica N. Fish**, Ph.D., is a Postdoctoral Research Fellow at the University of Texas at Austin Population Research Center and Visiting Assistant Professor in the Department of Family Science at the University of Maryland School of Public Health. Dr. Fish studies the sociocultural factors that shape the

development and health of sexual minorities. Her area of research, in particular, focuses on how prejudice and discrimination influence the prevalence and developmental patterns of substance use and mental health among sexual minority youth and adults. Among other findings, her research demonstrates the deleterious effects of discrimination on sexual minority health across the life course.

10. **Andrew R. Flores**, Ph.D., is Assistant Professor of Political Science in the Public Policy & Political Science Department at the Lorry I. Lokey Graduate School of Business and Public Policy at Mills College and a Visiting Scholar at the Williams Institute, UCLA School of Law. Dr. Flores studies attitude formation and change about marginalized groups, particularly lesbian, gay, bisexual, and transgender people (LGBT); the political behavior of LGBT people with a central focus on the role of linked fate in LGBTQ politics, and research on the demography of LGBT people; and the experiences of LGBT people while incarcerated. Dr. Flores has also analyzed the effects of social attitudes about LGBT populations on the physical and mental health of LGBT populations. Dr. Flores's research has appeared in or are forthcoming in the *American Journal of Public Health*, *Political Psychology, Public Opinion Quarterly*; the *Journal of Social Issues*, *Political Research Quarterly*; *Politics, Groups, and Identities*; the *Journal of Youth and Adolescence*; *Aggression and Violent Behavior*; the *International Journal of Public Opinion Research*; *Research and Politics*, *Transgender Studies Quarterly;* and the *Indiana Journal of Law and Social Equality*.

11. **David M. Frost**, Ph.D., is a Senior Lecturer (Associate Professor) in Social Psychology in the Department of Social Science at University College London. His research focuses on close relationships, stress, stigma, and health. His primary line of research examines on how stigma, prejudice, and discrimination constitute minority stress and, as a result, affect the health and well-being of marginalized individuals. He also studies how couples psychologically experience intimacy within long-term romantic relationships and how their experience of intimacy affects their health. These two lines of research combine within recent projects examining same-sex couples' experiences of stigmatization and its resulting impact on their relational, sexual, and mental health. His research has been published in several top tier social science, public health, and policy journals and has been recognized by grants and awards from the U.S. National Institutes of Health, the Society for the Psychological Study of Social Issues, and the New York Academy of Sciences.

12. **Nanette Gartrell**, M.D., is a Visiting Distinguished Scholar at the Williams Institute, 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. Dr. Gartrell is a psychiatrist, researcher, and writer whose 48 years of scientific investigations have focused primarily on sexual minority parent families. Dr. Gartrell is the principal investigator of the U.S. National Longitudinal Lesbian Family Study, now in its 31st year. 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. "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.

13. **Jeremy Goldbach**, Ph.D., is an Assistant Professor at the University of Southern California Suzanne Dworak-Peck School of Social Work. Dr. Goldbach joined the faculty in 2012 after completing both his master's and doctoral degrees in social work at the University of Texas at Austin. His research is broadly focused on the relationship between social stigma, minority stress, and health among lesbian, gay, bisexual and transgender (LGBT) youth and adults. He has conducted studies in psychometric measurement development and is currently leading one of the first studies to examine how discrimination during adolescence may impact healthy development.

14. **Abbie E. Goldberg**, Ph.D., is an Associate Professor in the Department of Psychology at Clark University in Worcester, Massachusetts. She received her Ph.D. in clinical psychology from the University of Massachusetts Amherst. Her research examines diverse families, including lesbian- and gay-parent families and adoptive-parent families. A particular focus of her research is key life transitions (e.g., the transition to parenthood, the transition to kindergarten, and the transition to divorce) for same-sex couples. She has also studied the experiences of transgender college students, families formed through reproductive technologies, and bisexual

mothers partnered with men. She is the author of over 90 peer-reviewed articles and two books: Gay Dads (NYU Press) and Lesbian- and Gay-Parent Families (APA). She is the co-editor of LGBT-Parent Families: Innovations in Research and Implications for Practice (Springer) and the editor of the Encyclopedia of LGBTQ Studies (Sage). She has received research funding from the American Psychological Association, the Alfred P. Sloan Foundation, the Williams Institute, the Gay and Lesbian Medical Association, the Society for the Psychological Study of Social Issues, the National Institutes of Health, and the Spencer Foundation.

15. **Suzanne B. Goldberg**, J.D., is the Herbert and Doris Wechsler Clinical Professor of Law and founding director of the Sexuality and Gender Law Clinic at Columbia Law School. She also co-directs the Law School's Center for Gender & Sexuality Law. Professor Goldberg has written extensively about discrimination against lesbians, gay men, bisexuals and transgender people and has worked for nearly three decades on efforts to redress this discrimination.

16. **Gary J. Gates**, Ph.D., is a recognized expert on the geography and demography of the lesbian, gay, bisexual, and transgender (LGBT) population. Justice Anthony Kennedy cited his friend-of-the-court brief in his majority opinion in *Obergefell v. Hodges* (2015), holding that same-sex couples have a constitutional right to marriage. Dr. Gates holds a PhD in Public Policy and Management from the Heinz College, Carnegie Mellon University, a Master of Divinity degree from St. Vincent Seminary, and a Bachelor of Science degree in

Computer Science from the University of Pittsburgh at Johnstown. He is co-author of *The Gay and Lesbian Atlas* and publishes extensively on the demographic and economic characteristics of the LGBT population. National and international media outlets regularly feature his work. Dr. Gates is retired as a Distinguished Scholar and Research Director at the Williams Institute, UCLA School of Law. He has also held positions as a Senior Researcher at Gallup, a Research Associate at the Urban Institute in Washington, DC and Director of the AIDS Intervention Project in Altoona, PA.

17. **John C. Gonsiorek**, Ph.D., holds a Diplomate in Clinical Psychology from the American Board of Professional Psychology. He is past president of American Psychological Association Division 44, and has published widely on sexual orientation and identity. He is a fellow of APA Divisions 9, 12, 29, 36, and 44. Until August 2012, he was Professor in the PsyD Program at Argosy University/Twin Cities; and has taught at a number of other institutions. For over 25 years, he had an independent practice of clinical and forensic psychology in Minneapolis, and provided expert witness evaluation and testimony on a number of areas, including sexual orientation. Expert witness testimony regarding sexual orientation has included helping prepare *amicus curiae* briefs for the American Psychological Association; testimony in major cases includes: *Evans et al, v. Romer et al*., *Equality Foundation et al. v. Cincinnat*i, and *Nabozny v. Podlezny et al*. He has been a consulting editor for *Professional Psychology: Research & Practice,* and currently serves as Founding Editor for

Psychology of Sexual Orientation and Gender Diversity. His major publications include: Homosexuality: Research implications for public policy, and Homosexuality and psychotherapy: A practitioner's handbook of affirmative models.

18. **Perry N. Halkitis**, Ph.D., M.S., M.P.H., is dean of the Rutgers School of Public Health at Rutgers University–New Brunswick. Previously, he was professor of global public health, applied psychology, and medicine at NYU, where he has focused a significant amount of his research on HIV/AIDS, drug abuse, and mental health disease and how they are impacted by psychiatric and psychosocial factors. Dr. Halkitis also served as senior associate dean of the New York University (NYU) College of Global Public Health; director of NYU's Center for Health, Identity, and Behavior and Prevention Studies; and interim chair of the Department of Biostatistics at the College of Global Public Health. As senior associate dean for academic and faculty affairs at the NYU College of Global Public Health, Dr. Halkitis managed the academic portfolio of the college and administers the curriculum; directed faculty appointments and hiring; and participated in the college's and university's fund-raising efforts. He was NYU's inaugural associate dean for research and doctoral studies from 2005 to 2013 and earlier chaired the NYU Department of Applied Psychology.

19. **Gary W. Harper**, Ph.D., M.P.H., is a Professor of Health Behavior and Health Education, Professor of Global Public Health, and Director of the Office of Undergraduate Education at the School of Public Health at the University of Michigan. Dr.

Harper has conducted extensive research for more than 20 years with sexual minority youth/young adults, and has authored more than 130 publications in peer-reviewed academic journals. His research and community work have focused on the health and well-being of sexual minority youth and young adults, especially gay/bisexual male youth of color. This work includes the development of evidence-based interventions aimed at improving the health and well-being of sexual minority youth and young adults who experience discrimination, prejudice, and stigma. Dr. Harper's health promotion interventions for sexual minority youth are being utilized by community organizations and health centers in various states across the U.S., as well as in Kenya. Dr. Harper has testified as an expert witness in the City and County of San Francisco, California, and was appointed by the 2008 U.S. Secretary of Health and Human Services (under the George W. Bush administration) to serve on the Department of Health and Human Service's Office on AIDS Research Advisory Council.

20. **Amira Hasenbush**, J.D., M.P.H., is the Jim Kepner Law and Policy Fellow at the Williams Institute, UCLA School of Law. She researches discrimination based on sexual orientation and gender identity, family law issues for LGBT parents and children, and the legal needs of people living with HIV. She has completed empirical research on the existence and impact of public accommodations laws at the state and local level.

21. **Mark L. Hatzenbuehler**, Ph.D., is Associate Professor of Sociomedical Sciences and Sociology at Columbia University's Mailman School

of Public Health. Dr. Hatzenbuehler's research examines how structural forms of stigma—including social policies and community-level norms—increase risk for adverse health outcomes among members of stigmatized populations, with a particular focus on lesbian, gay, and bisexual individuals. He also developed a widely cited theoretical model that identifies psychosocial mechanisms linking stigma-related stressors to the development of psychopathology. Dr. Hatzenbuehler has published over 100 peer-reviewed articles and book chapters, and his work has been published in several leading journals, including *American Psychologist, Psychological Bulletin, American Journal of Public Health,* and *JAMA Pediatrics*. In recognition of this work on stigma and health inequalities, Dr. Hatzenbuehler received the 2015 Louise Kidder Early Career Award from the Society for the Psychological Study of Social Issues, the 2016 Early Career Award for Distinguished Contributions to Psychology in the Public Interest from the American Psychological Association, and the 2016 Janet Taylor Spence Award for Transformational Early Career Contributions from the Association for Psychological Science.

22. **Jody L. Herman**, Ph.D., is Scholar of Public Policy at the Williams Institute, UCLA School of Law. Dr. Herman has worked on issues of poverty, women's rights, and anti-discrimination policy development with non-profit research, advocacy, and direct-service organizations in the United States and Mexico. Before joining the Williams Institute, she worked as a research consultant on issues of voting rights in low-income minority communities and gender identity discrimination. She served as a co-

author on the groundbreaking report Injustice at Every Turn, based on the National Transgender Discrimination Survey conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality. At the Williams Institute, her work has included research on the fiscal and economic impact of marriage for same-sex couples, the fiscal impact of employment discrimination against people who are transgender, and the development of trans-inclusive questions for population-based surveys. Her main research interests are the impact of gender identity-based discrimination and issues related to gender regulation in public space and the built environment.

23. **Ning Hsieh**, Ph.D., is an assistant professor of sociology at Michigan State University. Dr. Hsieh studies disparities in health outcomes and health care access by sexual orientation. Her research focuses on how sexual minorities' experiences of marginalization, prejudice, and discrimination contribute to their lower access to social, economic, and other coping resources, which eventually leads to poorer mental and physical health. Her recent publications reveal the heterogeneity in health risks among sexual minorities, suggesting that sexual minorities of color and bisexual individuals are particularly disadvantaged in health and healthcare experience.

24. **Laura T. Kessler**, J.D., J.S.D., is a Professor of Law at the University of Utah, S.J. Quinney School of Law. Dr. Kessler studies discrimination and families. Her expertise includes the harms of discrimination with regard to marriage, parentage, child custody, and family leave for LGB

individuals. Professor Kessler has developed a theory of equal citizenship for LGB individuals rooted in their intimate relationships. Her papers document the long and continuing history of disapproval of LGB relationships; how this denial serves to disrespect and subordinate gays and lesbians; and the consequent emotional, political, and expressive significance for LGB individuals of legal recognition of their intimate relationships. Her research is widely cited and recognized as providing rigorous, comprehensive, interdisciplinary analyses of the stubborn problem of discrimination against minority families, including LGB families. She was co-author of Brief of Amici Curiae Family Law Professors in Support of Plaintiffs-Appellees and Affirmance, filed in *Kitchen v. Herbert*, 755 F.3d 1193 (10th Cir. 2014), addressing, among other issues, the harm of the state of Utah's marriage ban to the well-being of different-sex couples and their children.

25. **Suzanne A. Kim**, J.D., is Professor of Law at Rutgers Law School at Rutgers University in Newark. Her research interests include the socio-legal regulation of intimacy; discrimination; intersections of family law with gender, sexuality, culture, and race; critical legal theory; law and social science; and vulnerability and resilience, including as concerning minority stress. Professor Kim has served as Associate Dean for Faculty Development at Rutgers Law. A recipient of the Dream Professor Award from the Association of Black Law Students at Rutgers Law, Professor Kim has been a visiting scholar at Emory University's interdisciplinary Vulnerability and the Human Condition Initiative and Columbia Law School's Center for Gender and

Sexuality Law and has also taught at Fordham Law School. Professor Kim also serves on the Executive Committee of the Institute for Research on Women at Rutgers University.

26. **Nancy J. Knauer**, J.D., is a Professor of Law and Director of the Law & Public Policy Program at Temple University, Beasley School of Law. For the past twenty-five years, Professor Knauer has explored the impact of federal policies on the lives of LGBT people. She is the author of Gay and Lesbian Elders: History, Law and Identity Politics in the US and more than forty academic articles, books, and book chapters. Her most recent scholarship focuses on the challenges faced by LGBT older adults, including health disparities and issues related to minority stress. Professor Knauer has received a Dukeminier Award and the Stu Walter Prize from the Williams Institute for her scholarship on LGBT aging issues. She is the co-founder of the Aging, Law & Society Collaborative Research Network of the Law & Society Association and served on the Executive Committee of the Family Law Institute of the National LGBT Bar Association. Professor Knauer was selected as one of 26 law professors from across the nation to be featured in the book What the Best Law Teachers Do, published by Harvard University Press in 2013.

27. **David J. Lick**, Ph.D., is User Experience Researcher at Facebook. Dr. Lick received his doctorate in Psychology from the University of California, Los Angeles. His research examines a number of issues related to sexual orientation, ranging from the psychological factors that contribute to prejudice against LGBT people to the downstream

health consequences of such prejudice. He recently collaborated on a scientific review that synthesized the growing body of research linking sexual minorities' experiences with prejudice to physical health disparities. He and his colleagues outlined the psychological, physiological, and behavioral pathways through which prejudice could hinder overall health for LGBT people. Dr. Lick has received numerous honors and awards for his work, including funding from the National Science Foundation, American Psychological Association, American Psychological Foundation, and Society for the Psychological Study of Social Issues.

28. **Marguerita Lightfoot**, Ph.D., is Professor of Medicine at the University of California, San Francisco School of Medicine. She is Chief for the Division of Prevention Science, Director of the Center for AIDS Prevention Studies (CAPS), Director of the UCSF Prevention Research Center and she holds the Walter Gray Endowed Chair. As a counseling psychologist, her research focus has been on improving the health and well-being of adolescents and young adults as well as the development of efficacious interventions to reduce health disparities among those populations disproportionately burdened by HIV and poorer mental and physical health outcomes. Her domestic and international research has included developing culturally appropriate interventions for runaway/homeless youth, juvenile justice involved adolescents, youth in medical clinics and settings, youth with a parent living with HIV, youth living with HIV, and LGBT youth, among others. She also studies the factors and approaches that strengthen resilience and mitigate the societal

impacts of stressors among these vulnerable populations of youth.

29. **Christy Mallory**, J.D., is the Director of State & Local Policy at the Williams Institute, UCLA School of Law. She studies the prevalence and impact of discrimination against LGBT people and same-sex couples in areas such as employment, housing, public accommodations, and education. Her work has been published in various journals and books, including *When Mandates Work* (UC Press, 2013), the *Loyola of Los Angeles Law Review*, the *LGBTQ Policy Journal at the Harvard Kennedy School*, and the *Albany Government Law Review*.

30. **Michael P. Marshal**, Ph.D., is an Associate Professor of Psychiatry at the University of Pittsburgh, and a Licensed Clinical Psychologist. Dr. Marshal is also a Standing Member of the "Health Disparities and Equity Promotion" Study Section within the Center for Scientific Review, at the National Institutes of Health (NIH). His expertise includes the investigation of mental health disparities among lesbian, gay, and bisexual (LGB) adolescents, particularly adolescents under the age of 18 years old. Dr. Marshal's program of research has been supported by multiple NIH-funded grants. His peer-reviewed publications have provided strong scientific evidence for the following: (1) On average, compared with heterosexual adolescents, LGB adolescents report higher rates of substance use, depressive symptoms, suicidality, and violent victimization experiences; (2) Mental health disparities among LGBT adolescents persist as they transition into young adulthood; and (3) Consistent with Dr. Ilan Meyer's Minority Stress Model, gay-

related victimization experiences are strongly associated with these disparities.

31. **Miguel Muñoz-Laboy**, Dr.P.H., is an Associate Professor of Social Work at Temple University's College of Public Health. Dr. Muñoz-Laboy conducts studies on: 1) social and cultural factors that impact access to HIV/sexually transmitted infections, mental health, and/or substance abuse treatments in Latino communities in the United States; 2) the roles of acculturative stress and minority stress in the health and well-being for bisexual populations; and 3) linkage and retention in HIV among Latinos(as) with severe opioids use disorder. Drawing on Dr. Ilan Meyer's minority stress model, Muñoz-Laboy published research has documented how sexual minority stress increased the severity of anxiety and depressive symptoms among Latino bisexual men. To support his research program, he has received nine grants by the U.S. National Institutes of Health and private foundations as the Principal Investigator (PI) or co-Principal Investigator (co-PI) and has served as co-Investigator in 11 additional grants. Dr. Muñoz-Laboy has published over 70 articles in peer-reviewed journals, authored 10 chapters in edited books, and co-edited two books.

32. **John Pachankis**, Ph.D., is an Associate Professor of Public Health at Yale University. Dr. Pachankis studies the mental health of sexual and gender minority individuals. He developed a highly-cited model of stigma concealment, which has been used to understand the reasons that people conceal stigmatized identities and the psychological costs of doing so. He also studies the psychological impact of

stigma and discrimination on sexual and gender minority mental health over the lifespan. Drawing on his background as a clinical psychologist, he has translated this research into some of the first evidence-based mental health treatments for LGBT individuals. He has tested the delivery of these treatments via novel technologies (e.g., smartphones), in diverse settings (e.g., Eastern Europe), and with diverse segments of the LGBT community (e.g., rural youth). He is the recipient of the 2017 Distinguished Contributions to Knowledge award of the American Psychological Association's Division 44.

33. **Charlotte J. Patterson**, Ph.D., is a professor of Psychology at the University of Virginia. She is best known for her research on the role of sexual orientation in human development and family lives—specifically for her work on child development in lesbian- and gay-parented families. Patterson's research has been published in the field's top journals and she has co-edited four books on the psychology of sexual orientation. Patterson is a Fellow of the American Psychological Association (APA) and of the Association for Psychological Science (APS) and a past president of the Society for Psychological Study of Lesbian, Gay, and Bisexual Issues. She has won a number of awards, including APA's Distinguished Contributions to Research in Public Policy Award. She also served as a member of the United States Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues, whose 2011 report on LGBT health disparities was instrumental in leading the National Institutes of Health to reorganize research and increase funding for studies in this area.

34. **John L. Peterson**, Ph.D., is emeritus professor of psychology at Georgia State University. Prior to his faculty position at Georgia State, he was on the faculty at the University of California, San Francisco, in the Department of Medicine. Dr. Peterson studies the effects of sexual prejudice and violence toward sexual minorities and psychological issues related to the HIV/AIDS prevention among nonwhite gay and bisexual men. His work has been well cited regarding the interactive effects of sexual prejudice, masculine ideology, and violence toward sexual minorities and the sociocultural and psychological factors associated with HIV risk behavior and the social determinants of racial disparity in HIV infection. Dr. Peterson served on the Institute of Medicine (IOM) Committee on Lesbian, Gay, Bisexual & Transgender Health Issues and Research Gaps at the National Academies.

35. **Nancy Polikoff**, J.D., is Professor of Law at American University Washington College of Law where she teaches Family Law and a seminar on Children of LGBT Parents. She was previously the Visiting McDonald/Wright Chair of Law at UCLA School of Law and Faculty Chair of the Williams Institute. For more than 40 years, she has been writing about, teaching about, and working on litigation and legislation about LGBT families. Among her many publications is the book *Beyond (Straight and Gay) Marriage: Valuing All Families under the Law* (2008). Professor Polikoff was instrumental in the development of the legal theories that support second-parent adoption and custody and visitation rights for legally unrecognized parents. She was successful counsel in *In re M.M.D.*, which

established joint adoption for lesbian, gay, and unmarried couples in DC, and *Boswell v. Boswell*, a Maryland case that overturned restrictions on a gay noncustodial father's visitation rights. From 2007-2009, she played a primary role in the drafting and passage of groundbreaking parentage legislation in DC. She is a former chair of the Association of American Law Schools Section on Sexual Orientation and Gender Identity Issues. In 2011, Professor Polikoff received the Dan Bradley award from the National LGBT Bar Association, the organization's highest honor.

36. **Ellen D.B. Riggle**, Ph.D., is Professor of Political Science and Gender and Women's Studies at the University of Kentucky. Dr. Riggle studies the impact of stigma and identity strengths on the health and well-being of LGBT people and same-sex couples. Her areas of research include the effects of minority stress on LGBT individuals and same-sex couples, how laws and policies affect LGBT individuals' reports of distress and well-being, and the role of positive LGBT identity factors in well-being and resilience. Dr. Riggle is the co-author of A Positive View of LGBTQ: Embracing Identity and Cultivating Well-Being, winner of the 2012 American Psychological Association Division 44 Distinguished Book Award, and Happy Together: Thriving as a Same-Sex Couple in Your Family, Workplace, and Community (published by the American Psychological Association LifeTools series).

37. **Sharon Scales Rostosky**, Ph.D., is Professor and Director of Training in the Counseling Psychology program at the University of Kentucky. She is also a licensed psychologist. Dr. Rostosky uses

qualitative and quantitative methodologies to document the negative psychosocial impacts of prejudice and discrimination against LGB individuals and same-sex relationships that is sourced at all levels of the ecological system (intrapersonal, interpersonal, and socio-cultural). Her research on same-sex couple relationships was first funded by the American Psychological Foundation in 2000 and most recently by NIH in 2017. In addition to over 70 peer-reviewed articles, Dr. Rostosky has co-authored two books based on her research findings: *A Positive View of LGBTQ: Embracing Identity and Cultivating Well-Being* (Riggle & Rostosky, 2012, Rowman & Littlefield; American Psychological Association Division 44 Distinguished Book Award for 2012.), and *Happy Together: Thriving as a Same-Sex Couple in Your Family, Workplace, and Community* (Rostosky & Riggle, 2015, American Psychological Association).

38. **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 Dr. Rothblum 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.

39. **Jocelyn Samuels**, J.D., is the Executive Director of the Williams Institute with close to three decades of experience in interpretation and enforcement of federal civil rights laws. She has served in numerous roles in the federal government, including as Acting Assistant Attorney General for the Civil Rights Division at the U.S. Department of Justice, and Director of the Office of Civil Rights at the U.S. Department of Health and Human Services. She has deep expertise in issues related to LGBT law and policy, including with respect to barriers that continue to limit access for the LGBT community to services and benefits and the application of existing laws to discrimination based on sexual orientation and gender identity.

40. **R. Bradley Sears**, J.D., is the David Sanders Distinguished Scholar of Law and Policy at the Williams Institute and Associate Dean of Public Interest Law at UCLA School of Law. Over the past two decades, Sears has published a number of research studies and articles, primarily on discrimination against LGBT people in the workplace in the private and public sectors, HIV discrimination by health care providers, the economic and fiscal impact of discrimination against same-sex couples, and the economic and fiscal impact of LGBT health disparities at the state-level.

41. **Ari Ezra Waldman**, J.D., Ph.D., is an Associate Professor of Law at New York Law School. He is the Director of the Innovation Center for Law and Technology and the Founder and Director of the Institute for CyberSafety, a full service academic and direct outreach program that includes, among other things, the first and, to-date, only law school clinic

representing LGBTQ victims of online harassment. Professor Waldman's research focuses, in relevant part, on the frequency and effects of bullying and cyberbullying on marginalized populations; the impact face-to-face and online harassment have on queer youth and adolescent success and health; and how federal, state, and local laws and policies can reduce cybervictimization and improve the lives of members of the LGBTQ community. His work has been published in leading law reviews and his forthcoming work explores nonconsensual image sharing among gay men and the effect of mobile apps on queer social life. He is an internationally sought-after speaker and commentator on privacy and cyberharassment.

42. **Bianca D.M. Wilson**, Ph.D., is a Senior Scholar of Public Policy at the Williams Institute, UCLA School of Law, and 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 and the UCSF Lesbian Health and Research Center 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.

43. **Richard G. Wight**, Ph.D., M.P.H., is a retired Researcher from the Department of Community Health Sciences at the UCLA School of Public Health. For more than two decades, he conducted interdisciplinary research on stress and health experiences of individuals vis-à-vis the people and places around them, and his work has been widely published in the U.S. and internationally. His early publications were among the first to address public health and health policy issues relating to informal AIDS caregiving in the United States and he is an expert on the neighborhood context of health. Wight has developed life course studies that examine aging, minority stress, and health processes among the growing population of midlife and older lesbians and gay men, with a particular focus on the health effects of same-sex legal marriage. His recent work examines minority stress and health experiences of the parents of sexual minorities.

Institutional affiliations for identification purposes only

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March 27, 2018

The Honorable Alex M. Azar, II
Secretary
U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (RIN 0945-ZA03), 83 Fed. Reg. 3880 (January 26, 2018)

Dear Secretary Azar:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments to the Department of Health and Human Services (HHS) in response to the Notice of Proposed Rulemaking (Proposed Rule or Proposal) on "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," issued by the Office of Civil Rights (OCR). In its Proposed Rule, OCR proposes to revise existing regulations and create new regulations to interpret and enforce more than 20 federal statutory provisions related to conscience and religious freedom. Under OCR's broad interpretation of these provisions, individuals, health care organizations, and other entities would be allowed to refuse to provide or participate in medical treatment, services, information, and referrals to which they have religious or moral objections. This would include services related to abortion, contraception (including sterilization), vaccination, end-of-life care, mental health, and global health support, and could include health care services provided to patients who are lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ).

For the reasons discussed below, the AMA believes the Proposed Rule would undermine patients' access to medical care and information, impose barriers to physicians' and health care institutions' ability to provide treatment, impede advances in biomedical research, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions about their legal and ethical obligations to treat patients. We are very concerned that the Proposed Rule would legitimize discrimination against vulnerable patients and in fact create a right to refuse to provide certain treatments or services. Given our concerns, we urge HHS to withdraw this Proposal.

The AMA supports conscience protections for physicians and other health professional personnel. We believe that no physician or other professional personnel should be required to perform an act that violates good medical judgment, and no physician, hospital, or hospital personnel should be required to perform any act that violates personally held moral principles. As moral agents in their own right, physicians are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. According to the *AMA Code of Medical Ethics*, "physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities."

Conscience protections for medical students and residents are also warranted. The AMA supports educating medical students, residents, and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal, and psychological principles associated with termination of pregnancy, while maintaining that the observation of, attendance at, or any direct or indirect participation in abortion should not be required.

Nonetheless, while we support the legitimate conscience rights of individual health care professionals, the exercise of these rights must be balanced against the fundamental obligations of the medical profession and physicians' paramount responsibility and commitment to serving the needs of their patients. As advocates for our patients, we strongly support patients' access to comprehensive reproductive health care and freedom of communication between physicians and their patients, and oppose government interference in the practice of medicine or the use of health care funding mechanisms to deny established and accepted medical care to any segment of the population.

According to the AMA *Code of Medical Ethics*, physicians' freedom to act according to conscience is not unlimited. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician. The Code provides guidance to physicians in assessing how and when to act according to the dictates of their conscience. Of key relevance to the Proposed Rule, the *Code* directs physicians to:

- Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- Be mindful of the burden their actions may place on fellow professionals.
- Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

The ethical responsibilities of physicians are also reflected in the AMA's long-standing policy protecting access to care, especially for vulnerable and underserved populations, and our anti-discrimination policy, which opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age. We are concerned that the Proposed Rule, by attempting to allow individuals and health care entities who receive federal funding to refuse to provide *any* part of a health service or program based on religious beliefs or moral convictions, will allow discrimination against patients, exacerbate health inequities, and undermine patients' access to care.

We would like to note that no statutory provision requires the promulgation of rules to implement various conscience laws that have been in existence for years. We believe physicians are aware of their legal obligations under these requirements and do not think that the promulgation of this rule is necessary to enforce the conscience provisions under existing law. OCR has failed to provide adequate reasons or a satisfactory explanation for the Proposed Rule as required under the Administrative Procedure Act (APA). As OCR itself acknowledges, between 2008 and November 2016, OCR received 10 complaints alleging violations of federal conscience laws; OCR received an additional 34 similar complaints between November 2016 and January 2018. In comparison, during a similar time period, from fall 2016 to fall 2017, OCR received over 30,000 complaints alleging violations of either HIPAA or civil rights. These numbers demonstrate that the Proposed Rule to enhance enforcement authority over conscience laws is not necessary.

OCR's stated purpose in revising existing regulations is to ensure that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate, in violation of federal laws. We believe that several provisions and definitions in the Proposed Rule go beyond this stated purpose and are ambiguous, overly broad, and could lead to differing interpretations, causing unnecessary confusion among health care institutions and professionals, thereby potentially impeding patients' access to needed health care services and information. The Proposed Rule attempts to expand existing refusal of care/right of conscience laws—which already are used to deny patients the care they need—in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions specifically related to the service or research activity to which they object. But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they are working on. Such an attempted expansion goes beyond what the statute enacted by Congress allows.

We are concerned that the scope of the services and programs that would be covered under the Proposed Rule is broader than allowed by existing law. While OCR claims that it is trying to clarify key terms in existing statutes, it appears that they are actually redefining many terms to expand the meaning and reach of these laws. For example, "health program or activity" is defined in the proposed regulatory text to include "the provision or administration of any health-related services, health service programs and research activities, health-related insurance coverage, health studies, or any other service related to health or wellness whether directly, through payments, grants, contracts, or other instruments, through insurance, or otherwise." Likewise, "health service program" is defined in the proposed regulatory text to include "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by [HHS]." These definitions make clear that OCR intends to interpret these terms to include an activity related <u>in any way</u> to providing medicine, health care, or any other service related to health or wellness, including programs where HHS provides care directly, grant programs such as Title X, programs such as Medicare where HHS provides reimbursement, and health insurance programs where federal funds are used to provide access to health coverage, such as Medicaid and CHIP. The definitions inappropriately expand the scope of the conscience provisions to include virtually any medical treatment or service, biomedical and behavioral research, and health insurance.

Furthermore, the Proposed Rule's new and expanded definitions often exceed, or are not in accordance with, existing definitions contained within the existing laws OCR seeks to enforce. For example, "health care entity" is defined under the Coats and Weldon Amendments to include a limited and specific range of individuals and entities involved in the delivery of health care. However, the Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term by including a wide range of individuals, e.g., not just health care professionals, but any personnel, and institutions, including not only health care facilities and insurance plans, but also plan sponsors and state and local governments. This impermissibly expands statutory definitions and will create confusion.

We are also concerned that the proposed rule expands the range of health care institutions and individuals who may refuse to provide services, and broadens the scope of what qualifies as a refusal under the applicable law beyond the actual provision of health care services to information and counseling about health services, as well as referrals. For example, "assist in the performance" is defined as "participating in any program or activity with an articulable connection to a given procedure or service." The definition also states that it includes "counseling, referral, training, and other arrangements for the procedure, health service, or research activity." While "articulable connection" is not further explained, OCR states in the preamble that it seeks to provide broad protection for individuals and that a narrower definition, such as a definition restricted to those activities that constitute direct involvement with a procedure, health service, or research activity, would not provide sufficient protection as intended by Congress.

However, this definition goes well beyond what was intended by Congress. Specifically, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization. The statute does not contain a definition for the phrase "assist in the performance." Senator Church, during debate on the legislation, stated that, "the amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation." Read in conjunction with the rest of the proposed rule, it is clear this definition is intended to broaden the amendment's scope far beyond what was envisioned when the amendment was enacted. It allows any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

In a similar fashion, the proposed definition of "workforce" extends the right to refuse not only to an entity's employees but also to volunteers and trainees. When both of these definitions are viewed together, this language seems to go well beyond those who perform or participate in a particular service to permit, for example, receptionists or schedulers to refuse to schedule or refer patients for medically necessary services or to provide patients with factual information, financing information, and options for medical treatment. It could also mean that individuals who clean or maintain equipment or rooms used in procedures to which they object would have a new right of refusal and would have to be accommodated. We believe this could significantly impact the smooth flow of health care operations for physicians, hospitals, and other health care institutions and could be unworkable in many circumstances.

The AMA is concerned that the Proposed Rule fails to address the interaction with existing federal and state laws that apply to similar issues, and thus is likely to create uncertainty and confusion about the rights and obligations of physicians, other health care providers, and health care institutions. Most notably, the Proposal is silent on the interplay with Title VII of the Civil Rights Act of 1964 and guidance by the Equal Employment Opportunity Commission, which along with state laws govern religious discrimination in the workplace. Title VII provides an important balance between employers' need to accommodate their employees' religious beliefs and practices—including their refusal to participate in specific health care activities to which they have religious objections—with the needs of the people the employer must serve. Under Title VII, employers have a duty to reasonably accommodate an employee or applicant's religious beliefs or practices, unless doing so places an "undue hardship" on the employer's business. It is unclear under the Proposed Rule if, for example, hospitals would be able to argue that an accommodation to an employee is an undue hardship in providing care. The Proposed Rule also could put hospitals, physician practices, and other health care entities in the impossible position of being forced to hire individuals who intend to refuse to perform essential elements of a job. Under Title VII, such an accommodation most likely would not be required.

Additional concerns exist for physicians with respect to their workforce under this Proposal. The Proposed Rule is unclear about what a physician employer's rights are in the event that an employee alleges discrimination based on moral or religious views when in fact there may be just cause for adverse employment decisions. For example, if a physician declines to hire an individual based on a lack of necessary skill, compensation and/or benefit requests out of the physician's budget, or simply because the individual is not a good fit in the office, but the individual also happens to be opposed to providing care to LGBTQ patients, does the physician open him/herself up to risk of a complaint to OCR? If so, physicians will be forced to substantially increase their documentation related to hiring and other decision-making related to human resources, adding administrative burden to already overworked practices. These considerations must not be overlooked by regulators, as OCR's enforcement mechanisms include the power to terminate federal funding for the practice or health care program implicated.

Adding to a practice's administrative burden is the Proposal's requirement that physicians submit both an assurance and certification of compliance requirements to OCR. Despite its reasoning in the preamble that HHS is "concerned that there is a lack of knowledge" about federal health care conscience and associated anti-discrimination laws, it remains unclear why OCR would require physicians to make two separate attestations of compliance to the same requirements, particularly given the administration's emphasis on reducing administrative burden in virtually every other space in health care. At the very least, OCR should (1) streamline the certification and assurance requirements with those already required on the HHS portal; and (2) expand the current exemptions from such requirements to include physicians participating not only in Medicare Part B, but also in Medicare Part C and Medicaid, as was the case in the 2008 regulation implementing various conscience laws. We reiterate, however, that we believe the overall compliance attestation requirements are unnecessary. If HHS' concern is about lack of awareness of the conscience laws, the AMA stands ready to assist with the agency's educational efforts in place of increased administrative requirements.

The Proposed Rule also seems to set up a conflict between conscience rights and federal, state, and local anti-discrimination laws, as well as policies adopted by employers and other entities and ethical codes of conduct for physicians and other health professionals. These laws, policies, and ethical codes are designed to protect individuals and patients against discrimination on the basis of race, gender, gender

identity, sexual orientation, disability, immigration status, religion, and national origin. It is unclear under the Proposed Rule how these important anti-discrimination laws, policies, and ethical codes will apply in the context of the expanded conscience rights proposed by OCR. The Proposed Rule also fails to account for those providers that have strongly held moral beliefs that motivate them to treat and provide health care to patients, especially abortion, end-of-life care, and transition-related care. For example, the Church Amendment affirmatively protects health care professionals who support or participate in abortion or sterilization services yet there is no acknowledgement of it in the Proposal.

Moreover, the Proposed Rule appears to conflict with, and in fact contradict, OCR's own mission, which states that "The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; *to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination*; and to protect the privacy and security of health information in accordance with applicable law" (emphasis added). In the past, HHS and OCR have played an important role in protecting patient access to care, reducing and eliminating health disparities, and fighting discrimination. There is still much more work to be done in these areas given disparities in racial and gender health outcomes and high rates of discrimination in health care experienced by LGBTQ patients. The Proposed Rule is a step in the wrong direction and will harm patients.

Likewise, the Proposed Rule does not address how conscience rights of individuals and institutions apply when emergency health situations arise. For example, the federal Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals that have a Medicare provider agreement and an emergency room or department to provide an appropriate medical screening to any patient requesting treatment to determine whether an emergency medical condition exists, and to either stabilize the condition or transfer the patient if medically indicated to another facility. Every hospital, including those that are religiously affiliated, is required to comply with EMTALA. By failing to address EMTALA, the Proposed Rule might be interpreted to mean that federal refusal laws are not limited by state or federal legal requirements related to emergency care. This could result in danger to patients' health, particularly in emergencies involving miscarriage management or abortion, or for transgender patients recovering from transition surgery who might have complications, such as infections.

We are also concerned that the Proposed Rule could interfere with numerous existing state laws that protect women's access to comprehensive reproductive health care and other services. For example, the Proposed Rule specifically targets state laws that require many health insurance plans to cover abortion care (e.g., California, New York, and Oregon). OCR overturns previous guidance that was issued by the Obama administration providing that employers sponsoring health insurance plans for their employees were not health care entities with conscience rights; OCR argues that the previous guidance misinterpreted federal law, and, as discussed previously, proposes to add plan sponsors to the definition of health care entities. Likewise, the Proposed Rule could conflict with, and undermine, state laws related to contraceptive coverage. In addition, the Proposed Rule requires entities to certify in writing that they will comply with applicable Federal health care conscience and associated anti-discrimination laws. Under the broad language of the rule, hospitals, insurers, and pharmacies could claim they are being discriminated against if states attempt to enforce laws that require insurance plans that cover other prescription drugs to cover birth control, ensure rape victims get timely access to and information about emergency contraception, ensure that pharmacies provide timely access to birth control, and ensure that

hospital mergers and sales do not deprive patients of needed reproductive health services and other health care services.

In conclusion, the AMA believes that, as currently drafted, the Proposed Rule could seriously undermine patients' access to necessary health services and information, negatively impact federally-funded biomedical research activities, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions about their legal and ethical obligations to treat patients. Given our concerns, we urge HHS to withdraw this proposed rule. If HHS does decide to move forward with a final rule, it should, at the very least, reconcile the rule with existing laws and modify the provisions we have identified to ensure that physicians and other health providers understand their legal rights and obligations.

Sincerely,

James L. Madara, MD

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March 22, 2018

Submitted electronically through www.regulations.gov

The Honorable Alex Azar
Secretary of Health and Human Services
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Office for Civil Rights
Hubert H. Humphrey Building, Room 509F
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Attn: Docket HHS-OCR-2018-0002 (RIN 0945-ZA03)
Re: Protecting Statutory Conscience Rights in Health Care

Dear Secretary Azar:

The County of Santa Clara ("County") submits these comments in response to the Department of Health and Human Services' (HHS) proposed rule, Protecting Statutory Conscience Rights in Health Care.[1]

The County, established in 1850, is a charter county and political subdivision of the State of California. Its mission is to protect the health, safety, and welfare of 1.9 million County residents. The County owns and operates Santa Clara Valley Medical Center ("SCVMC"), a fully integrated and comprehensive public health care delivery system that provides critical health care to residents of Santa Clara County regardless of their ability to pay. SCVMC, which includes a 574-bed tertiary care hospital with a Level 1 trauma center and 11 ambulatory care clinics, is the only public safety-net health care provider in Santa Clara County, and the second largest such provider in California. SCVMC provides the vast majority of the health care services available to poor and underserved patients in the County. The County also owns and operates Valley Health Plan ("VHP"), which participates in California's health insurance marketplace under the Affordable Care Act.

[1] 83 Fed. Reg. 3880 (proposed Jan. 26, 2018).

As set forth below, the proposed regulation: (1) improperly attempts to broaden the substantive scope of statutory conscience-based protections; (2) if adopted, may be improperly interpreted to invite discrimination against patients who face significant barriers to care; and (3) if adopted, will impose unnecessary burdens on safety-net providers such as the County.

A. The Proposed Regulation Improperly Attempts to Broaden the Substantive Scope of Statutory Conscience-Based Protections

Existing law provides an adequate framework for the enforcement of conscience-based protections, which protect under certain circumstances health care workers who refuse to participate in certain procedures or services based on their religious beliefs or "moral convictions." In addition, Title VII of the Civil Rights Act of 1964 provides an employment law framework for religious accommodations. The proposed regulation is not only unnecessary in light of the current framework, but it also improperly attempts to legislate heightened conscience-based protections that Congress has not recognized. Through its "further definition of Federal health care conscience and associated anti-discrimination laws," the proposed regulation seeks to vastly expand the scope of conscience-based protections in a way that substantially increases the likelihood that already-marginalized patients will face additional barriers in accessing health care.[2] Such an effect on patients seeking care undermines HHS's mission "to enhance and protect the health and well-being of all Americans."[3]

1. The proposed regulation improperly broadens the meaning of "referral or refer for," which may result in health care workers turning patients away from a facility when others at the facility are willing to provide care.

The proposed regulation's broad definitions of "assist in the performance" and "referral or refer to" in sections 88.3(a)(2)(v) and 88.2 sweep beyond the statutory language and may be improperly interpreted as permitting individual health care workers to turn patients away from a facility, without providing *any* information, when the objected-to services are in fact provided at that facility.[4] The definition in Section 88.2 of "refer or refer to" as including "the provision of any information . . . by any method" goes beyond the County's understanding of what a referral is.[5] The County is concerned that individual health care workers might improperly interpret the proposed regulation as permitting them to refuse *any* form of patient assistance, including notifying them that such services are provided by the County at that facility. For example, a provider might interpret the proposed regulation as allowing her, based on "moral convictions," to turn away, without providing *any* information, a patient at SCVMC experiencing abdominal pain related to an intra-uterine device, when there are many other providers at SCVMC who are

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[2] *Id.* at 3891.

[3] *Introduction: About HHS*, HHS, https://www.hhs.gov/about/strategic-plan/introduction/index.html, attached as Exhibit 1.

[4] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3925 (§ 88.3(a)(2)(v)); *id.* at 3924 (§ 88.2).

[5] *Id.*

willing to treat that patient. Health care professionals are obligated to provide their patients with complete and accurate information about their treatment options. Failure to do so could result in liability for the providers, incomplete or deficient treatment of patients, and violation of ethical and legal principles.

Nothing in the proposed regulation supports HHS's conclusion that Congress intended such a broad extension of statutory conscience-based protections. HHS contends in the commentary to the proposed regulation that because the statutes use the terms "make arrangements for" and "refer for" services, Congress intended a broad definition of "referrals."[6] But this is not persuasive evidence that Congress intended the definition of "referral or refer to" to be as broad as it is in the proposed regulation: "provision of *any information. . . by any method*."[7] Stating that the County provides the requested services, even if the particular health care worker objects to providing them, is not "making arrangements for" a service that the provider has a religious objection to performing. In particular, the conscience-based protections must be read in light of Congress's robust, generally applicable non-discrimination statutes, including Section 1557 of the Affordable Care Act, Titles II and III of the Americans with Disabilities Act, and Title VI of the Civil Rights Act of 1964, that apply in certain health care settings.

Although HHS states that its proposed definition of "referral or refer to" will "address confusion the Department perceives among the public about what sorts of actions may be properly regarded as referrals for the purposes of protecting rights of conscience under the statutes at issue in this proposed rule,"[8] the substantive rewriting of statutory rights will result in greater confusion, because patients will not know whether they are getting complete information or a full range of treatment options. In delegating to the Office of Civil Rights (OCR) enforcement authority over the conscience-based protection statutes, Congress did not delegate the authority to transform the statutes into a broad license to discriminate and to provide patients with incomplete, deficient, or no treatment options based on a boundless array of "moral convictions," some of which may be contrary to non-discrimination statutes, and many more of which may conflict with HHS's mission to improve the health care of *all* Americans.

2. *The proposed regulation's reinterpretation of the Weldon Amendment is likely to limit access to comprehensive health insurance options.*

As applied to the Weldon Amendment,[9] the proposed regulation's definition of "health care entity" is likely to create additional barriers to accessing care, because it will likely limit

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[6] *Id.* at 3895.

[7] *Id.* (emphasis added).

[8] *Id.*

[9] The Weldon Amendment, incorporated in the HHS appropriations acts, provides that "[n]one of the funds made available in this Act may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."

access to health insurance with comprehensive coverage of reproductive services. The proposed regulation adds "a plan sponsor" to the definition of "health care entity" under the Weldon Amendment.[10] This would greatly expand the universe of entities permitted to challenge a state's requirement to "provide, pay for, provide coverage of, or refer for, abortion."[11] HHS's proposed justification for expanding the definition of "health care entity"—that "[t]he amendment's broad and non-exhaustive definition indicates that the amendment takes an inclusive approach with respect to the health care entities it protects and should not be interpreted narrowly,"[12]—is not based on any legislative history, nor is it a license to go beyond the plain meaning of the statute. Congress did not delegate authority to HHS to expand the scope of the Weldon Amendment.

It is even more problematic that the proposed regulation attempts to reinterpret the Weldon Amendment to broadly allow health care entities to refuse to "provide, pay for, provide coverage of, or refer for abortions,"[13] regardless of whether entities have a conscience-based objection to doing so. HHS offers no evidence that refusals unrelated to conscience-based objections—such as financial or operational motivations—are intended to be protected under the Weldon Amendment. Rather, both the legislative history of the Weldon Amendment, and judicial interpretations of it, compel the contrary conclusion.[14] And even though economically or operationally driven refusals to provide abortion-related services or referrals have nothing to do with civil rights, the proposed regulation would make OCR's enforcement authority available to entities that merely have an economic or operational objection to providing such services. Contrary to HHS's mission, such a delegation would likely serve only to decrease the availability of health insurance options that provide comprehensive coverage of reproductive services.

B. The Proposed Regulation, If Adopted, May Be Improperly Interpreted as Inviting Discrimination Against Patients Who Already Face Significant Barriers to Care

If adopted, the proposed regulation will likely invite discrimination against patients who already face significant barriers to accessing care, such as lesbian, gay, bisexual, transgender, or queer (LGBTQ) people. Although a full discussion of the myriad of health care consumers who may be affected by the proposed regulation is beyond the scope of this comment, the proposed

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Consolidated Appropriations Act, 2017, Public Law 115-31, § 507(d)(1), 131 Stat. 135. It defines "health care entity" to include "an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan." *Id.* at § 507(d)(2).

[10] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3890–91, 3924 (§ 88.2).

[11] *Id.* at 3925–26 (§ 88.3(c)(2)).

[12] *Id.* at 3890.

[13] *Id.* at 3925–26 (§ 88.3(c)(2)).

[14] *See* Letter from Jocelyn Samuels, Director, OCR, to Catherine W. Short, Vice President, Life Legal Def. Found., et al. (June 21, 2016) (citing *California ex rel. Lockyer v. United States*, 450 F.3d 436, 441 (9th Cir. 2006); 150 Cong. Rec. H10090 (Statement of Rep. Weldon) (Nov. 20, 2004)).

regulation's likely effect on LGBTQ people, who frequently encounter discrimination and other barriers to accessing medical care, serves as an example of the harmful impact the regulation is likely to have.

Discrimination against LGBTQ people in health care settings is well documented. In one study, more than half of all respondents had experienced at least one of the following when seeking health care: refusals of needed care, providers refusing to touch them or using excessive precautions, harsh or abusive language, providers blaming them for their health status, or physically rough or abusive conduct.[15] In that study, eight percent of lesbian, gay, or bisexual respondents reported they had been refused needed health care because of their sexual orientation, and nearly 27 percent of transgender respondents reported being refused care because of their transgender status.[16] The percentages of LGBT people of color and low-income LGBT people who reported being refused care are much higher than the percentages for survey respondents as a whole.[17]

One respondent to a survey of transgender people reported, "I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."[18] Another study, based on a review of complaints filed with OCR, describes a situation in which a transgender woman was recovering from an appendectomy, and the treating doctor, who "does not deal with 'these kinds' of patients," refused to call her by the correct pronouns.[19] Some medical providers have explicitly asserted religious-based reasons for denying care to LGBTQ people or their families, such as a pediatrician who refused to treat the newborn daughter of a lesbian couple.[20]

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[15] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* 10 (2010), *available at* https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf, attached as Exhibit 2.

[16] *Id.*

[17] *Id.* at 12. The County generally uses the acronym LGBTQ but uses "LGBT" when referring to the cited study, which uses that acronym.

[18] Jaime Grant et al., Nat'l Center for Transgender Equality & Nat'l Gay and Lesbian Task Force, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey* 73 (2011), *available at* http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, excerpt attached as Exhibit 3.

[19] Sharita Gruberg & Frank J. Bewkes, Ctr. for Am. Progress, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial* (Mar. 7, 2018), *available at* https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf, attached as Exhibit 4.

[20] Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal about It*, Washington Post (Feb. 19, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it/?utm_term=.a59cf2f3df0a, attached as Exhibit 5.

Refusing to provide medical care to consumers based on sex, sexual orientation, or gender identity is a form of sex discrimination prohibited by federal law. As an entity covered by the Affordable Care Act, the County complies with the ACA's non-discrimination protections in Section 1557, 42 U.S.C. § 18116(a), which prohibits discrimination based on sex and other protected characteristics in health programs and activities. In addition, as a local government that seeks to ensure the health, safety, and welfare of its 1.9 million residents, the County has a significant interest in eliminating discrimination and barriers to health care for *all* of its residents. To understand the health needs of the County's LGBTQ residents, the County's Public Health Department performed an LGBTQ Health Assessment in 2013.[21] Among other things, the study showed that 12 percent of LGBTQ survey respondents were "denied or given lower quality health care" in the 12 months preceding the survey due to their sexual orientation and/or gender identity.[22]

The County is concerned that the proposed regulation, if adopted, will invite medical providers to discriminate against LGBTQ health care consumers, among others, in violation of federal non-discrimination law. Not only does the proposed regulation appear to invite discriminatory conduct by expanding the reach of statutory conscience-based protections as discussed above, but it also oversimplifies them in the language it proposes to use to raise awareness among providers. The Notice in Appendix A tells providers they "have the right to decline to participate in, refer for, undergo, or pay for certain health care-related treatments, research, or services . . . which violate your conscience, religious beliefs, or moral convictions under Federal law."[23] This is not limited to the types of procedures contemplated in the statutory provisions discussed in the proposed rule. Such notice might encourage a provider, for example, to refuse to treat a transgender patient who comes to the emergency room seeking care for a broken arm based on the provider's "moral convictions," even though such refusal of service would violate federal non-discrimination law and the Emergency Medical Treatment and Labor Act.[24] And, if the notice is seen by a patient, this might discourage open communication with the provider, for fear that services will be denied. If HHS adopts the proposed regulation, it must address the empirical evidence which strongly suggests that marginalized patients will face heightened barriers in accessing care. And the notice must be compliant with all other applicable laws.

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[21] Santa Clara Cnty Pub. Health Dep't, *Status of LGBTQ Health: Santa Clara County 2013* (2013), *available at* https://www.sccgov.org/sites/phd/hi/hd/Documents/LGBTQ%20Report%202012/LGBT%20Health%20Assessment.pdf, attached as Exhibit 6.

[22] *Id.*

[23] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3931.

[24] 42 U.S.C. § 18116(a); 42 U.S.C. § 1395dd.

C. The Proposed Regulation, If Adopted, Would Be an Unnecessary Burden to Safety-Net Providers Such as the County of Santa Clara

The proposed regulation's projected costs, which HHS states will be $815 million over the course of five years, far outweigh any expected benefits that could possibly stem from the expected increase in the supply of health care providers who maintain conscience-based objections. As a result, the proposed regulation, if adopted, would be an unnecessary burden to safety-net providers such as the County, which rely on limited public funds to provide essential health care services to *all* patients on a non-discriminatory basis. As illustrated above, an effect of the proposed regulation will likely be increased discrimination against patients who already face barriers in accessing care.

The proposed regulation's discussion of "ancillary benefits for patients," such as "assist[ing] patients in seeking counselors who share their deepest held convictions,"[25] ignores the much more substantial harm that the proposed regulation will likely cause to patients who are refused medical services, referrals to services, information about such services or referrals, or even information about where such information might be obtained, based on the religious beliefs or "moral convictions" of providers. The proposed regulation asserts that "[f]acilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities."[26] But providers may interpret the regulation as allowing them to refuse to communicate *any* information to patients based on the provider's "moral convictions."

Surprisingly, the proposed regulation's cost-benefit analysis does *not* consider the potential impact or costs directly impacting patients, including costs resulting from "health outcomes or other effects of protecting conscience rights."[27] Studies show that discrimination, and the potential for discrimination, deter marginalized populations such as LGBTQ people from seeking medical care.[28] And discrimination negatively impacts health outcomes. As HHS's HealthyPeople 2020 initiative has noted, LGBTQ people "face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[29]

In addition, the proposed regulation vastly underestimates the costs of compliance for safety-net providers such as the County. Because the proposed regulation vastly expands the

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[25] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3916–17.

[26] *Id.* at 3917.

[27] *Id.* at 3916, 3918.

[28] Shabab Ahmed Mirza & Caitlin Rooney, Ctr. for Am. Progress, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/, attached as Exhibit 7.

[29] HHS Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health*, HealthyPeople 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, attached as Exhibit 8.

substantive scope of statutory conscience-based protections, the projected estimate of *one* attorney hour to review the final rule[30] grossly underestimates the time that would be required to fully examine the rule's implications for existing County policies and practices related to conscience-based protections, as well as applicable non-discrimination policies at the federal, state, and local level. Similarly, the projected estimate for time required to post approximately five notices[31] ignores the reality of large health and hospital systems like the one operated by the County, which encompasses many facilities in many locations. The burden of this requirement is particularly unnecessary for entities like the County, which already ensures that employees are provided notice of their right to assert conscience-based protections through robust policies that allow employees to opt-out of participation in certain services in advance if those services conflict with a staff member's cultural values, ethics, or religious beliefs.[32]

D. Conclusion

As discussed above, the proposed regulation is an unlawful and unnecessary burden on providers and may invite discrimination against vulnerable populations who already face barriers to health care. The County urges HHS to rescind the proposed regulation.

Very truly yours,

JAMES R. WILLIAMS
County Counsel

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[30] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3912.

[31] *Id.* at 3914.

[32] *See, e.g.*, Memorandum from Paul Lorenz to SCVMC Employees, Non-Participation in Certain Patient Care (Aug. 9, 2017); Memorandum from Paul Lorenz to SCVMC Employees, Medically Ineffective Interventions, Requests Concerning (May 8, 2015); Agreement Between Cnty. of Santa Clara & Registered Nurses Prof'l Ass'n (Nov. 10, 2014 through Oct. 20, 2019).

EXHIBIT 1

Introduction: About HHS

Mission Statement

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

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Organizational Structure

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through programs and initiatives that cover a wide spectrum of activities, serving and protecting Americans at every stage of life, from conception. HHS is responsible for almost a quarter of all Federal outlays and administers more grant dollars than all other Federal agencies combined.

Eleven operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies, administer HHS's programs. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interconnectedness of our world requires that HHS engage globally to fulfill its mission. In addition, staff divisions provide leadership, direction, and policy guidance to the Department.

The organizational chart for HHS and a description of the Agencies and Offices can be found on the Department's website at http://www.hhs.gov/.

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Cross-Agency Collaborations

Improving health and human services outcomes cannot be achieved by the Department on its own; collaborations are critical to achieve our goals and objectives.

HHS collaborates closely with other Federal departments and agencies on cross-cutting topics. For example, through the President's Management Council, the Department engages with other Federal departments to identify and adopt best practices on performance and management initiatives. Another example, focused on mission-critical efforts, is the Federal Interagency Workgroup that led the Healthy People 2020 development effort, bringing together Federal staff from the Department with partners in the U.S. Departments of Agriculture and Education.

Federal Advisory Committees enable the Department to collaborate with other Federal departments and agencies, as well as members of the public, on high-priority issues. For example, the Interdepartmental Serious Mental Illness Coordinating Committee, established by the 21st Century Cures Act of 2016 (Pub. L. 114–255), convenes senior leaders from 10 Federal agencies including HHS; the Departments of Justice, Labor, Veterans Affairs, Defense, Housing and Urban Development, and Education; and the Social Security Administration, along with 14 non-Federal public members, to improve Federal coordination of efforts to address the needs of adults with serious mental illness and youth with serious emotional disturbance.

Importantly, the Federal Government has a unique legal and political government-to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments. Executive Order 13175, *Consultation and Coordination with Indian Tribal Governments*, requires consultation with Indian Tribal governments when considering policies that affect Tribal communities. The Department's Tribal Consultation Policy - PDF, first developed with Tribal participation in 2004, was updated in 2010. HHS works with Tribal governments, Indian organizations, and other Tribal organizations to facilitate greater consultation and coordination between States and Tribes on health and human services issues.

HHS works closely with State, local, and U.S. territorial governments, providing funding for program operations and technical assistance. HHS also fosters critical global relationships, coordinates international engagement across HHS and the U.S. Government, and provides leadership and expertise in global health diplomacy and policy to contribute to a safer, healthier world.

In addition, HHS has strong partnerships with the private sector, academia, research institutions, and nongovernmental organizations, including religious and faith-based organizations. The Department partners with the private sector, such as regulated industries, academic institutions, trade organizations, and advocacy groups. The Department leverages resources from these organizations to enable HHS to

accomplish its mission through strategies that minimize the burden on, and increase the benefits to, the American public. This effort occurs through Tribes and faith-based and community initiatives as well as grantees in the private sector, such as academic and research institutions, and community-based nonprofit organizations, which provide many services at the local level.

The narrative and strategies listed under the Strategic Goals and Objectives in this document provide additional descriptions of how the Department collaborates with governmental and nongovernmental groups.

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Content created by Assistant Secretary for Planning and Evaluation (ASPE)

Content last reviewed on February 28, 2018

EXHIBIT 2

When Health Care Isn't Caring

Lambda Legal's Survey on Discrimination Against
LGBT People and People Living with HIV

Lambda Legal
making the case for equality

TABLE OF CONTENTS

Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

This project was directed by Lambda Legal's Director of Community Education and Advocacy Beverly Tillery

Research design and data analysis by Somjen Frazer Consulting (www.somjenfrazer.com)

Additional drafting by Rhea Hirshman

For more information on the National Health Care Fairness Survey and to view the original survey, visit www.lambdalegal.org/health-care-fairness.

When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010). Available at www.lambdalegal.org/health-care-report

EXECUTIVE SUMMARY

Many of us are vulnerable when we are ill or seeking health care services. For lesbian, gay, bisexual and transgender (LGBT) people and those living with HIV, that vulnerability is often exacerbated by disrespectful attitudes, discriminatory treatment, inflexible or prejudicial policies and even refusals of essential care. These barriers, in turn, can result in poorer health outcomes and often have serious and even catastrophic consequences.

This survey is the first to examine refusal of care and barriers to health care among LGBT and HIV communities on a national scale. We hope that these data will influence decisions being made about how health care is delivered in this country now and in the future.

In spring 2009, Lambda Legal and over 100 partner organizations distributed the survey to LGBT people and people living with HIV nationwide. The information in this report is gleaned from 4,916 respondents.

The respondents were not drawn from a random sample, but instead are people who chose to respond to the survey after it was promoted online and at events. The results are a rich and informative picture of the experiences of thousands of LGBT people and people living with HIV, but cannot be used to draw conclusions about the proportion of all LGBT people and people living with HIV who have had similar experiences. The data are powerful because they represent a diverse sampling of the LGBT and HIV communities with respect to sexual orientation, gender identity, HIV status, race and ethnicity, age and geography.

Discrimination and Barriers to Care

The results of this survey highlight enormous challenges that remain for LBGT communities and those living with HIV in accessing quality, non-discriminatory health care services. More than half of all respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive. **Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and nearly 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.**

- **LGBT people and people living with HIV are too often denied the care they need because of their sexual orientation, gender identity and/or HIV status.** Almost 8 percent of LGB respondents reported that they had been denied needed health care outright. Over a quarter of all transgender and gender-nonconforming respondents (almost 27 percent) reported being denied care and 19 percent of respondents living with HIV also reported being denied care.

- **LGBT people and people living with HIV are frequently treated in a discriminatory manner while trying to obtain care, including providers using harsh language, refusing to touch patients and blaming them for their health status.**

  - Just over 10 percent of LGB respondents reported that health care professionals used harsh language toward them; 11 percent reported that health professionals refused to touch them or used excessive precautions; and more than 12 percent of LGB respondents reported being blamed for their health status.

  - Almost 36 percent of respondents living with HIV reported that health care professionals refused to touch them or used excessive precautions and nearly 26 percent were blamed for their own health status.

  - Nearly 21 percent of transgender and gender-nonconforming respondents reported being subjected to harsh or abusive language from a health care professional, and almost 8 percent

reported experiencing physically rough or abusive treatment from a health care professional. Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health conditions.

- **In almost every category measured in this survey, transgender and gender-nonconforming respondents reported experiencing the highest rates of discrimination and barriers to care.** Transgender and gender-nonconforming respondents reported facing barriers and discrimination as much as two to three times more frequently than lesbian, gay or bisexual respondents.

- **In nearly every category, a higher proportion of respondents who are people of color and/or low-income reported experiencing discriminatory and substandard care.** For example, close to 33 percent of low-income transgender and gender-nonconforming respondents reported being refused care because of their gender identity and almost a quarter of low-income respondents living with HIV reported being denied care.

- **Respondents reported a high degree of anticipation and belief that they would face discriminatory care and such concerns were a barrier to seeking care.** Overall, 9 percent of LGB respondents are concerned about being refused medical services when they need them, and 20 percent of respondents living with HIV and over half of transgender and gender-nonconforming respondents share this same concern.

Survey respondents were somewhat more privileged than the LGBT population as a whole, with higher proportions having obtained advanced degrees, reporting higher household incomes and having better health insurance coverage. **Since these factors tend to improve access to care, this report likely *understates* the barriers to health care experienced by all LGBT people and those living with HIV.**

Key Recommendations

Health care institutions should:

- Establish nondiscrimination, fair visitation and other policies that prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status, recognize families of LGBT people and their wishes and provide a process for reporting and redressing discrimination if it occurs.

- Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly.

- Require health profession students and health professionals to undergo significant cultural competency training about sexual orientation, gender identity and expression and HIV status.

- Include training about the specific ways LGBT people and people living with HIV who are also people of color, low-income, seniors or members of other underserved populations may experience discrimination in health care settings and establish policies to prevent them.

- Advocate for laws and accreditation standards that require all providers to deliver to LGBT people and people living with HIV the same level of high-quality care afforded others.

Our federal, state and local governments should:

- Include coverage of LGBT people and those living with HIV in all antidiscrimination and equal opportunity mandates.

- Require all health care facilities and education programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and provide ongoing cultural competency training for all health care profession students and staff.

- Change laws to require recognition of the families of LGBT people, including those who live within less common family structures, and require health care providers to do the same.

- Eliminate overly broad religious exemptions that purport to exempt medical care from nondiscrimination laws.

- Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people and people living with HIV.

- Ensure that government-funded health research and surveys include sexual orientation and gender identity issues and demographic analysis so that more can be known about the health care discrimination experienced by our communities as well as about our communities' health care needs.

Individuals and organizations should:

- Educate themselves, each other and, when possible, health care providers about the rights and needs of LGBT patients and those living with HIV.

- Advocate for improved laws and policies.

- Use existing mechanisms that are appropriate — such as medical powers of attorney and other legal documents as well as formal legal relationships where that is a couple's choice — to create as much protection as possible for themselves and their loved ones.

- Fight back when discrimination occurs, including reporting discriminatory practices, sharing stories and contacting Lambda Legal and other advocacy organizations and/or attorneys.

About Lambda Legal and the Study

Lambda Legal is the oldest and largest national legal organization committed to achieving the full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those living with HIV. This survey was designed as part of Lambda Legal's national Health Care Fairness Campaign launched in 2009. The goals of the campaign are to bring together advocates, partners and consumers to educate policy-makers, health care providers and the general public about the need for health care fairness and to advocate for reforms that address the issues of greatest concern to LGBT people and people living with HIV. Chronicling the types and prevalence of barriers to care faced by the range of groups in our communities is a vital part of helping to address and eliminate them.

For more information about Lambda Legal, visit www.lambdalegal.org

HEALTH CARE FAIRNESS:
A PERSONAL ISSUE, A NATIONAL CAMPAIGN

Lambda Legal has been advocating for health care fairness through impact litigation, education and public policy work to make sure that LGBT people and those living with HIV have full and equal access to all medically appropriate health care without discrimination based on sexual orientation, gender identity or expression, HIV or family status. Some of the key components of health care fairness we have outlined include:

- privacy and confidentiality for all, including LGBT people and those living with HIV;
- recognition and respect for all families including same-sex couples and their children;
- equal access to affordable health care insurance for same-sex spouses, partners and their children, and elimination of discriminatory insurance policy exclusions for transgender care, reproductive health care or care based on HIV status;
- fair and comprehensive health care services for LGBT youth and adults in custody as well as those living with HIV;
- informed consent for HIV testing;
- protection of the rights of LGBT patients and those living with HIV to seek and obtain all medically appropriate care without restrictions based on the personal or religious views of providers;
- equal access to mental health and substance abuse treatment and services for LGBT people and people with living with HIV; and
- fair and compassionate services for LGBT seniors and older people living with HIV.

Because issues of health care access and fairness are so critical to the well-being of the LGBT and HIV communities, Lambda Legal made health care fairness one of our ten priority issue areas and in 2009 we chose to highlight these issues with a national **Health Care Fairness Campaign.** The goals of the campaign are to bring together advocates, partners and consumers to educate policy-makers, health care providers and the general public about the need for health care fairness and to advocate for reforms that address the issues of greatest concern to LGBT people and people living with HIV.

Why This Survey?

Anecdotal evidence suggests that LGBT individuals and people living with HIV in the United States — from all backgrounds — have less access to health care and face greater obstacles to navigating health care systems than do heterosexual people. For over three decades, Lambda Legal has been at the forefront of establishing recognition of the legal rights of LGBT people and people living with HIV. The organization's impact litigation cases present examples of the kinds of challenges many LGBT people and people living with HIV experience while trying to receive needed health care services every day. Our Legal Help Desk also consistently receives calls from LGBT people and people living with HIV with questions and concerns about how they have been treated by health care and health insurance providers.

Although there have been studies finding health disparities by sexual orientation in cancer screening, mental illness, substance abuse, smoking and some other commonly measured health status indicators, there are very few, if any, survey reports about the types of health care-related discrimination LGBT people and those living with HIV face, how common such experiences are and what impact this discrimination has on their care. Designed as part of Lambda Legal's national Health Care Fairness Campaign, this survey is the first to examine experiences with refusal of care and barriers to health care access among LGBT and HIV communities on a national scale.

With the nation in the midst of a vigorous debate about reforming the way health care is delivered, we at Lambda Legal and our partners want to ensure that the needs of LGBT people and those living with HIV are an integral part of the discussion. Chronicling the barriers to care faced by the range of groups in our communities and the scope of these problems is a vital part of helping to address these needs. We hope that these data will influence decisions being made now and in the future.

WHAT WE FOUND:
WHEN HEALTH CARE ISN'T CARING

Enormous challenges remain for lesbian, gay, bisexual and transgender (LGBT) communities and people living with HIV. Experiences of bias and outright hostility remain common in all areas of our lives. When those experiences occur in the context of obtaining health care, they are not only deeply distressing but potentially life-threatening.

The essential bond of trust between clinician and patient that many in the United States take for granted is not a given for LGBT people or people living with HIV. Whether because of prejudices, ignorance, outdated systems or short-sighted policies, many people across our communities are not receiving the health care they need.

The tables on the following pages, which present data from our health care fairness survey, illustrate this problem from two perspectives. Tables 1 to 5 show **patterns of discrimination and substandard care** experienced in specific interactions with medical providers. Table 6 deals with personal fears and alienation from the health care system. Such prevalent fears and alienation are **barriers to care.**

Discrimination and Substandard Care

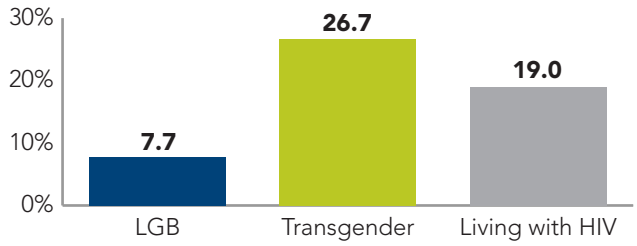
The responses we received are disturbing and require action. Respondents were asked to report whether they believed they received discriminatory care because of their sexual orientation, gender identity or HIV status. All the data reported below represent experiences that respondents felt were motivated by prejudice against lesbian, gay, bisexual, transgender people or people living with HIV. (Please note that the "transgender" category in the following charts includes both transgender and gender-nonconforming respondents because of the high visibility that puts both groups at a high risk for discrimination based on gender identity.)

More than half of all respondents reported that they have experienced at least one of the following types of

In 2008, Janice Langbehn (second from left) and Lisa Pond were about to depart from Miami on a family cruise with their three children. Pond suddenly collapsed and was rushed to Jackson Memorial Hospital. Janice was informed that she was in an antigay city and state, and she could expect to receive no information or acknowledgment as Lisa's partner or family. Hospital personnel would not allow Janice or their children to see Lisa until nearly eight hours after their arrival as Lisa slipped into a coma, even though Lisa's sister was allowed to visit as soon as she arrived. The next day, Lisa died. In 2008, Lambda Legal filed a lawsuit on behalf of the family. The court dismissed the case, agreeing with Jackson Memorial that the hospital has no obligation to allow their patients' visitors in their trauma unit. Lambda Legal and our partners continue to fight for fair visitation policies.

Langbehn v. Jackson Memorial Hospital

Table 1: I was refused needed health care



Guadalupe "Lupita" Benitez (left) was denied infertility treatment by the North Coast Women's Care Medical Group because she is a lesbian. Her former doctors are conservative Christians who claimed their religious beliefs gave them a right to withhold care from Benitez that they routinely provide to heterosexual patients. In 2001, Lambda Legal filed a lawsuit on behalf of Benitez fighting for the basic right of LGBT people to receive equal access to treatment from health care providers and tackling the issue of religiously motivated discrimination. In 2008, the California Supreme Court unanimously ruled in favor of Benitez, making clear that California's state law prohibiting discrimination must be followed.

Benitez v. North Coast Women's Care Medical Group

discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive. **Almost 56 percent of lesbian, gay or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.**

Almost 8 percent of LGB respondents reported that they had been denied needed health care because of their sexual orientation. Over a quarter of all transgender respondents (nearly 27 percent) reported being denied care and 19 percent of respondents living with HIV also reported being denied care because of their transgender or HIV status, respectively.

Many of our survey respondents also reported that they have been treated in a discriminatory manner while trying to receive care. Nearly 11 percent of LGB respondents have interacted with health care professionals who have used harsh language. That same percentage have encountered health care professionals who refused to touch them or used excessive precautions. More than 12 percent of LGB respondents were blamed for their health status.

Our survey showed that persons living with HIV are still facing ignorance, lack of respect and overt discrimination when accessing health care, with 19 percent of respondents reporting being refused needed health care. **Respondents living with HIV were most likely to report that health care professionals refused to touch them or used excessive precautions (nearly 36 percent) and blamed them for their own health status (nearly 26 percent).** And over 4 percent of respondents living with HIV reported being treated in a physically rough or abusive manner by health care providers.

The picture is even more disturbing for transgender and gender-nonconforming respondents, who experienced

Table 2: Health care professionals refused to touch me or used excessive precautions

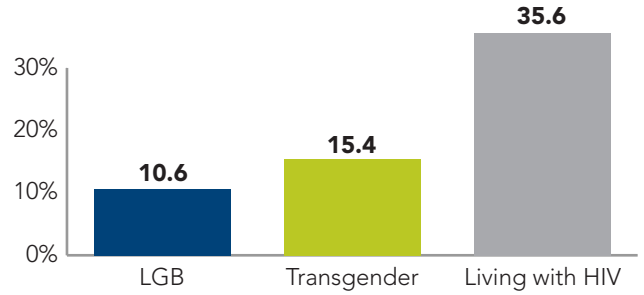


Table 4: Health care professionals blamed me for my health status

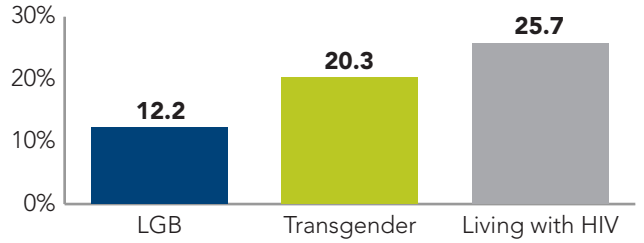


Table 3: Health care professionals used harsh or abusive language

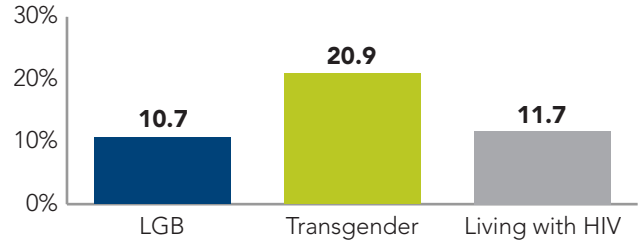
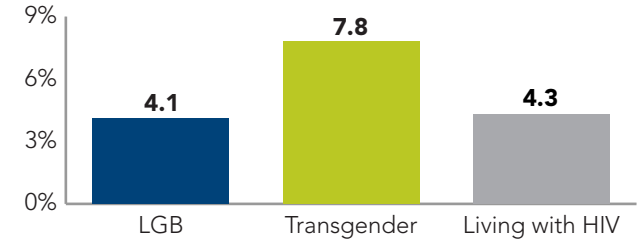


Table 5: Health care professionals were physically rough or abusive



the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent) and experiencing physically rough or abusive treatment (nearly 8 percent). Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health problems and illnesses.

In addition to the overall rates of substandard care, respondents of color and low-income respondents (defined in this survey as having a household income under $20,000) in nearly every category experienced higher rates of discrimination and substandard care. For example, while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of almost 33 percent. Over a quarter of low-income respondents living with HIV were refused care compared to 19 percent of respondents living with HIV overall. Almost 11 percent of low-income LGB respondents and LGB respondents of color were refused care compared to almost 8 percent of LGB people overall.

Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them while the overall rate among those with living with HIV was nearly 36 percent. Over 35 percent of low-income respondents living with HIV were blamed for their health status, in contrast to about a quarter of those living with HIV overall.

Low-income respondents and respondents of color often reported harsh language by medical providers. Almost 17 percent of low-income LGB respondents and 14 percent of LGB respondents of color reported experiencing harsh language compared to almost 11 percent of LGB respondents overall. Over a quarter of transgender respondents of color and 28 percent of low-income

transgender respondents reported harsh language compared to 21 percent of transgender respondents overall. And nearly 13 percent of respondents of color living with HIV and 19 percent of low-income respondents living with HIV experienced harsh language compared to almost 12 percent of respondents living with HIV overall.

People of color living with HIV and LBG people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals. Of the LGB respondents, 3 percent of whites and almost 7 percent of people of color reported experiencing such treatment; among those living with HIV, the figures were just over 3 percent for whites and nearly 8 percent for people of color.

Barriers to Care

In addition to asking about specific encounters with health care providers and systems, the Lambda Legal health care fairness survey also asked respondents about their fears and concerns about obtaining health care. Personal beliefs and perceptions about whether one can access quality health care have been shown to strongly affect whether and how individuals seek medical care and interact with medical professionals. Past experiences of bias, humiliation, harsh treatment and isolation as well as perceived bias by health care providers can cause LGBT people and people living with HIV to become alienated from the health care system and even reluctant to seek care. Such reluctance can in turn result in poorer health outcomes because of delays in diagnosis, treatment or preventive measures.

Overall bias and stigma in our society — conveyed through negative family, community, institutional and cultural messages about our lives, combined with discriminatory policies and practices — can result in unwillingness for LGBT people and people living with HIV to disclose to clinicians personal information that can be essential to proper diagnosis and/or treatment. At times, disclosure can be a catch-22 — that is, lack of disclosure about one's sexual orientation or gender identity can lead to inadequate care, while disclosure can make LGBT people more vulnerable to discrimination and denial of care. For transgender individuals, disclosing one's gender identity may result in discriminatory practices by insurance companies who refuse to cover necessary cross-gender health care, such as pap smears for transgender men or prostate screenings for transgender women.

Table 6: Fears and concerns about accessing health care

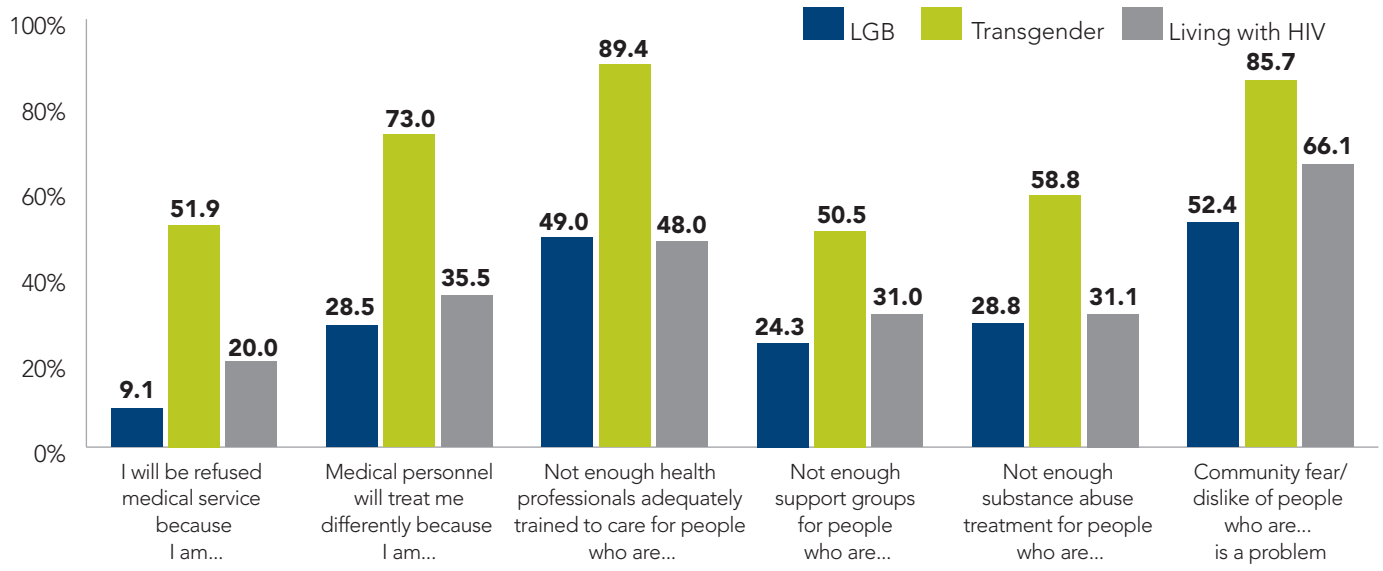


Table 6 shows the depth of the need for greater cultural competency throughout our health care systems to reduce serious barriers to care.

Survey respondents were asked to rate how much various factors make it hard for them to receive the care they need. Percentages reflect how many respondents designated each factor as "somewhat of a problem" or a "major problem" and indicate alarming amounts of perceived bias and barriers to care for LGB people and even greater alienation for people living with HIV and transgender people. (Please note: Only the responses from members of each group were counted in these statistics. For instance, the transgender group only includes responses from people who are transgender and gender non-conforming.)

Overall, nine percent of LGB respondents are concerned about being refused medical services when they need them. Over half of transgender respondents and 20 percent of respondents living with HIV share this concern. When asked about more specific concerns, the reports of perceived bias are even more disturbing. **For instance, nearly half of LGB respondents and respondents living with HIV and almost 90 percent of transgender respondents believe there are not enough medical personnel who are properly trained to care for them.** Mental health issues were also of particular concern to LGB people, transgender people and those living with HIV, with almost 28 percent of the respondents concerned that not enough mental health professionals are available to help them. **Over half of LGB respondents, two-thirds of respondents living with HIV and almost 86 percent of transgender respondents indicated that overall community fear or dislike of people like them is a barrier to care.**

In this survey, we also examined barriers to care based on gender expression. Regardless of their sexual orientation or gender identity, people who are gender-nonconforming— men who appear more feminine, women who appear more masculine and people who have a more androgynous appearance — often face bias, harassment and discrimination in our society. In fact, one of the common ways many LGBT people experience discrimination in our society is based on their gender expression. This was a particular concern for the people who answered our survey. **Thirty percent of all respondents stated that they fear medical personnel will treat them differently based on their gender expression and presentation.**

I called a gynecologist's office tying to schedule a hysterectomy. I told the receptionist that I was a transgender male. Two days later, I received a phone call telling me that the doctor did not take cases like mine and referring me to a hospital. I remember feeling like a freak. I called the second number. The receptionist told me they didn't deal with transgender men either. After I got over the hurt, I called another doctor's office. The receptionist told me that their office welcomed transgender clients. I told the doctor that I wanted a full hysterectomy. She performed an exam, Pap smear and ultrasound. She told me that the results showed that I was fine. I asked her again about the hysterectomy, this time telling her I would pay for it out of pocket. She continued to say that it would be unethical because there was nothing wrong with me. She was hiding her transphobia behind a bogus argument and dismissing a very real medical need. I told her that there *was* something wrong: "I am a man with a uterus. I need to have all female reproductive parts removed. I AM A MAN!" She refused. I left her office feeling like a freak again, vulnerable and depressed.

Tony Ferraiolo/ New Haven, CT

THE PATH TO HEALTH CARE FAIRNESS:
RECOMMENDATIONS FOR PROVIDERS, POLICY-MAKERS AND COMMUNITY MEMBERS

The findings in this survey raise serious concerns about the state of health care for the lesbian, gay, bisexual and transgender (LGBT) and HIV communities that must be addressed. Remedying the problems outlined in this report requires systemic change: an integrated combination of enforcement of legal protections that already exist, progressive legislation, thoughtful policy-making and ongoing education and training, all carried out with opportunities for community input.

The Critical Role of Cultural Competency

Increasing cultural competency should be one of the main methods for health care providers to address the discrimination experienced by LGBT people and people living with HIV and to close the gap in access to health care. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of health care, thereby producing better health outcomes.[1] According to the U.S. Department of Health and Human Services' Office of Minority Health, "It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it."[2]

Policies about discrimination, visitation, patients' rights, employment and other matters should clearly communicate that bias and discrimination of LGBT people and people living with HIV will not be tolerated. Policies should also outline a grievance process and provide access to redress if the policies are violated. Health care providers should also recognize and honor the wishes of the families of LGBT people. Even though our survey did not ask about discriminatory behavior and attitudes towards the families of LGBT people (questions were about individual interactions with health care systems and providers), such attitudes contribute significantly to creating an unwelcoming environment for all LGBT people.

Institutions should also clearly inform patients of their policies and practices and regularly solicit input from the LGBT and HIV communities.

Education is another important component to cultural competency. Institutions should provide initial training as a part of orientation for new staff and require ongoing education for all staff. The optimal provision of health care and prevention services to sexual and gender minorities requires providers to be sensitive to historical stigmatization, to be informed about continued barriers to care and to become aware of the cultural aspects of their interactions with LGBT patients.[3]

Forms, questionnaires and other written materials should be sensitive to and inclusive of LGBT people and their families and communicate the institution's commitment to providing an environment that meets the needs of all patients including LGBT people and people living with HIV. Where appropriate, institutions should also provide and advertise LGBT and HIV-specific services and specialized care such as support groups or HIV prevention programs.

When fully implemented, cultural competency can reduce the systemic health care discrimination experienced by LGBT people and people living with HIV. The Mautner Project, a national lesbian health organization, has a training curriculum, "Removing the Barriers: Providing Culturally Competent Care to Lesbians and Women Who Partner with Women," that explains the benefits of culturally competent care as including: increased access to

1 In Diane L. Adams, ed., *Health Issues for Women of Color: A Cultural Diversity Perspective* (Thousand Oaks, CA: Sage, 1995).

2 U.S. Department of Health and Human Services, Office of Minority Health, "What is Cultural Competency," http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11 (accessed January 10, 2010).

3 K. H. Mayer, J.B. Bradford, H. J. Makadon, R. Stall, H. Goldhammer, and S. Landers, "Sexual and Gender Minority Health: What We Know and What Needs to be Done," *American Journal of Public Health,* 98, no. 6 (2008): 989-995.

services; improved prevention and early intervention; more accurate diagnoses; improved treatment adherence and compliance and increased patient retention.

By focusing on cultural competence for all LGBT people and people with HIV, providers, policy-makers and members of the community can begin taking steps to address substandard and discriminatory care as well as additional barriers that prevent LGBT people and people living with HIV from obtaining quality health care.

Our Recommendations

Health care institutions and providers should:

- **Establish nondiscrimination, fair visitation and other policies that:**
  - prohibit bias and discrimination based on sexual orientation, gender identity and expression and HIV status including refusal of care, disrespectful or abusive treatment, the use of excessive precautions and blaming patients for their health conditions;
  - convey a commitment to equally serve and provide culturally competent care to LGBT and HIV communities;
  - recognize families of LGBT people and their wishes; and
  - provide a process for reporting and redressing discrimination if it occurs.
- **Develop and implement goals and plans to ensure that LGBT people and people living with HIV are treated fairly, including strategies to maintain diverse staff, complete an initial assessment of services for LGBT patients, collaborate with LGBT and HIV community partners and implement culturally sensitive grievance procedures.**
- **Require health profession students and health professionals to undergo significant cultural competency training about sexual orientation, gender identity and expression and HIV status so they will be able to provide respectful and nondiscriminatory care to LGBT people and people living with HIV.**

  Cultural competency needs to be implemented at both an institutional and individual level. Unfortunately, many professional schools and continuing education programs do not provide the training needed to teach culturally competent care for LGBT people and those living with HIV.[4] Ensuring that all medical, nursing, dental and other health profession students are trained in these issues as a mandatory part of the curriculum will increase the likelihood that they will have a basic understanding of the needs of the LGBT and HIV communities. Making cultural competency a key part of ongoing staff training and continuing education programs is equally important for ensuring that the inclusive policies of institutions are carried out consistently and uniformly.
- **Include training about gender identity and expression to ensure that the unique needs of transgender and gender-nonconforming people are addressed.**

  In almost every category measured in this survey, proportionately more transgender respondents reported discrimination in care and barriers to care. Providers need to take particular care to address the issues of transgender and gender-nonconforming people.
- **Include training about the specific ways LGBT people and people living with HIV who are also people of color, low-income, seniors or members of other underserved populations may experience discrimination in health care settings and establish policies to prevent discrimination.**

  Providers must address the discrimination experienced by low-income people and people of color and ensure that care is delivered in a culturally competent way to people who are part of more than one marginalized community. (For more discussion about the impact of health care discrimination on low-income people and people of color and the intersectionality of multiple

4 Ibid., 989-995.

forms of oppression, see Lambda Legal's supplemental health care fairness survey fact sheets.)

- **Advocate for laws and accreditation standards that require all providers to deliver to LGBT people and people living with HIV the same level of high-quality care afforded others.** Laws and standards that mandate LGBT and HIV-inclusive practices are needed so that all providers will offer the same level of care.

Federal, state and local governments should:

- **Include coverage of LGBT people and those living with HIV in all antidiscrimination and equal opportunity mandates including laws related to employment discrimination, access to public accommodations, harassment and freedom of expression.**
- **Require all health care facilities and educational programs that receive government funding to develop and implement goals, policies and plans to ensure that LGBT people and people living with HIV are treated fairly and require that they provide ongoing cultural competence training for all health care profession students and staff.**
- **Change laws to require recognition of the families of LGBT people, including those who live within less common family structures, and require health care providers to do the same.**
- **Eliminate overly broad religious exemptions that purport to exempt medical care from nondiscrimination laws.**

  Although questions about religion were not part of the survey, we know that, in an increasingly worrisome trend, some health care providers have claimed that their religious beliefs or affiliations allow them to deny providing the same care to LGBT individuals that they routinely offer to others. Providers should not be allowed to use their religious views or affiliations to circumvent antidiscrimination laws, medical ethics rules and professional standards of care.
- **Prohibit discriminatory practices by insurance providers that deny or limit coverage for needed care by LGBT people and people living with HIV, such as basic and/or gender transition care for transgender individuals or reproductive health care for LGBT people.**
- **Ensure that government-funded health research and surveys include sexual orientation and gender identity issues and demographic analysis so that more can be known about the health care discrimination experienced by our communities as well as about our communities' health care needs.**

Individuals and organizations should:

- **Educate themselves and each other about LGBT rights, and when possible, educate health care providers about the needs of LGBT patients and those living with HIV.**
- **Advocate for improved laws and policies.**
- **Report unfriendly and discriminatory practices and share referrals to friendly providers and institutions.**
- **Share stories of health care discrimination with organizations like Lambda Legal, as well as with policy-makers, friends, relatives and trusted co-workers.**
- **Create as much protection as possible for themselves and their loved ones using appropriate, existing mechanisms such as advance directives, medical powers of attorney and other legal documents as well as formal legal relationships such as domestic partnerships, civil unions and marriage, where that is a couple's choice.**
- **Fight back when discrimination occurs and contact Lambda Legal, other legal and advocacy organizations or a local attorney.**
- **Continue to fight attempts to roll back LGBT rights.**

METHODOLOGY:
HOW WE CONDUCTED THE SURVEY

In the spring and summer of 2009, Lambda Legal invited lesbian, gay, bisexual and transgender (LGBT), HIV and other partner organizations to join the national Health Care Fairness Campaign, asking them to promote the health care fairness survey and encouraging their participation in other aspects of this initiative. With the help of over 100 such organizations located in 35 states, the survey was distributed to LGBT people and people living with HIV nationwide. Participants included 25 national organizations and 75 local, state and regional organizations. Thirteen groups were specifically people of color organizations and 12 specifically focused on people living with HIV. Groups promoted the survey in various ways, including email requests to members and supporters; posting survey links on their websites and their social networking sites and distributing and collecting paper surveys where feasible.

Lambda Legal sent survey announcements and reminders to our email list, featured the survey on our web page and publicized the survey in Lambda Legal's *Impact* magazine and monthly eNews. Ads were placed on various LGBT blogs, web sites and in a few LGBT newspapers, and the survey was promoted on Facebook and Twitter. Wallet cards announcing the survey were distributed at 15 Pride festivals and several other LGBT events around the country. In a few cities, Lambda Legal staff and/or interns collected surveys at locations in the LGBT community. All survey promotional and informational materials were available in both English and Spanish, as was the survey itself. The survey was not based on a random sample, but used "convenience sampling" and "snowball sampling," which means that responses came from those who chose to take the survey and many learned about it through e-mails and blog posts.

A total of 5,941 people took the survey from June 10 to July 14, 2009. The information in this report is gleaned from the 4,916 surveys that remained after invalid surveys (postal codes outside the U.S., missing key demographic info, not LGBT or living with HIV) were excluded from the sample.

WHO RESPONDED

The tables below provide demographic information about the 4,916 individuals whose responses are reflected in this report. Because of the complexity of our communities, checking more than one category was an option for several of the demographic questions, so that some results add up to more than 100 percent.

Sexual Orientation

Slightly over half the respondents, or 2,727 people, identified as gay, with just fewer than 30 percent, or 1,453 people identifying as lesbian. The categories of queer (nearly 16 percent or 774 people) and same-gender loving (just over 5 percent or 261 people) include both women and men, as does the bisexual category (just over 11 percent percent or 542 people). A very small number of responses came from heterosexuals (just over 1 percent or 66 people), who are either living with HIV or transgender.

Gender Identity

Table 8 shows that almost 56 percent of all respondents identified as male and almost 38 percent of all respondents identified as female. These numbers include transgender and nontransgender respondents. Almost 53 percent (2,593 people) identified as non-transgender male and nearly 33 percent (1,614) as non-transgender female; 8 percent (397) as transgender (either transfeminine or transmasculine); just over 4 percent (220) as gender-nonconforming; and almost 2 percent (83) as two-spirit.

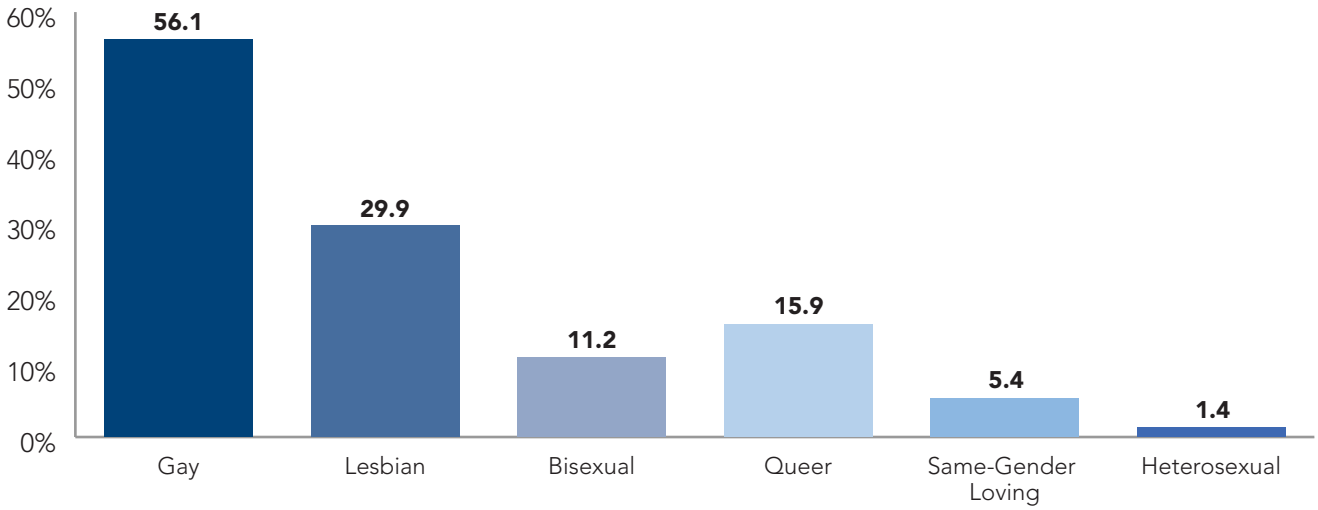
"Transgender" is an umbrella term that refers to people whose gender identity and/or gender expression differs from the sex they were assigned at birth. In general use, the term may include but is not limited to transsexuals, cross-dressers and other gender-variant people. In the related chart (Table 8), transgender respondents are listed as either "transmasculine" (individuals who were assigned the sex "female" at birth, but whose gender identity is along the masculine spectrum of gender) or "transfeminine" (individuals who were assigned the sex "male" at birth, but whose gender identity is along the feminine spectrum of gender). "Gender-nonconforming" (GNC) refers to individuals whose external manifestation of their gender identity does not conform to society's expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian or bisexual but may identify as gender-free, androgynous or moving back and forth between gender identities. The term "two-spirit" is a culturally specific category related to traditions among Native Americans/American Indians.

Race and Ethnicity

Eighty-six percent of all respondents or 4,241 people identified as White and slightly over 18 percent or 892 people identified as people of color – meaning that they selected a racial/ethnic category other than or in addition to White. These numbers add up to more than 100 percent because some of the multiracial people selected white and another race or ethnicity.

Table 9 displays the racial and ethnic distribution of the people of color who completed the survey. Of the total survey respondents, almost 8 percent or 373 people were Latina/o; close to 5 percent or 231 people were Black; almost 4 percent or 176 people were American Indian; 3 percent or 153 people were Asian; and 1 percent or 48 people were Middle Eastern. Again, the numbers add up to more than 100 percent because respondents could choose more than one category. Almost 6 percent of all survey respondents, or 285 people, identified as multiracial. While Asians and American Indians who responded to the survey were proportionately represented compared to the overall population in the United States, Blacks, Latina/os and Middle Eastern respondents were underrepresented compared to their representation in the U.S. population as a whole. This underrepresentation indicates an ongoing need for more consistent and better-targeted outreach to communities of color.

Table 7: Sexual orientation



Totals more than 100% because respondents could select more than one category.

Table 8: Current gender identity

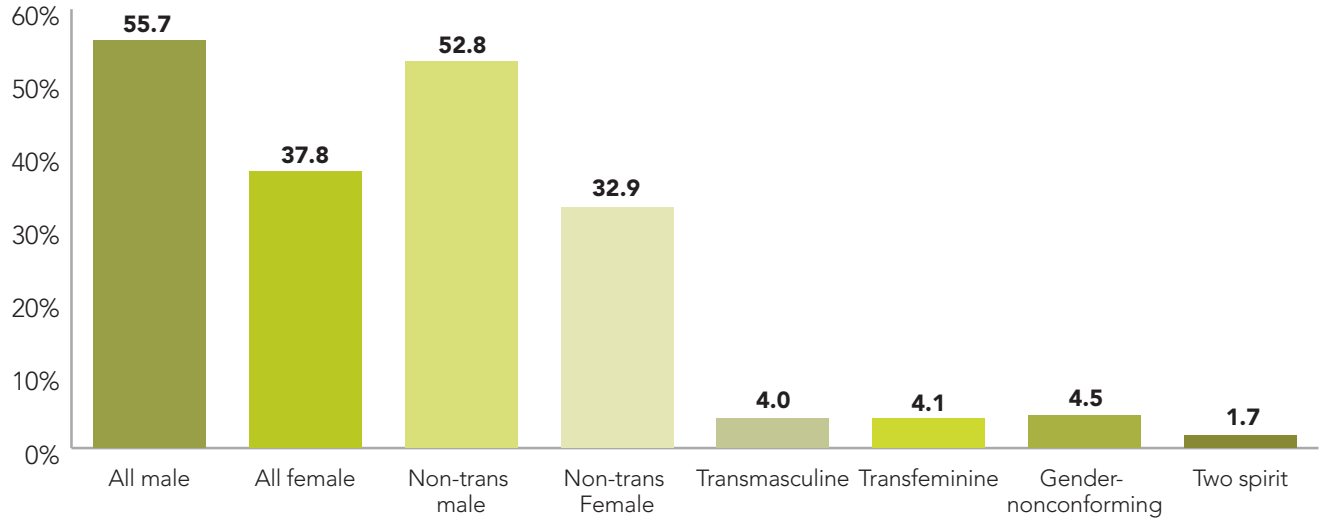
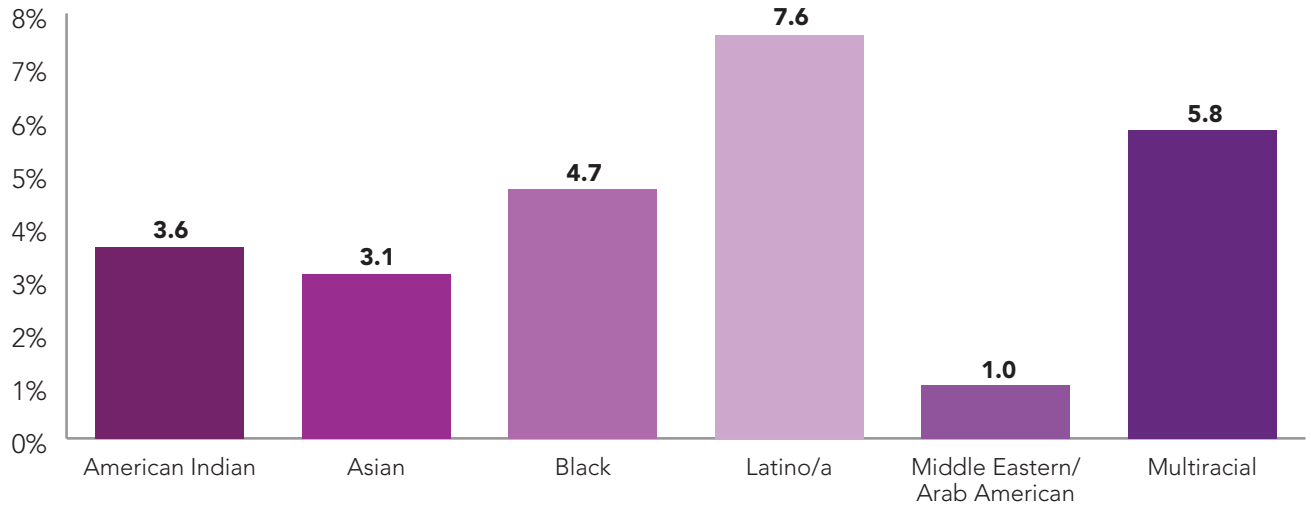


Table 9: Race and ethnicity of people of color respondents



Other Demographics

All age groups are represented in the survey with responses somewhat skewed towards the 25-44 age group.

The survey generally achieved geographic distribution, with respondents from all fifty states and Washington, DC, although California provided a disproportionate number of respondents (nearly 21 percent or 985 people).

Individuals living with HIV were over 13 percent of the sample, or 662 people.

An important fact to note is that survey respondents were somewhat more privileged than the LGBT population as a whole, with higher proportions having obtained college, graduate and professional degrees; reporting higher household incomes and having better health insurance coverage. According to a groundbreaking study by the Williams Institute of the University of California School of Law, the stereotype of LGBT people as an affluent elite with high levels of education and income is debunked by more than a decade of research showing that LGBT people actually have lower incomes than comparable heterosexual individuals and households and that existing research strongly hints at a sizable presence of LGBT people among the low end of the income distribution in the United States.[5] A recent study conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force also found that transgender respondents experience poverty at a much higher rate than the general population, with more than 15 percent reporting incomes of $10,000 or lower, double the rate of the general population.[6]

Since people who are affluent, educated and insured are more likely to be well-served by health care systems, this report likely *understates* the barriers to health care experienced by LGBT people and those with living with HIV.

5 R. Albeda, M. V. L. Badgett, A. Schneebaum, and G. J. Gates, "Poverty in the Lesbian, Gay, Bisexual and Transgender Community," http://www.law.ucla.edu/WilliamsInstitute/pdf/LGBPovertyReport.pdf (accessed November 23, 2009).

6 National Center for Transgender Equality and National Gay and Lesbian Task Force, "National Transgender Discrimination Survey," http://www.thetaskforce.org/downloads/release_materials/tf_enda_fact_sheet.pdf (accessed December 28, 2009).

Table 10: Age

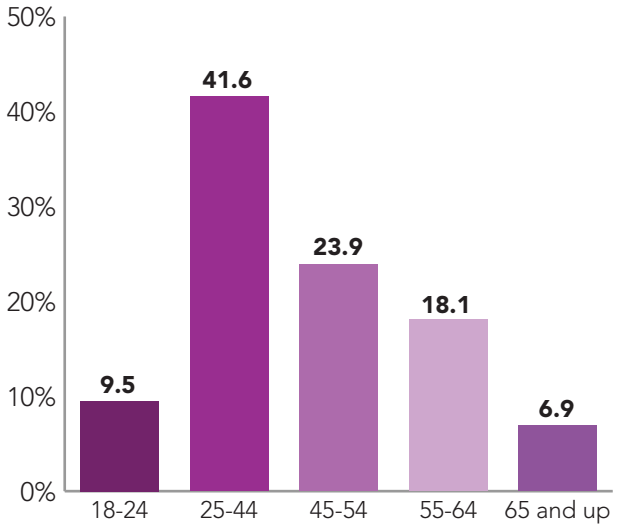


Table 11: HIV status

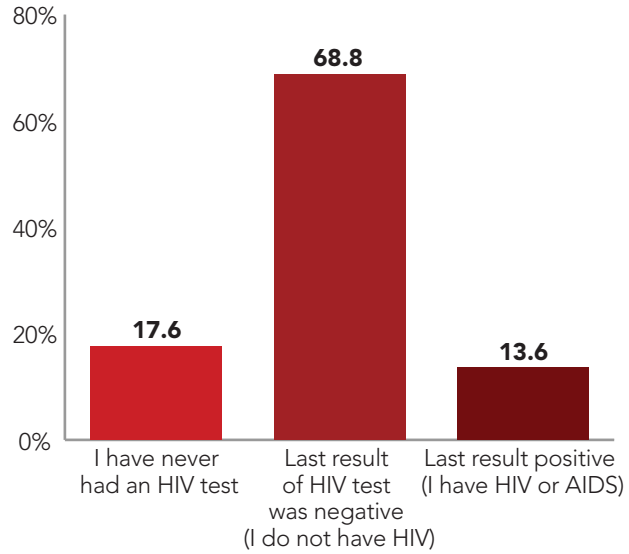


Table 12: Employment status

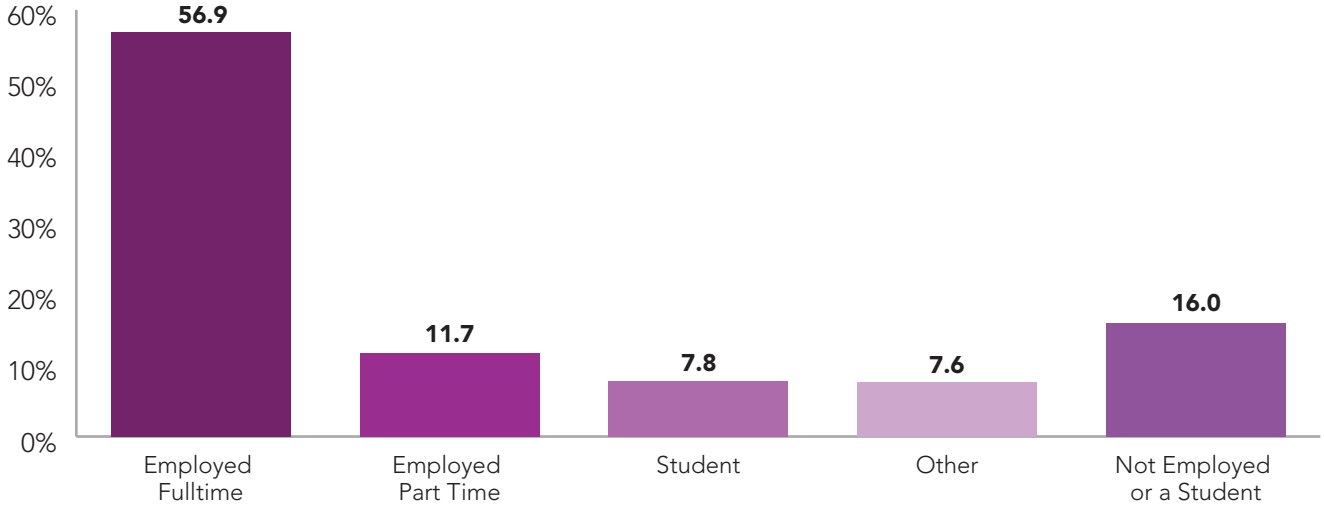


Table 13: Household income

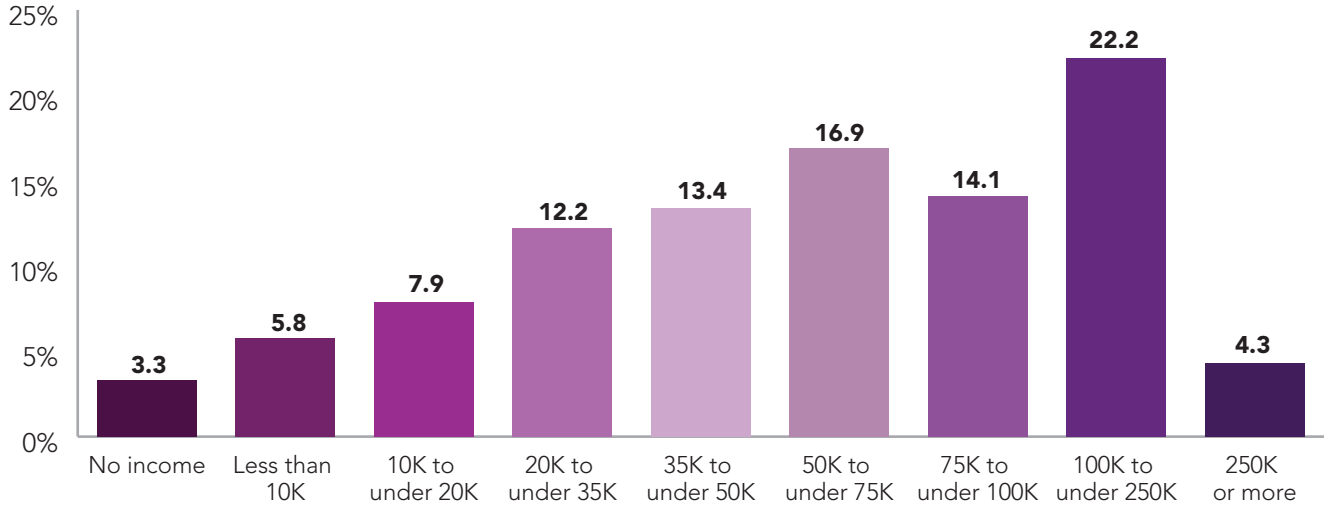
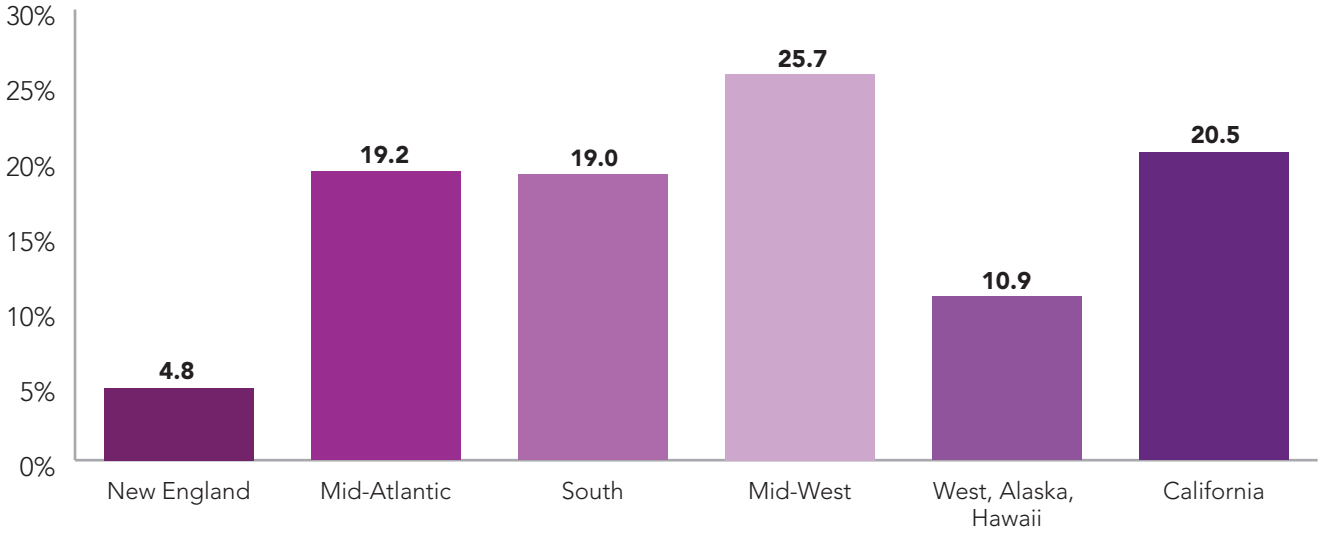


Table 14: Geographic distribution of responses



GLOSSARY:
EXPLANATION OF SURVEY TERMS

This section was created to enhance understanding of the terms in this report. However, it's important to remember that people defy labels. Identity is fluid and self-defined. Not everyone will fit into a definition, label or box, no matter how large we make it.

Advance directive, also known as a living will, is a legal document that gives instructions specifying what medical actions should be taken in the event that a person is no longer able to make decisions due to illness or incapacity.

AIDS or Acquired Immune Deficiency Syndrome is generally used to refer to the most advanced stages of HIV progression in which the human immune system becomes compromised, leaving the body susceptible to opportunistic infections it could otherwise defeat. There is some debate among medical professionals as to what actually constitutes a progression to AIDS and whether the term should continue to be used at all.

Bisexual people are attracted to and/or sexually active with people regardless of gender.

Convenience sampling is a technique for developing a research sample which involves drawing from that part of the population which is close to hand, readily available or convenient. This technique is different from random sampling.

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings – in the context of this study, to increase the quality of health care, thereby producing better health outcomes.

Gay people are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. "Gay" can refer either to women or men, but for the purposes of this report refers to men unless otherwise specified.

Gender expression refers to the way a person expresses gender through dress, grooming habits, choice of name and pronoun, mannerisms, activities, etc.

Gender identity is an individual's emotional and psychological sense of being male or female. Gender identity is not necessarily the same as an individual's biological identity. In this survey, when the terms "male" and "female" are used alone, they refer to people who do not have transgender and gender-nonconforming identities, while transgender and gender-nonconforming people are identified by their current gender and the terms "transgender" and/or "gender non-conforming."

Gender-nonconforming (GNC) refers to individuals whose external manifestation of their gender identity does not conform to society's expectations of gender roles. A gender-nonconforming person may or may not identify as transgender, gay, lesbian or bisexual.

HIV or human immunodeficiency virus (HIV) is a retrovirus that targets the human immune system. Progression of HIV infection can lead to a serious compromise of immune system function, leaving the body open to opportunistic infections against which it could normally defend.

HIV positive people are living with HIV, although they might not have AIDS.

Homophobia refers to hatred, fear of or discrimination against lesbian, gay or bisexual people based on their sexual orientation.

Lesbians are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. "Lesbian" refers exclusively to women while "gay" can refer either to women or men.

LGBT stands for lesbian, gay, bisexual or transgender.

Low-income is defined for the purposes of this report as having an annual household income of less than $20,000.

Medical power of attorney is a legal document that gives someone the legal authority to act on an individual's behalf regarding health care decisions if they ever become incapacitated or unable to communicate.

People living with HIV includes all people who are infected with HIV, including people who have been diagnosed with AIDS and those who are HIV positive.

Queer is an identity used by people who reject conventional categories such as "LGBT" or embrace a political identity as 'queer' in addition to being LGB and/or T. It also may include heterosexuals who embrace a non-normative or counter-normative sexual identity.

Same-gender loving is a term most often used in communities of color to describe people with same-sex attractions since gay, homosexual, bisexual or lesbian can carry negative connotations to some people.

Sexual orientation generally refers to people's sexual behavior or attraction.

Snowball sampling is a technique for developing a research sample where existing study subjects recruit future subjects from among their acquaintances. Thus the sample group appears to grow like a rolling snowball. As the sample builds up, enough data is gathered to be useful for research. This sampling technique is often used in hidden populations which are difficult for researchers to access.

Transexual is an older term which originated in the medical and psychological communities. Many transgender people prefer the term "transgender" to "transexual." Some transexual people still prefer to use the term to describe themselves. However, unlike transgender, transexual is not an umbrella term, and many transgender people do not identify as transexual.

Transfeminine is a broad term used to describe individuals who were assigned the sex "male" at birth, but whose gender identity is along the feminine spectrum of gender. This can encompass those who have medically transitioned and those who have not, and may include (but is not limited to) those who identify as transwomen, MTF (male-to-female), transgender female, transexual female, genderqueer, etc.

Transgender is a word commonly used to describe people who live in a gender different from the one assigned to them at birth. People often use this word to describe not only people who have changed their gender through surgery or cross-gender hormone treatment, but also people who have non-medical gender transitions or identify as transgender but do not seek to change their gender legally or medically. For the purposes of this report, "transgender" categories include people who self-identified as transgender and those who indicated a current gender identity that is different from what they stated was the sex on their birth certificate.

Transmasculine is a broad term used to describe individuals who were assigned the sex "female" at birth, but whose gender identity is along the masculine spectrum of gender. This can encompass those who have medically transitioned and those who have not, and may include (but is not limited to) those who identify as transmen, FTM (female-to-male), transgender male, transexual male, genderqueer, etc.

Transphobia refers to hatred, fear of or discrimination against transgender people based on their gender identity or expression.

Two-spirit is a culturally-specific gender-nonconforming identity within the culture and heritage of American Indian/Native American.

OUR PARTNERS

We'd like to thank the following groups that have joined as partners in Lambda Legal's national Health Care Fairness Campaign for helping to promote the health care fairness survey and disseminate and utilize these findings. We would not have been able to collect responses from such a large and diverse group of people without their help and support. It should be noted that our partners did not participate in the writing of this report nor the development of the policy recommendations.

9 to 5 California
9 to 5 National Association of Working Women
Adolescent AIDS Program
Aeromestiza
Affirmations
AIDS Legal Referral Panel
AIDS Project El Paso
Al Gamea
Allgo
Alliance for Full Acceptance
American Friends Service Committee
Asian Pacific Islander Coalition on HIV/AIDS (APICHA)
Atlanta Lesbian Health Initiative
Basic Rights Oregon
BCC (Beth Chayir Chadoshim)
Best Koeppel APLC
BGLAD @ SCU Law
Bienestar
Boston Alliance of LGBT Youth, Inc. (BAGLY)
Bronx Pride
Brothas & Sistas, Inc.
CAEAR Foundation
Cascade AIDS Project
Center for Medicare Advocacy, Inc.
Centerlink
Circle of Voices
COLAGE
Community HIV/AIDS Mobilization Project (CHAMP)
Crossdressers International
Dr. Maxwell Anderson & Associates
Emotional Healing and Empowerment Center
Entre Hermanos
Equality North Carolina
Equality Texas
Family Equality Council
Feminist Health Center
Gay & Lesbian Center of South Nevada
Gay and Lesbian Medical Association
Gay, Lesbian and Straight Education Network
Gender Just
Gender Rights Advocacy Association of New Jersey
Georgia Equality
Giovanni's Room
Glory To God Christian Church
Human Rights Campaign
Identity, Inc
Indiana Equality
International Federation for Gender Education
International Gay & Lesbian Human Rights Commission
Kentucky Fairness Alliance

Knoxville/Knox County, Department of Air Quality Management

Latino Commission on AIDS

Legal Voice

LGBT Center New Orleans

LGBT Community Center of Greater Cleveland

LGBT Center, UCSF

Life Healing Center

Lighthouse Community Center

Love Makes a Family

Lotus Monk

Mautner Project

Metropolitan Community Church of Louisville

Missoula AIDS Council

Mocha Center

More Light Presbyterians

National Coalition for LGBT Health

National Gay & Lesbian Task Force

National Senior Citizens Law Center

National Youth Advocacy Coalition

Nevada Association of Latin Americans (NALA)

NIA Collective

New York Association for Gender Rights Advocacy

Northern Colorado AIDS Project

One Iowa

Our House

OUTLaw

Palm Beach County Human Rights Council

PFLAG National

PFLAG Bozeman

PFLAG Omaha

PFLAG Tulsa

Planned Parenthood of Southern Finger Lakes

Pride Collective & Community Center

Pro Latino

PROMO

Public Health - Seattle & King County

Rainbow Access Initiative

Rainbow Center

Rainbow Community Center

Raising Women's Voices for the Health Care We Need

Tennessee Transgender Political Coalition

The Butch/Femme Society

The MergerWatch Project

The Sperm Bank of California

The Wall - Las Memorias

Tomboy Magazine

Topeka AIDS Project

Transgender Individuals Living Their Truth (TILTT)

Transgender Legal Defense Fund

Triangle Foundation

Tri-City Health Center

Two Spirit Society of Denver

UCC Coalition for LGBT Concerns

Utah Pride Center

Ventura County Rainbow Alliance (VCRA)

Whitman-Walker Clinic

Wilson Resource Center

Workmen's Circle, So California Arberter Ring Edcuation Center

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Lambda Legal is a national organization committed to achieving full recognition of the civil rights of lesbians, gay men, bisexuals, transgender people and those with HIV through impact litigation, education and public policy work.

If you feel you have been discriminated against, please call Lambda Legal's Help Desk at (866) 542-8336 or visit www.lambdalegal.org/help/online-form

Lambda Legal
making the case for equality

EXHIBIT 3

Injustice at Every Turn

A Report of the National Transgender Discrimination Survey

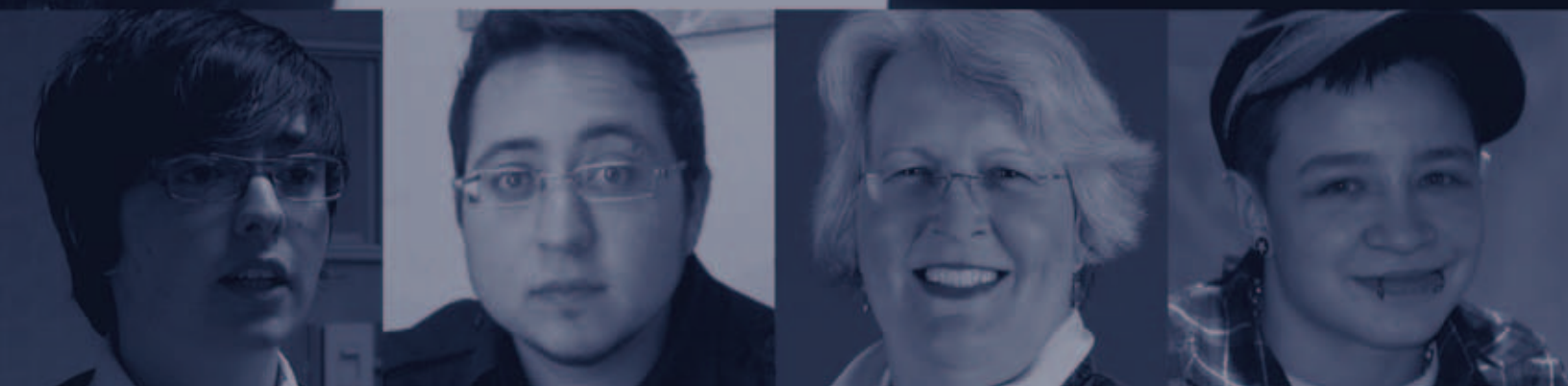
Lead authors in alphabetical order:

Jaime M. Grant, Ph.D.
Lisa A. Mottet, J.D.
Justin Tanis, D.Min.

with Jack Harrison
Jody L. Herman, Ph.D.
and Mara Keisling

National Center for TRANSGENDER EQUALITY

National Gay and Lesbian Task Force



INJUSTICE AT EVERY TURN:

A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY

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About the National Center for Transgender Equality

The National Center for Transgender Equality is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people. By empowering transgender people and our allies to educate and influence policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country.

About the National Gay and Lesbian Task Force

The mission of the National Gay and Lesbian Task Force is to build the grassroots power of the lesbian, gay, bisexual and transgender (LGBT) community. We do this by training activists, equipping state and local organizations with the skills needed to organize broad-based campaigns to defeat anti-LGBT referenda and advance pro-LGBT legislation, and building the organizational capacity of our movement. Our Policy Institute, the movement's premier think tank, provides research and policy analysis to support the struggle for complete equality and to counter right-wing lies. As part of a broader social justice movement, we work to create a nation that respects the diversity of human expression and identity and creates opportunity for all.

RECOMMENDED CITATION

Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

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HEALTH

Access to health care is a fundamental human right that is regularly denied to transgender and gender non-conforming people.

Transgender and gender non-conforming people frequently experience discrimination when accessing health care, from disrespect and harassment to violence and outright denial of service. Participants in our study reported barriers to care whether seeking preventive medicine, routine and emergency care, or transgender-related services. These realities, combined with widespread provider ignorance about the health needs of transgender and gender non-conforming people, deter them from seeking and receiving quality health care.

Our data consistently show that racial bias presents a sizable additional risk of discrimination for transgender and gender non-conforming people of color in virtually every major area of the study, making their health care access and outcomes dramatically worse.

KEY FINDINGS IN HEALTH

- Survey participants reported that when they were sick or injured, they **postponed medical care** due to discrimination (28%) or inability to afford it (48%).
- Respondents faced **serious hurdles to accessing health care**, including:
  - **Refusal of care**: 19% of our sample reported being refused care due to their transgender or gender non-conforming status, with even higher numbers among people of color in the survey.
  - **Harassment and violence in medical settings**: 28% of respondents were subjected to harassment in medical settings and 2% were victims of violence in doctor's office.
  - **Lack of provider knowledge**: 50% of the sample reported having to teach their medical providers about transgender care.
- The **majority of survey participants have accessed some form of transition-related medical care** despite the barriers; the majority reported wanting to have some type of surgery but have not had any surgeries yet.
- **If medical providers were aware of the patient's transgender status, the likelihood of that person experiencing discrimination increased**.
- Respondents reported **over four times the national average of HIV infection**, 2.64% in our sample compared to .6% in the general population, with rates for transgender women at 4.28%, and with those who are unemployed (4.67%) or who have done sex work (15.32%) even higher.[1]
- Over a quarter of the respondents **misused drugs or alcohol specifically to cope with the mistreatment** they faced due to their gender identity or expression.
- A staggering **41% of respondents reported attempting suicide** compared to 1.6% of the general population, with unemployment, bullying in school, low household income and sexual and physical associated with even higher rates.

Access to Healthcare

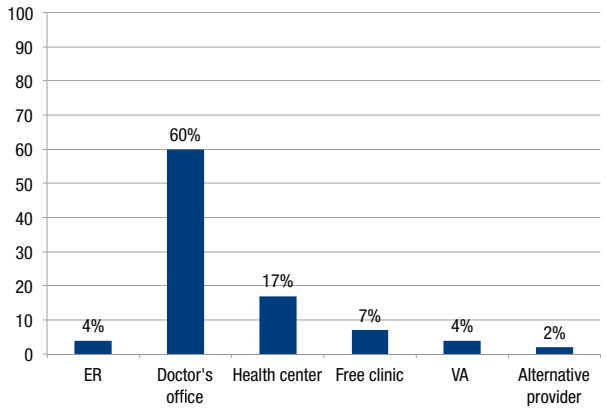
HEALTH CARE SETTINGS

A majority of study participants sought care ("when you are sick or need advice about your health") through a doctor's office (60%); however a sizable minority used health centers and clinics (28%). Four percent (4%) of respondents primarily used emergency rooms for care. Several studies have shown that individuals who use emergency rooms for primary care experience more adverse health outcomes than those who regularly see a primary physician.[2] Factors that correlated with increased use of emergency rooms (ERs) among our respondents were:

- Race—17% of African-Americans used ERs for primary care, as did 8% of Latino/a respondents;
- Household income—8% of respondents earning under $10,000 per year used ERs for primary care;
- Employment status—10% of unemployed respondents and 7% of those who said they had lost their jobs due to bias used ERs for primary care;
- Education—13% of those with less than a high school diploma used ERs for primary care.

Visual conformers and those who had identity documents that matched their presentation had high rates of using doctor's offices for their care.

Primary Source of Medical Care for Respondents



Health Care Experiences

DISCRIMINATION BY MEDICAL PROVIDERS

19% of our sample reported being refused care altogether, due to their gender identity or expression, with even higher numbers among people of color in the survey.

Denial of health care and multiple barriers to care are commonplace in the lives of transgender and gender non-conforming people. Respondents in our study seeking health care were denied equal treatment in doctor's offices and hospitals (24%), emergency rooms (13%), mental health clinics (11%), by EMTs (5%) and in drug treatment programs (3%).[3] Female-to-male respondents reported higher rates of unequal treatment than male-to-female respondents. Latino/a respondents reported the highest rate of unequal treatment of any racial category (32% by a doctor or hospital and 19% in both emergency rooms and mental health clinics).

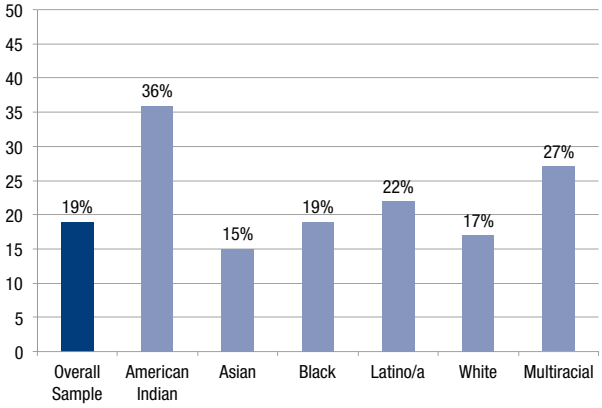
We also asked whether respondents had been ***denied service altogether*** by doctors and other providers.[4] Nineteen percent (19%) had been refused treatment by a doctor or other provider because of their transgender or gender non-conforming status.

Twenty-four percent (24%) of transgender women reported having been refused treatment altogether and 20% of transgender men did. Respondents who reported they had lost jobs due to bias (36%); American Indians (36%); those who worked in the underground economy (30%); those on public insurance (28%); and those who transitioned (25%) experienced high occurrence of refusal to treat.

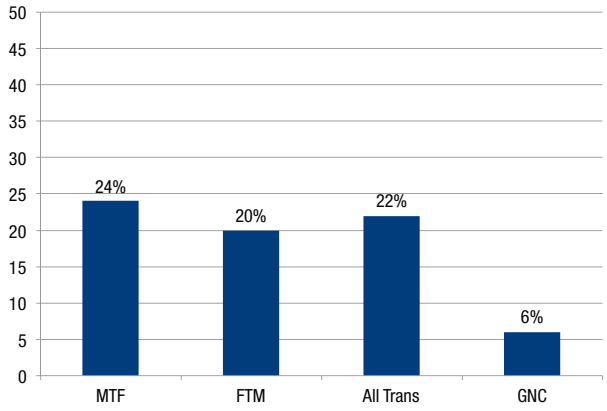
"After an accident on ice, I was left untreated in the ER for two hours when they found my breasts under my bra while I was dressed outwardly as male."

"I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."

Refusal to Provide Medical Care by Race



Refusal to Provide Care by Gender Identity/Expression



"I have had general practitioners refuse to accept me as a patient on the basis of having a history of gender identity disorder."

VIOLENCE AND HARASSMENT WHEN SEEKING MEDICAL TREATMENT

Doctors' offices, hospitals, and other sources of care were often unsafe spaces for study participants. Over one-quarter of respondents (28%) reported verbal harassment in a doctor's office, emergency room or other medical setting and 2% of the respondents reported being physically attacked in a doctor's office.

2% of respondents reported being physically attacked in a doctor's office.

28% reported being verbally harassed in a medical setting.

Those particularly vulnerable to physical attack in doctors' offices and hospitals include those who have lost their jobs (6%); African-Americans (6%); those who done sex work, drug sales or other work in the underground economy (6%); those who transitioned before they were 18 (5%); and those who are undocumented non-citizens (4%).

In emergency rooms, 1% reported attack. Those more vulnerable to attack include those who are undocumented (6%); those who have worked in the underground economy (5%); those who lost their jobs (4%); and Asian respondents (4%). Obviously, harassment and physical attacks have a deterrent effect on patients seeking additional care and impact the wider community as information about such abuses circulates.

"My experiences in dealing with hospital personnel after my rape was not pleasant and lacked a lot of sensitivity to trans issues."

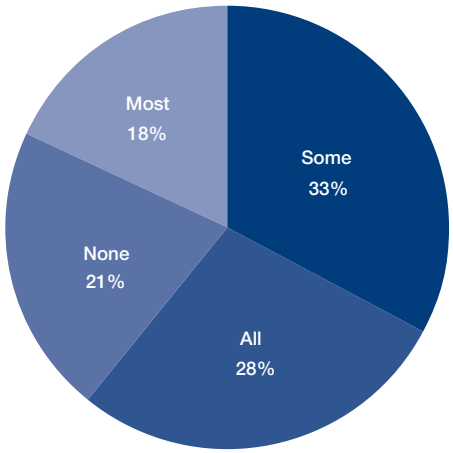
"When I tried to kill myself and was taken to a suicide center, I was made fun of by staff and treated roughly."

"I was forced to have a pelvic exam by a doctor when I went in for a sore throat. The doctor invited others to look at me while he examined me and talked to them about my genitals."

OUTNESS AND DISCRIMINATION

Twenty-eight percent (28%) of respondents said they were out to all their medical providers. Eighteen percent (18%) said they were out to most, 33% said some or a few, and 21% were out to none.

When Seeking Medical Care, How Many People Know or Believe You Are Transgender or Gender Non-Conforming?



Doctors can provide more effective care when they have all medically relevant information about their patients. Unfortunately, our data shows that doctors' knowledge of a patient's transgender status increases the likelihood of discrimination and abuse. Medical professionals' awareness of their patient's transgender status ***increased experiences of discrimination*** among study participants up to eight percentage points depending on the setting:

- **Denied service altogether:** 23% of those who were out or mostly out to medical providers compared to 15% of those who were not out or partly out
- **Harassment in ambulance or by EMT**: 8% of those who were out or mostly out to medical providers compared with 5% of those who were not out or partly out
- **Physically attacked or assaulted in a hospital**: 2% of those who were out or mostly out to medical providers compared with 1% of those who were not out or partly out

"I have been harassed and physically assaulted on the street. One time, I didn't go the hospital until I went home, changed [out of feminine] clothes, and then went to the emergency room in male mode. I had a broken collar bone as a result of that attack."

"I rarely tell doctors of my gender identity. It just seems so hard to explain what "genderqueer" means in a short doctor's appointment. I also am reluctant to take the risk of discrimination; I need to be healthy more than I need to be out to my doctors. I hate making this compromise. But I'm not quite that brave yet."

"Denial of health care by doctors is the most pressing problem for me. Finding doctors that will treat, will prescribe, and will even look at you like a human being rather than a thing has been problematic. Have been denied care by doctors and major hospitals so much that I now use only urgent care physician assistants, and I never reveal my gender history."

MEDICAL PROVIDERS' LACK OF KNOWLEDGE

50% of the sample reported having to teach their medical providers about transgender care.

When respondents saw medical providers, including doctors, they often encountered ignorance about basic aspects of transgender health and found themselves required to "teach my provider" to obtain appropriate care. Fully 50% of study respondents reported having to teach providers about some aspect of their health needs; those who reported "teaching" most often include transgender men (62%), those who have transitioned (61%) and those on public insurance (56%).

"I have several health issues and have been refused care by one doctor who 'suggested' that I go someplace else because she could not treat me since she 'did not know anything about transgender people.' "

POSTPONEMENT OF NECESSARY AND PREVENTIVE MEDICAL CARE

One fourth of study participants reported delaying needed care because of disrespect and discrimination from medical providers.

We asked respondents whether they postponed or did not try to get two types of health care: preventive care "like checkups" and necessary care "when sick or injured." We found that many postponed care because they ***could not afford it*** and many postponed care because of ***discrimination and disrespect from providers***.

A large number of study participants postponed necessary medical care due to inability to afford it, whether seeking care when sick or injured (48%), or pursuing preventive care (50%). Transgender men reported postponing any care due to inability to afford it at higher rates (55%) than transgender women (49%).

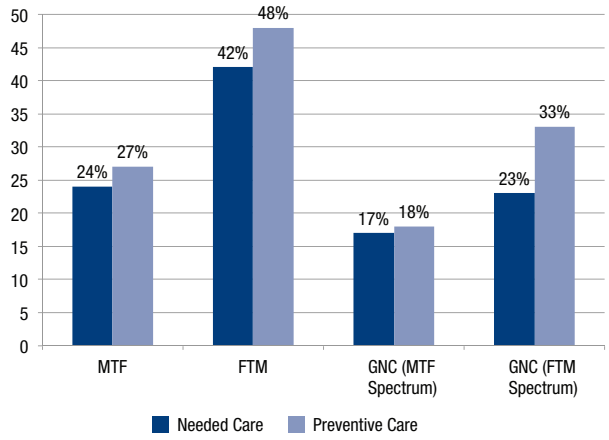
Insurance was a real factor in delayed care: those who have private insurance were much less likely to postpone care because of inability to afford it when sick or injured (37%) than those with public (46%) or no insurance who postponed care (86%).

In terms of preventive care, those without insurance reported delaying care due to inability to afford it much more frequently (88%) than those with private insurance (39%) or public insurance (44%). Failing to obtain preventive care is known to lead to poor long-term health outcomes.

Due to discrimination and disrespect, 28% postponed or avoided medical treatment when they were sick or injured and 33% delayed or did not try to get preventive health care. Female-to-male transgender respondents reported postponing care due to discrimination and disrespect at a much higher frequency (42%, sick/injured; 48% preventive) than male-to-female transgender respondents (24%, sick/injured; 27% preventive). Those with the highest rates of postponing care when sick/injured included those who have lost a job due to bias (45%) and those who have done sex work, sold drugs, or done other work in the underground economy for income (45%). Twenty-nine percent (29%) of respondents who were "out" or "mostly out" to medical providers reported they had delayed care when ill and 33% postponed or avoided preventive care because of discrimination by providers.

"The transition and health care has been expensive, all at a time where my main source of income (my law practice) deteriorated. I have exhausted my savings and the equity from selling my home just to pay medical and living expenses."

Postponement Due to Discrimination by Providers



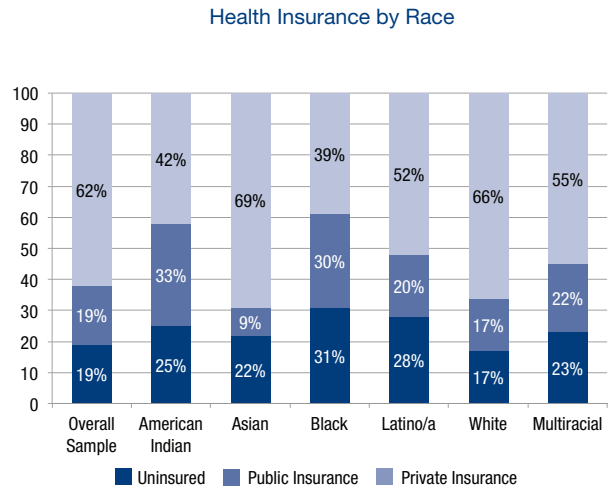
ACCESS TO INSURANCE

Study participants were less likely than the general population to have health insurance, more likely to be covered by public programs such as Medicare or Medicaid, and less likely to be insured by an employer.

Nineteen percent (19%) of the sample lacked any health insurance compared to 17% of the general population.[5] Fifty-one percent (51%) had employer-based coverage compared to 58% of the general population.[6]

African-American respondents had the worst health insurance coverage of any racial category: 39% reported private coverage and 30% public. Thirty-one percent (31%) of Black respondents reported being uninsured; by contrast 66% of white respondents reported private insurance, 17% public insurance and 17%

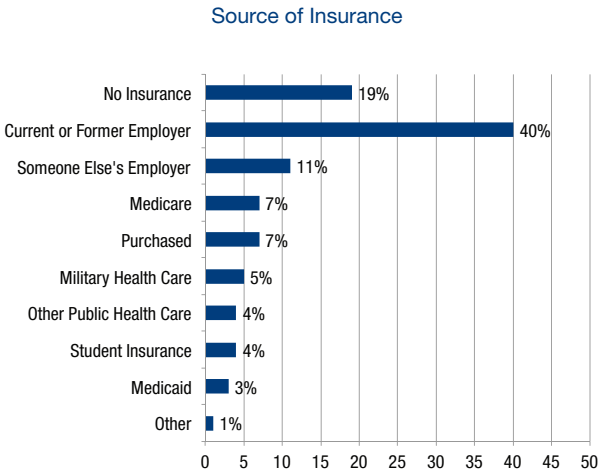
uninsured. In the general population, 68% have private insurance and 28% have public insurance.[7]



Undocumented non-citizens had very low rates of coverage: 26% reported private insurance, 37% public insurance, and 36% no insurance. The South was the worst region for coverage where 59% of respondents reported private insurance, 17% public insurance and 25% no insurance.

Transgender women reported private insurance at 54%, public insurance at 24% and 22% were uninsured. Transgender men reported private insurance at 68%, public insurance at 13% and 19% with no insurance. Transgender respondents, overall, reported private insurance at 60%, public insurance at 20% and 20% had no insurance. Gender non-conforming respondents were insured at higher rates than their transgender counterparts, with 73% reporting private insurance, 11% public insurance, and 17% uninsured.

"I have been living with excruciating pain in my ovaries because I can't find a doctor who will examine my reproductive organs." (from a transgender man)



Transition-related Care

The majority of survey participants have accessed some form of transition-related medical care despite the barriers.

Most survey respondents had sought or accessed some form of transition-related care. Counseling and hormone treatment were notably more utilized than any surgical procedures, although the majority reported wanting to "someday" be able to have surgery. The high costs of gender-related surgeries and their exclusion from most health insurance plans render these life-changing (in some cases, life-saving) and medically necessary procedures inaccessible to most transgender people.

Throughout this section, we focus primarily on transgender people rather than on gender non-conforming people, though they too may also desire and sometimes use various forms of gender-related medical care.

The World Professional Association for Transgender Health (WPATH) publishes Standards of Care[8] which are guidelines for mental health, medical and surgical professionals on the current consensus for providing assistance to patients who seek transition-related care. They are intended to be flexible to assist professionals and their patients in determining what is appropriate for each individual. The Standards of Care are a useful resource in understanding the commonly experienced pathways through transition-related care.

"My choices for health coverage at my employer all exclude any treatment for transgender issues, even though they cover things like hormones for other people."

COUNSELING

Counseling often plays an important role in transition. Because of the WPATH Standards of Care, medical providers often require a letter from a qualified counselor stating that the patient is ready for transition-related medical care; transgender people may seek out counseling for that purpose. Counseling may also play a role in assisting with the social aspects of transition, especially in dealing with discrimination and family rejection.

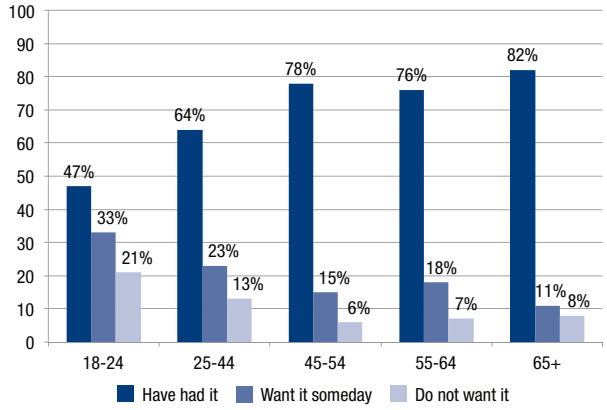
Seventy-five percent (75%) of respondents received counseling related to their gender identity and an additional 14% hoped to receive it someday. Only 11% of the overall sample did not want it. Those who identified as transgender were much more likely to have had counseling (84%) than those who are gender non-conforming (48%). Eighty-nine percent (89%) of those who medically transitioned have received counseling, as have 91% of those who had some type of surgery.

Part of counseling can involve receiving a gender-related mental health diagnosis such as "Gender Identity Disorder." Many doctors require this diagnosis before providing hormones or surgical treatment, but the diagnosis itself is widely criticized for categorizing naturally occurring gender variance as pathological.[9] Fifty-percent (50%) of study participants have received a gender-related mental health diagnosis. Transgender women reported a higher rate of diagnosis (68%) than transgender men (56%); and transgender-identified participants had a substantially higher rate of diagnosis (63%) than gender non-conforming respondents (11%).

HORMONE THERAPY

Sixty-two percent (62%) of respondents have had hormone therapy, with the likelihood increasing with age; an additional 23% hope to have it in the future. Transgender-identified respondents accessed hormonal therapy (76%) at much higher rates than their gender non-conforming peers, with transgender women more likely to have accessed hormone therapy (80%) than transgender men (69%). Almost all respondents who reported undertaking transition-related surgeries also reported receiving hormone therapy (93%).

Hormone Therapy by Age of Respondent

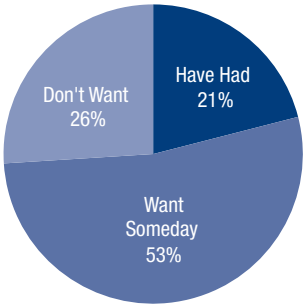


"I can no longer afford health care of any kind. I am fully transitioned and thus reliant upon estradiol as my body produces neither estrogens nor androgens in sufficient quantity. I am unable to go to the doctor for my prescriptions, and thus have been unable to buy my hormones for over one year. Thus I watch my hair falling out, my nails dissolve and am weak and tired like a far older lady than I am."

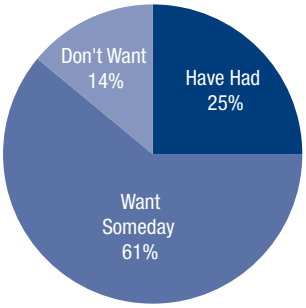
SURGERY—MALE-TO-FEMALE

Transgender women may elect to undertake a variety of surgeries, including breast augmentation, orchiectomy (removal of testes), vaginoplasty (creation of a vagina and/or removal of the penis), and facial feminization surgeries. We asked respondents to report on whether they had, or wanted, breast augmentation surgery, orchiectomies and vaginoplasties. As the charts below show, most transgender women reported wanting or having these surgeries. In addition, 17% reported having had facial surgery.[10] However, it is impossible to know how many others would desire or utilize surgery if it was more financially accessible.

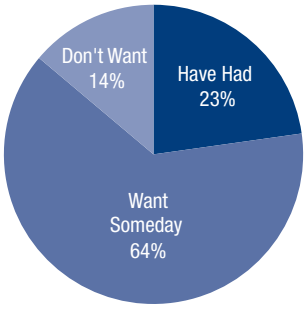
MTF Breast Augmentation Surgery



MTF Orchiectomy



MTF Vaginoplasty

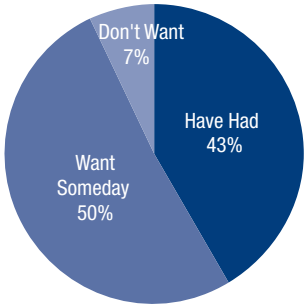


"I cannot afford gender reassignment surgery which is crucial to my mental well being and thoughts of suicide are always present."

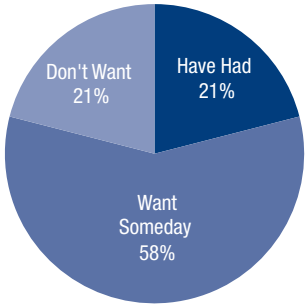
SURGERY—FEMALE-TO-MALE

Transgender men may elect to undertake a variety of surgeries, including chest reconstruction, hysterectomy, metoidioplasty and other genital surgeries. We asked respondents to report on chest surgery; hysterectomy; metoidioplasty, which releases the clitoris; surgeries that create testes; and phalloplasty, which surgically creates a penis and testes. The majority of FTM transgender-identified respondents wanted to have, or have already had, chest surgery and a hysterectomy. However, when it came to genital surgeries, very few reported having such surgeries; a slim majority (53%) reported desiring other genital surgery such as metoidioplasty in addition to the 3% that have had it; and one-quarter (27%) wanted to have a phalloplasty in addition to the 1% who have had it. It is impossible to know how these rates would change if these surgeries were more financially accessible.

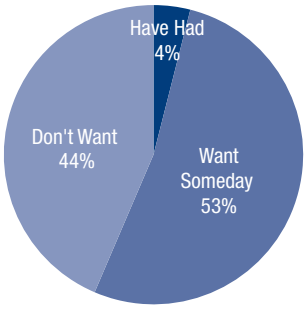
FTM Chest Surgery



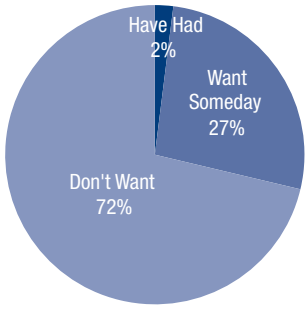
FTM Hysterectomy



FTM Metoidioplasty/ Creation of Testes



FTM Phalloplasty



"I have also have had several bouts with depression and anxiety disorders and once ended up in the emergency room for depression. I still bounce in and out of depression due to not being able to get the appropriate surgical procedures."

Health Vulnerabilities

Survey participants reported poorer health outcomes than the general population in a variety of critical health areas.

PHYSICAL VIOLENCE AND SEXUAL ASSAULT

"As a child because I acted "girly," I was a victim of severe child abuse, and was sexually assaulted. I avoided transitioning until I came to the point of suicide."

In questions related to experiences in educational settings, at work, in interactions with police and with family members, at homeless shelters, accessing public accommodations, and in jails and prisons, respondents were asked about physical violence or sexual violence, or both, committed against them because of their gender identity/expression. There was no *general question* asked about whether respondents had ever experienced any bias-motivated violence, and further, there was no question that asked to report on violence that was not *specifically motivated* by anti-transgender bias.

Twenty-six percent (26%) of respondents had been physically assaulted in at least one of these contexts because they were transgender or gender non-conforming. Ten percent (10%) of respondents were sexually assaulted due to this bias.

Having been physically or sexually assaulted aligned with a range of other negative outcomes, as described below in each relevant section.

HIV

Respondents reported over four times the national average of HIV infection.

Respondents reported an HIV infection rate of 2.64%,[11] over four times the rate of HIV infection in the general United States adult population (0.6%) as reported by the United Nations Programme on HIV/AIDS and the World Health Organization.[12] People of color reported HIV infection at substantially higher rates: 24.90% of African-Americans, 10.92% of Latino/as, 7.04% of American Indians, and 3.70% of Asian-Americans in the study reported being HIV positive. This compares with national rates of 2.4% for African Americans, .08% Latino/as, and .01% Asian Americans.[13] Non-U.S. citizens in our sample reported more than twice the rate of HIV infection of U.S. citizens (2.41%), with documented non-citizens at 7.84% and undocumented at 6.96%.

Doing sex work for income clearly was a major risk factor, with 61% of respondents who were HIV positive reporting they had done sex work for income. To consider this from a different angle, of all the people in our sample who had done sex work, 15.32% reported being HIV positive.

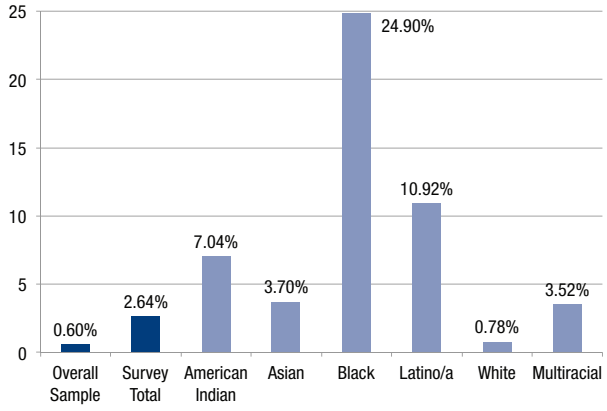
Among survey participants, 88% of those who reported being HIV positive identified as either MTF or gender non-conforming on the male-to-female spectrum. The reported rate of HIV infection for the MTF transgender respondents was 4.28%. The reported rate of HIV infection for FTM respondents was .51%, lower than the national average.

Other categories that reported substantially higher HIV rates than the sample as a whole were:

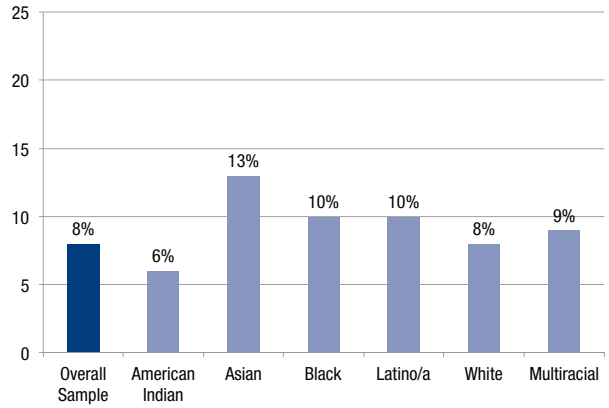
- Those without a high-school diploma (13.49%)
- Those who had been sexually assaulted due to bias (10.13%)
- Those with household income below $10,000 a year (6.40%)
- Those who had lost a job due to bias (4.59%) or reported being unemployed (4.67%)

Eight percent (8%) of our sample reported that they did not know their HIV status. Transgender women and transgender men had equal rates of not knowing, both 8%, with transgender respondents also at 8% and gender non-conforming respondents at 9%. Those most likely not to know their HIV status include undocumented non-citizens (17%), those with household incomes under $10,000/year (14%), and those with lower educational attainment (those with no high school diploma and high school diploma only, both at 13%).With regard to race, Asian respondents were least likely to know their status (13%).

HIV Infection By Race, Compared to U.S. General Population



HIV Status Unknown By Race



DRUG AND ALCOHOL USE

The National Institutes of Health (NIH) estimate that 7.3% of the general public abuses or is dependent on alcohol, while 1.7% abuses or is dependent on non-prescription drugs.[14] Eight percent (8%) of study participants reported currently using alcohol or drugs specifically to cope with the mistreatment that they received as a result of being transgender or gender non-conforming, while 18% said they had done so in the past but do not currently. We did not ask about general use of alcohol and drugs, only usage which the respondents described as a coping strategy for dealing with the mistreatment they face as transgender or gender non-conforming persons.

26% use or have used alcohol and drugs to cope with the impacts of discrimination.

Doing sex work, drug sales, and other work in the underground economy for income more than doubles the risk of alcohol or drug use because of mistreatment, with 19% of these respondents currently using alcohol and/or drugs while 36% reported that they had done so in the past. Those who have been the physically attacked due to bias also had a higher rate of current alcohol and drug misuse (15%) as did those who have been sexually assaulted due to bias (16%). Also at elevated risk were those who had lost a job due to discrimination; 12% reported currently using drugs and alcohol, while 28% have done so in the past.

"I do not use drugs but my drinking has increased over the past 3 years due to stress and loneliness."

"When I started coming out, I stopped the drinking and stopped the depression medicines. When I started living full time in my real gender, I blossomed into an outgoing, loving, giving person."

Alcohol and drug use decreased by age among our participants, as they did in studies of the general population,[15] with those 65 years and above reporting less than half the rate of use (4%) of those who are the 18-44 age range (9%). This contrasts with studies of LGBT populations that show a less dramatic decrease in use over the life cycle;[16] however, because our study only asked about use connected to mistreatment, the comparisons with both the general population and LGBT studies are not precise.

SMOKING

Thirty percent (30%) of our sample reported smoking daily or occasionally, compared to 20.6% of U.S. adults.[17] Studies of LGBT adults show similar rates to those in our study, with elevated rates of 1.1-2.4 times that of the general population,[18] and a 2004 California study found a 30.7% smoking rate for transgender people.[19] In the general population, men smoke at higher rates than women, but in LGBT studies, women smoke at higher rates than men. Our sample resembled the LGBT data regarding elevated smoking levels but differed in that more men than women in our sample smoke, a pattern that is closer to that of the general population. When asked if they would "like to quit," 70% of smokers in the study selected yes.

Comparative Smoking Rates from Other Studies,[20] Compared to Our Study

	General Population	Lesbian and Gay	Bisexual	Our Sample
Men	23.1%	26.5-30.9%	29.5-38.1%	33%
Women	18.3%	22.3-26%	30.9-39.1%	29%

Visual conformers were less likely to be current smokers (27%) than visual non-conformers (37%), suggesting that the stress caused by the additional mistreatment that visual non-conformers face may be involved in the development of an addiction to nicotine. Similarly, those who have been physically assaulted due to bias (40%) and sexually assaulted due to bias (45%) have higher smoking rates than their peers who were not assaulted.

SUICIDE ATTEMPTS

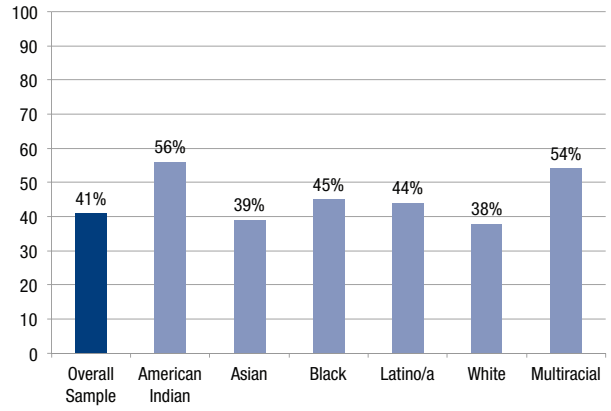
When asked "have you ever attempted suicide?" 41% of respondents answered yes. According to government health estimates, five million, or 1.6% of currently living Americans have attempted suicide in the course of their lives.[21] Our study asked if respondents had ever attempted suicide while most federal studies refer to suicide attempts within the last year; accordingly it is difficult to compare our numbers with other studies. Regardless, our findings show a shockingly high rate of suicidality.

41% of respondents reported attempting suicide.

The National Institute for Mental Health (NIMH) reports that most suicide attempts are signs of extreme distress, with risk factors including precipitating events such as job loss, economic crises, and loss of functioning.[22] Given that respondents in this study reported loss in nearly every major life area, from employment to housing to family life, the suicide statistics reported here cry out for further research on the connection between the consequences of bias in the lives of transgender and gender non-conforming people and suicide attempts.[23]

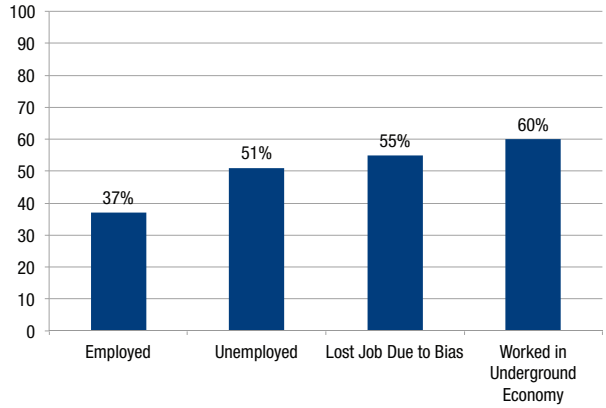
NIMH also reports that generally African-Americans, Latino/as and Asians have much lower suicide rates than whites and American Indians; our sample showed a different pattern of risk for suicide by race, with Black and Latino/a respondents showing dramatically elevated rates in comparison to their rates in the general population.

Suicide Attempt by Race



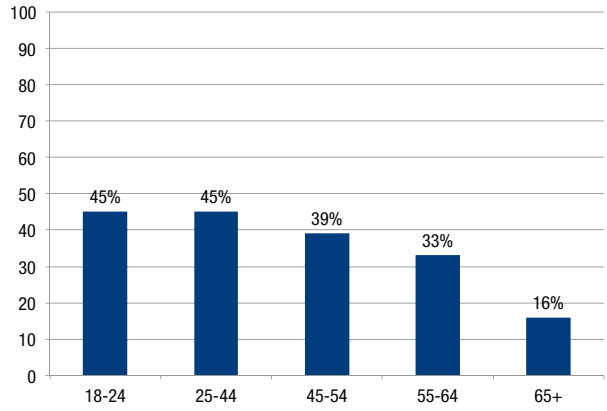
Respondents' work status and experiences of discrimination in employment also had a sizable impact on their likelihood of having attempted suicide.

Suicide Attempt by Employment



In terms of age group risk, the highest rates of suicide attempts in this study were reported among those in the 18-24 age group (45%) and 25-44 age group (45%), with only 16% of those over 65 reporting a suicide attempt. These rates are inverse to the general population, which shows a higher incidence of attempts among older Americans than youth.[24]

Suicide Attempts by Age



Our questionnaire did not ask at what age the respondents made suicide attempts and therefore it is difficult to draw conclusions about the risk of suicide over their life spans. However, there are a number of attributes that align with an increased rate of attempted suicide. High risk groups include visual non-conformers (44%) and those who are generally out about their transgender status (44%). Those who have medically transitioned (45%) and surgically transitioned (43%) have higher rates of attempted suicide than those who have not (34% and 39% respectively).

Over half of those bullied, harassed, assaulted, or expelled due to bias in school attempt suicide.

Those who were bullied, harassed, assaulted, or expelled because they were transgender or gender non-conforming in school (at any school level) reported elevated levels of suicide attempts (51% compared with 41% of our sample as a whole). Most notably, suicide attempt rates rise dramatically when teachers were the reported perpetrators: 59% for those harassed or bullied by teachers, 76% among those who were physically assaulted by teachers and 69% among those who were sexually assaulted by teachers. These numbers speak to the urgency of ending violence and harassment of transgender students by both their peers and their teachers.

Education and household income both align with suicide rates, with those earning $10,000 annually or less at extremely high risk (54%), while those making more than $100,000 are at comparatively lower risk (26%), while still tremendously higher than the general population. Those who have not completed college attempted suicide at higher rates (48% among those with no high school diploma, 49% for those with a high school diploma only, and 48% for those with some college education) while those have completed college (33%) or graduate school (31%) have lower rates.

Those who had survived violence perpetrated against them because they were transgender or gender non-conforming were at very high risk; 61% of physical assault survivors reported a suicide attempt, while sexual assault survivors reported an attempt rate of 64%.

"My suicide attempt had a lot to do with the fact that I felt hopeless and alone in regards to my gender identity."

CONCLUSIONS FOR HEALTH

Respondents reported serious barriers to health care and outrageous frequencies of anti-transgender bias in care, from disrespect to refusal of care, from verbal harassment to physical and sexual abuse. Transgender people of color and low-income respondents faced substantially elevated risk of abuse, refusal of care, and poor health outcomes than the sample as a whole.

The data gathered here speak to a compelling need to examine the connection between multiple incidences of discrimination, harassment and abuse faced by our respondents in the health care system and the high risk for poor health outcomes. Additionally, our data suggest that discriminatory events are commonplace in the daily lives of transgender people and that this has a cumulative impact—from losing a job because of bias to losing health insurance; from experiencing health provider abuse to avoiding health care; from long-term unemployment to turning to work on the streets. The collective impact of these events exposed our respondents to increased risk for HIV infection, smoking, drug/alcohol use, and suicide attempts.

It is important to note that the traumatic impact of discrimination also has health care implications. Transgender people face violence in daily life; when this risk is compounded by the high rates of physical and sexual assault they face while accessing medical care, health care costs increase, both to treat the immediate trauma as well as ongoing physical and psychological issues that may be created.

As we have seen across a number of categories in the survey, the ability to work substantially impacts transgender health. In particular, those who have been fired due to anti-transgender bias and those who have done sex work, drug sales, or other work in the underground economy are much more likely to experience health risks that are shown to lead to poorer health outcomes.

Discrimination in the health care system presents major barriers to care for transgender people and yet a majority of our survey participants were able to access some transition-related care, with 75% receiving counseling and 62% obtaining hormones. Genital surgery, on the other hand, remains out of reach for a large majority, despite being desired by most respondents. This is one important reason why legal rights for transgender people must never be determined by surgical status.

"I saw a doctor in New York and told her how I wanted [chest surgery]. She looked at me sternly and said, 'I can't believe you are wasting my time. Do you know what your problem is? You just want to be a boy. You want to be a boy and that's never gonna happen so just do yourself a favor and get over it.' Then she left the room abruptly. I grabbed my things and bolted down the street, feeling like the biggest freak in the world."

RECOMMENDATIONS FOR HEALTH

- Anti-transgender bias in the medical profession and U.S. health care system has catastrophic consequences for transgender and gender non-conforming people. This study is a call to action for the medical profession:
  - The medical establishment should fully integrate transgender-sensitive care into its professional standards, and this must be part of a broader commitment to cultural competency around race, class, and age;
  - Doctors and other health care providers who harass, assault, or discriminate against transgender and gender non-conforming patients should be disciplined and held accountable according to the standards of their professions.
- Public and private insurance systems should cover transgender-related care; it is urgently needed and is essential to basic health care for transgender people.
- Ending violence against transgender people should be a public health priority, because of the direct and indirect negative effect it has on both victims and on the health care system that must treat them.
- Medical providers and policy makers should never base equal and respectful treatment and the attainment of appropriate government-issued identity documents on:
  - Whether an individual has obtained surgery, given that surgeries are financially inaccessible for large majorities of transgender people because they are rarely covered by either public or private insurance;
  - Whether an individual is able to afford or attain proof of citizenship or legal residency.
- Rates of HIV infection, attempted suicide, drug and alcohol abuse, and smoking among transgender and gender non-conforming people speak to the overwhelming need for:
  - Transgender-sensitive health education, health care, and recovery programs;
  - Transgender-specific prevention programs.
- Additional data about the health outcomes of transgender and gender non-conforming people is urgently needed:
  - Health studies and other surveys need to include gender identity as a demographic category;
  - Information about health risks, outcomes and needs must be sought specifically about transgender populations;
  - Transgender people should not be put in categories such as “men who have sex with men” (MSM) as transgender women consistently are and transgender men sometimes are. Separate categories should be created for transgender women and transgender men so HIV rates and other sexual health issues can be accurately tracked and researched.

EXHIBIT 4

Center for American Progress

The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial

By Sharita Gruberg and Frank J. Bewkes March 7, 2018

After six years and nearly 25,000 public comments, the U.S. Department of Health and Human Services (HHS) issued a rule in May 2016 to implement Section 1557 of the Affordable Care Act (ACA), clarifying that discrimination based on sex stereotyping and gender identity is impermissible sex discrimination under the law.[1] This position was in line with growing case law to support prohibitions against sex discrimination covering LGBTQ people.[2]

In December 2016, however, the U.S. District Court for the Northern District of Texas issued a nationwide injunction prohibiting HHS from enforcing the regulation's prohibition on discrimination on the basis of gender identity, and, to date, the current administration has failed to defend the regulation.

Franciscan Health, formerly Franciscan Alliance Inc., is a religiously affiliated health care alliance. Along with eight states and two other private health care providers, it sued HHS over the regulation.[3] They alleged that doctors would be forced against their will to perform medical procedures that are contrary to their religious beliefs and that they believe are harmful to the patient. Most specifically, they objected to providing medical treatments related to gender transition, especially for children. The rule implementing Section 1557 requires providers to offer medically necessary health care services to transgender people if those services are within their scope of practice. Franciscan Alliance claimed that following their beliefs and performing procedures for some people, such as mastectomies for cancer patients, but not others, such as "top surgery" for transgender patients, would open them to liability. Due to this concern, they even went so far as to claim that doctors would be forced to cease providing certain medical care treatments for all patients in order to exempt themselves from providing transition-related care to which they have a religious objection.

To learn more about the nature of anti-LGBTQ discrimination in health care and HHS's enforcement of Section 1557's protections for LGBTQ people, the Center for American Progress conducted an analysis of closed complaints of discrimination based on sexual orientation, sex stereotyping related to sexual orientation, and gender identity. HHS received

these complaints prior to the injunction. The analysis revealed that the majority of patients who filed such complaints of discrimination with HHS had not been denied care related to gender transition. Rather, transgender patients who filed complaints were often denied in general, unrelated to transition-related treatments, solely because of their gender identity.

This finding is significant, because Franciscan Alliance's stated concern in *Franciscan Alliance v. Burwell* is that the implementation of Section 1557 would force its doctors to help patients with gender transition care. But the data show that health care providers most often discriminate against transgender people simply for being who they are—not based on the care they need. With the majority of discrimination complaints grounded in gender identity rather than gender transition, the desire of opponents—including Franciscan Alliance—to undo Section 1557's protections for transgender people would have sweeping consequences and possibly indicates an underlying animus toward transgender people generally. CAP's analysis of these claims indicates that, if successful for Franciscan Alliance, *Franciscan Alliance v. Burwell*'s attack on gender identity discrimination protections would allow many forms of discrimination against patients—such as refusing to use proper pronouns and to provide reproductive health care simply because a person's gender presentation does not match their ID or records—and undermine the quality of care for many people while increasing litigation costs for providers.

Thankfully, a different federal court ruled in September 2017 that discrimination on the basis of gender identity is sex discrimination prohibited under Section 1557 itself.[4] This ruling affirmed that transgender individuals can go directly to court, rather than file gender identity discrimination complaints through the administrative procedures of the Office of Civil Rights (OCR) at HHS.[5] Since gender identity discrimination is prohibited sex discrimination under the ACA itself, the administration should not amend the rule interpreting Section 1557 in response to *Franciscan Alliance*; to the contrary, it should continue to defend the rule and fight to overturn the injunction.

Section 1557's nondiscrimination protections

Section 1557 prohibits discrimination by any health program or activity receiving federal assistance; health programs and activities administered by HHS; and marketplaces under the ACA, on the basis of race, color, national origin, sex, age, or disability.[6] The definition of what constitutes sex discrimination in Section 1557 is informed by the prohibitions against sex discrimination in Title IX of the Education Amendments of 1972, as well as Title VII of the Civil Rights Act of 1964.[7] The courts have clarified that discrimination on the basis of gender identity is sex discrimination, despite the stance of the Trump administration.[8] In other words, as a federal court recently found, "Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections."[9] (see text box) The ACA offers protections regardless of the status of its implementing regulations.

Prescott v. Rady Children's Hospital-San Diego

In September 2017, the U.S. District Court for the Southern District of California ruled on *Prescott v. Rady Children's Hospital-San Diego*, a case brought by a mother on behalf of her deceased transgender son.[10] Kyler, her son, had battled with gender dysphoria, depression, and suicidal ideation. His mother sought help at Rady Children's Hospital-San Diego (RCHSD), where hospital staff proceeded to repeatedly misgender Kyler. Unfortunately, RCHSD did not correct the behavior after it was brought to light by Kyler's mother; instead, it discharged Kyler from psychiatric hold early. Kyler died by suicide a month later. The court's ruling in this case was in response to an order on a motion to dismiss, so the merits of Kyler's mother's claim that her son was discriminated against were not addressed. The court did, however, hold that the discrimination claim based on Kyler's transgender identity arose from the language of the ACA itself, rather than the implementing regulation, and that the claim was plausible.

To provide further clarity on the nature of the protections afforded by the ACA, HHS issued a rule that interpreted the sex discrimination prohibition in Section 1557 to prohibit discrimination based on sex stereotyping and gender identity.[11] There is growing case law to support prohibitions against sex stereotyping, including sexual orientation discrimination.[12] The rule specifies that insurers are prohibited from denying or limiting health insurance or coverage because of someone's gender identity; that there cannot be a categorical exclusion from insurance coverage for transition-related care; and that if health services are ordinarily available to individuals of a certain sex, they cannot be denied to a transgender person for whom they are medically relevant. For example, a gynecologist cannot refuse to perform a Pap test or mammogram on a transgender man. The rule is in line with what the vast majority of insurers have already done. A 2017 study of 71 insurers in 18 states found that 90 percent of insurers did not include transgender-specific exclusions and nearly one-third affirmatively stated that medically necessary treatment for gender dysphoria is covered.[13] The rule also clarifies that persistently and intentionally refusing to use a transgender person's correct name and gender pronoun constitutes impermissible harassment on the basis of sex and that transgender people must have access to facilities and programs consistent with their gender identity.

The OCR is charged with accepting and investigating complaints under Section 1557. The statute also provides a private right of action, allowing individuals who experience discrimination to file a lawsuit under Section 1557.

Even without a formal finding of discrimination, the OCR can work with health care providers to take proactive steps to ensure LGBTQ patients are protected from discrimination like it did with The Brooklyn Hospital Center. In July 2015, the OCR reached a voluntary settlement agreement with The Brooklyn Hospital Center after a transgender

woman filed a complaint with the office that the hospital violated Section 1557 when it assigned her to a double occupancy patient room with a man despite her gender identity.[14] The hospital agreed to adopt new nondiscrimination policies and train employees on compliance with those policies.[15]

Analysis of sexual orientation and gender identity discrimination complaints under Section 1557

On January 24, 2017, CAP submitted a Freedom of Information Act (FOIA) request to HHS for complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the ACA from March 23, 2010, to January 20, 2017. In response, CAP received information about a subset of complaints that were received by the agency and were closed—a total of 34 complaints from 2012 through 2016. Review of the documents, however, indicated that the Brooklyn Hospital Center case was not among the complaints provided. These FOIA data do not reflect complaints that remain open or that have been held without action based on the *Franciscan Alliance* litigation. In the final rule interpreting Section 1557, HHS estimated that, each year, it receives a total of 15 to 20 Section 1557 complaints that cannot be filed under other statutes. HHS, however, predicted this number would increase following publication of the proposed rule.[16] Among the complaints, which sometimes had more than one issue claim, there were 31 claims involving gender identity discrimination and six involving sexual orientation discrimination.[17] In two instances, HHS completed its investigation and found the complaints were substantiated; in other words, HHS issued actual findings of discrimination. Most of the closed complaints resulted in the subject of the complaint taking voluntary corrective action. In 22 cases, the covered entity worked with HHS to institute trainings or change policies or HHS provided technical assistance to address the complaint.

Most complaints involved denials of care or insurance coverage because of a person's gender identity

The most common complaints involved individuals being denied care because of their gender identity or transgender status. There were 13 such closed complaints among the 31 complaints involving gender identity discrimination that CAP reviewed. Complaints included a transgender woman being denied a mammogram because of her gender identity; transgender people being denied sexual assault medical forensic examinations; and a transgender man being refused a screening for a urinary tract infection because the clinic claimed it only provided those screenings to women.

One of the next most common complaints involved people being denied insurance coverage because of their gender identity. Five of these complaints were denials of coverage for transition-related care; however, there was one incident of an individual who was

refused insurance coverage for reproductive health care because of his gender identity and another because the insurer would only cover genetic testing for breast cancer for women and not for a transgender man—despite the fact that the testing was recommended by the complainant's doctor.

- Additional examples of discrimination in the complaints include:[18]

- A transgender woman went to the hospital with cold symptoms, but her care was delayed because of repeated questions about her gender identity and inappropriate questions about her anatomy at intake.

- A transgender woman with a disability was repeatedly harassed by the driver of a medical transport service that took her to and from her doctor's appointments.

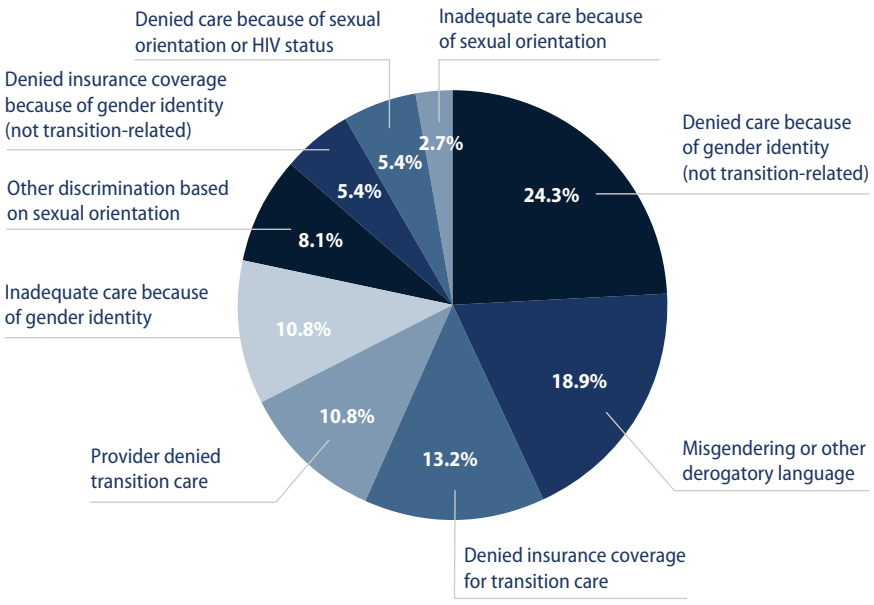
- A woman was separated from her wife during an emergency room visit and her wife was not permitted to enter her room for more than two hours.

- While recovering from an appendectomy, the doctor treating a transgender woman refused to call her by the correct pronouns and said the doctor does not deal with "these kinds" of patients.[19]

FIGURE 1

Forms of health care discrimination against LGBTQ people reported in closed complaints to HHS

Percentage of times each issue was asserted



Note: Figure based on 34 complaints that included a total of 37 issue claims. Several complaints included more than one issue claim.

Source: Data are from documents on file with the authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the Department of Health and Human Services for complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 2010 to January 20, 2017.

Many complaints were resolved through voluntary corrective action rather than costly litigation

The plaintiffs in *Franciscan Alliance* claimed that they feared facing costly litigation as a result of the rule. However, what the available complaints show is that HHS overwhelmingly worked with the subject of the complaint to amend policies and implement trainings to teach staff how to treat transgender patients without discrimination, rather than taking them to court. This was true for all cases involving the misgendering of patients—seven of the 37 closed issue claims CAP reviewed—and for nearly all cases involving coverage or provision of transition-related care—11. HHS investigations had uncovered evidence to substantiate two of the complaints CAP obtained. In one of two complaints, a receptionist told a transgender person the clinic would not perform surgery because the "Lord does not approve."[20] After the complaint was filed and HHS investigated, the clinic offered to proceed with the surgery, updated its nondiscrimination policy, formulated new policies on transgender health care, and trained its staff on the policy. While the *Franciscan Alliance* litigation relied heavily on hypothetical scenarios—and misstatements of accepted medical standards of care—regarding transgender children, none of the complaints CAP reviewed involved transition-related care for a minor.[21]

Finally, beyond the outright denial of care, there were five complaints involving patients who alleged receiving substandard care because of their sexual orientation or gender identity. These involved situations where someone's care was delayed or they were released from a hospital prematurely. In these instances, the subjects of the complaints took voluntary corrective action and trained their staff on nondiscrimination obligations under the law and LGBTQ cultural competency. There were also two complaints of people being treated differently because their spouse was the same sex. In these cases, the subjects of the complaints also voluntarily trained staff or changed their record-keeping policies to ensure all married couples were treated the same.

In the two instances CAP reviewed where the complaints were substantiated by HHS, the subjects of the complaints also took corrective actions. In addition to the case mentioned above, an individual was denied a flu shot because they were HIV-positive. In this case it was determined they were discriminated against on the basis of having a disability.

Finally, contrary to assertions made by the plaintiffs in *Franciscan Alliance*, in no case did HHS threaten to sue or withhold federal funding, nor did it order a health care professional to perform a service against their medical judgment.

Conclusion

Reviewing this subset of Section 1557 complaints resolved by HHS shows that the enforcement of the statute was working well to resolve very real issues of discrimination, and that the fears raised by the *Franciscan Alliance* lawsuit are not well-founded.

Research shows that discrimination affects whether transgender people are able to receive timely, quality care, as well as the willingness of transgender people to seek care in the future. A survey by CAP found 23.5 percent of transgender respondents avoided doctor's offices in the past year out of fear of facing discrimination.[22] Robust enforcement of the ACA's nondiscrimination protections reassures these Americans that they will not be refused for discriminatory reasons.

Contrary to the findings of the Texas court in *Franciscan Alliance*,[23] Section 1557's implementing rule simply creates a regulatory structure and administrative process for enforcing what the ACA already requires. A claim for anti-transgender discrimination already existed under the ACA. The implementing rule is important, because its administrative procedures enable victims to seek redress without the costs and time associated with litigation. The present analysis suggests that this process has often worked well for those who have availed themselves of it.

As *Franciscan Alliance v. Burwell* proceeds, the ACA's protections remain in effect and continue to be critical for addressing the well-documented health disparities facing LGBTQ people.[24] However, due to costs of litigation and the apparent success of the closed administrative claims, it is vital that the administrative process remain an avenue for addressing discrimination grievances. Unfortunately, HHS indicated in recent court filings that rather than preserving this critical mechanism for protecting LGBTQ people from discrimination, it is rewriting the rule and likely removing explicit protections for LGBTQ people.[25] HHS also recently announced that it will open a separate civil rights office that is solely focused on defending religious refusals to provide health care. HHS' recent actions do not signal a commitment to protecting all Americans' access to care. Rather, they further underline the Trump administration's commitment to undermining the basic rights, health, and well-being of LGBTQ people.[26]

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Endnotes

1 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities," *Federal Register* 81 (96) (2016), available at https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities; Kellan Baker, "LGBT Protections In Affordable Care Act Section 1557," *Health Affairs*, June 6, 2016, available at http://www.healthaffairs.org/do/10.1377/hblog20160606.055155/full/.

2 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities." See, for example, *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004), available at https://scholar.google.com/scholar_case?case=9882340233444710 66&q=Smith+v.+City+of+Salem,+378+F.3d+566&hl=en&as_sdt=20006&as_vis=1.

3 See *Franciscan Alliance Inc. v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex., 2016).

4 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017), available at https://www.courthousenews.com/wp-content/uploads/2017/09/Trans-Rady-MTD-ORDER.pdf.

5 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017).

6 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."

7 Legal Information Institute, "42 U.S. Code § 18116 – Nondiscrimination," available at https://www.law.cornell.edu/uscode/text/42/18116 (last accessed February 2018).

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9 *Prescott v. Rady Children's Hospital-San Diego,* 2017 WL 4310756, at *4 (S.D. Cal., 2017).

10 *Prescott v. Rady Children's Hospital-San Diego*, 2017 WL 4310756 (S.D. Cal., 2017).

11 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."

12 See, for example, *Hively v. Ivy Tech Community College of Indiana* 853 F.3d 339 (7th Cir. 2017), available at http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2017/D04-04/C:15-1720:J:Wood:aut:T:fnOp:N:1942256:S:0; *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004), available at https://scholar.google.com/scholar_case?case=9882340233444710 66&hl=en&as_sdt=6&as_vis=1&oi=scholarr; *Koren v. Ohio Bell Telephone Co.*, 894 F. Supp. 2d 1032, 1038 (N.D. Ohio 2012), available at http://courtweb.pamd.uscourts.gov/courtwebsearch/ndoh/YdIx_0N8uG.pdf; *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212, 1223 (D. Or. 2002), available at https://scholar.google.com/scholar_case?case=12565249645123009449&hl=en&as_sdt=6&as_vis=1&oi=scholarr.

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16 U.S. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities."

17 One case in CAP's FOIA response was an employment discrimination case that was submitted to the wrong agency and was not included in the authors' totals. Data are from documents on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.

18 Data are from documents on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.

19 Data from documents are on file with authors. Documents were accessed through a January 24, 2017, Freedom of Information Act request to the U.S. Department of Health and Human Services for copies of de-identified complaints of discrimination based on gender identity, sexual orientation, and sexual orientation-related sex stereotyping under Section 1557 of the Affordable Care Act from March 23, 2010 to January 20, 2017.

20 Ibid.

21 But see *Cruz et al v. Zucker*, 218 F.Supp.3d 246, 247 (S.D.N.Y., 2016), available at https://cases.justia.com/federal/district-courts/new-york/nysdce/1:2014cv04456/428588/134/0.pdf?ts=1467894220, which finds that New York State's age exclusion for Medicaid coverage of transition-related care violated Section 1557 and Title XIX of the Social Security Act, based in part on published clinical standards and expert testimony supporting coverage.

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EXHIBIT 5

The Washington Post

Morning Mix

Pediatrician refuses to treat baby with lesbian parents and there's nothing illegal about it

By Abby Phillip February 19, 2015

A Michigan pediatrician declined to treat the infant daughter of a lesbian couple in yet another example of the growing tensions between advocates for LGBT rights and those who want greater religious expression protections.

Krista and Jami Contreras were eager to bring their 6-day-old infant for her first doctor visit after her birth in October. The doctor that they had carefully chosen knew they were lesbians and after the first prenatal visit, they were under the impression that everything was fine. But the morning they arrived for the appointment after baby Bay's birth, another doctor in the practice greeted them instead.

"The first thing Dr. Karam said was, 'I'll be your doctor, I'll be seeing you today because Dr. Roi decided this morning that she prayed on it and she won't be able to care for Bay,' " Jami told WJBK. "Dr. Karam told us she didn't even come to the office that morning because she didn't want to see us."

['Relationship with Jesus' doesn't justify florist's refusal to serve gay couple, judge rules]

In a handwritten letter to the couple months later, their would-be doctor Vesna Roi explained what happened.

> "After much prayer following your prenatal, I felt that i would not be able to develop the personal patient-doctor relationships that I normally do with my patients," Roi wrote in her letter on Feb. 9. "I felt that it was an exciting time for the two of you and I felt that if I came in and shared my decision it would take away much of the excitement. That was my mistake. I should not have made that assumption and I apologize for that."

The incident has raised valid questions about whether Roi's actions were justified, ethical or even legal.

"As far as we know, Bay doesn't have a sexual orientation yet so I'm not really sure what that matters," Jami added to WJBK. "We're not your patient — she's your patient. And the fact is that your job is to keep babies healthy and you can't keep a baby

healthy that has gay parents?

[This Colorado baker refused to put an anti-gay message on cakes. Now she is facing a civil rights complaint.]

The answer is: It depends.

Ethically speaking, the American Medical Association takes a strong stance against denying care to people because of their sexual orientation — and it is reasonable to assume, the sexual orientation of their parents.

But their ethical guidance is just that: Guidance. Doctors aren't bound by it.

"Respecting the diversity of patients is a fundamental value of the medical profession and reflected in long-standing AMA ethical policy opposing any refusal to care for patients based on race, gender, sexual orientation, gender identity or any other criteria that would constitute invidious discrimination," said Gregory Blaschke, chair of the AMA's LGBT Advisory Committee, in a statement to the Detroit Free Press.

But what about the legality of it all? Well, that depends, too.

There's no federal law prohibiting doctors or any other service providers or merchants from refusing service to gay people. And in Michigan, there's no state law prohibiting it either.

"There's no law that prohibits it," Wayne State University constitutional law Prof. Robert Sedler explained to the Free Press. "It's the same as a florist refusing to sell flowers for a same-sex wedding."

And while individual states have taken steps to ban the practice, Michigan is considering going in exactly the opposite direction.

[Some conservatives urging right not to serve gays on religious grounds]

A House bill that would allow adoption agencies to refuse placements based on moral or religious grounds is under consideration in the legislature. And last year, the Michigan House passed a controversial "religious freedom" bill, but it stalled in the Senate. The bill was introduced in the state Senate in this year's legislative session in January.

Backers of Michigan's "religious freedom" legislation, Michigan House Speaker James "Jase" Bolger, explained it to the The Post's Sandhya Somashekhar this way:

> He said he was compelled by the stories of business owners who have been punished for declining to participate in same-sex weddings, such as the couple in Upstate New York who provided their barn to gay couples for receptions but balked when asked to host a same-sex wedding ceremony. The couple was fined.

> "I have been stunned at the number of Americans arguing that the only place people can practice their religion is while they're hiding in their homes and hiding in their churches, and once they leave their home and their church they are not allowed to practice their religion," Bolger said.

The wave of same-sex marriage legalization across the country has only emboldened conservatives to turn to legislative alternatives that would codify "religious freedoms" or their right to refuse service to gay people based on moral or religious beliefs.

Roi didn't specify that Bay's lesbian parents were the reason felt she couldn't serve as her doctor. But the subtext was clear. And with no law prohibiting the practice, the couple has little choice but to accept it.

"When we started calling other pediatricians, my first thing on the phone was, we're lesbian moms — is this okay with you?" Krista told the Free Press.

82 Comments

Abby Phillip is a national political reporter covering the White House for The Washington Post.

EXHIBIT 6

STATUS OF LGBTQ HEALTH: SANTA CLARA COUNTY 2013

Santa Clara County PUBLIC HEALTH

LGBTQ Health Assessment

- Historically, very limited data available on LGBTQ health in Santa Clara County
- Board President Ken Yeager, State of the County 2013
- *First* health assessment of Lesbian, Gay, Bisexual, Transgender and Queer SCC residents
- Goal: understand health needs of LGBTQ residents to identify priorities, strategies, and resources to address disparities

Timeline

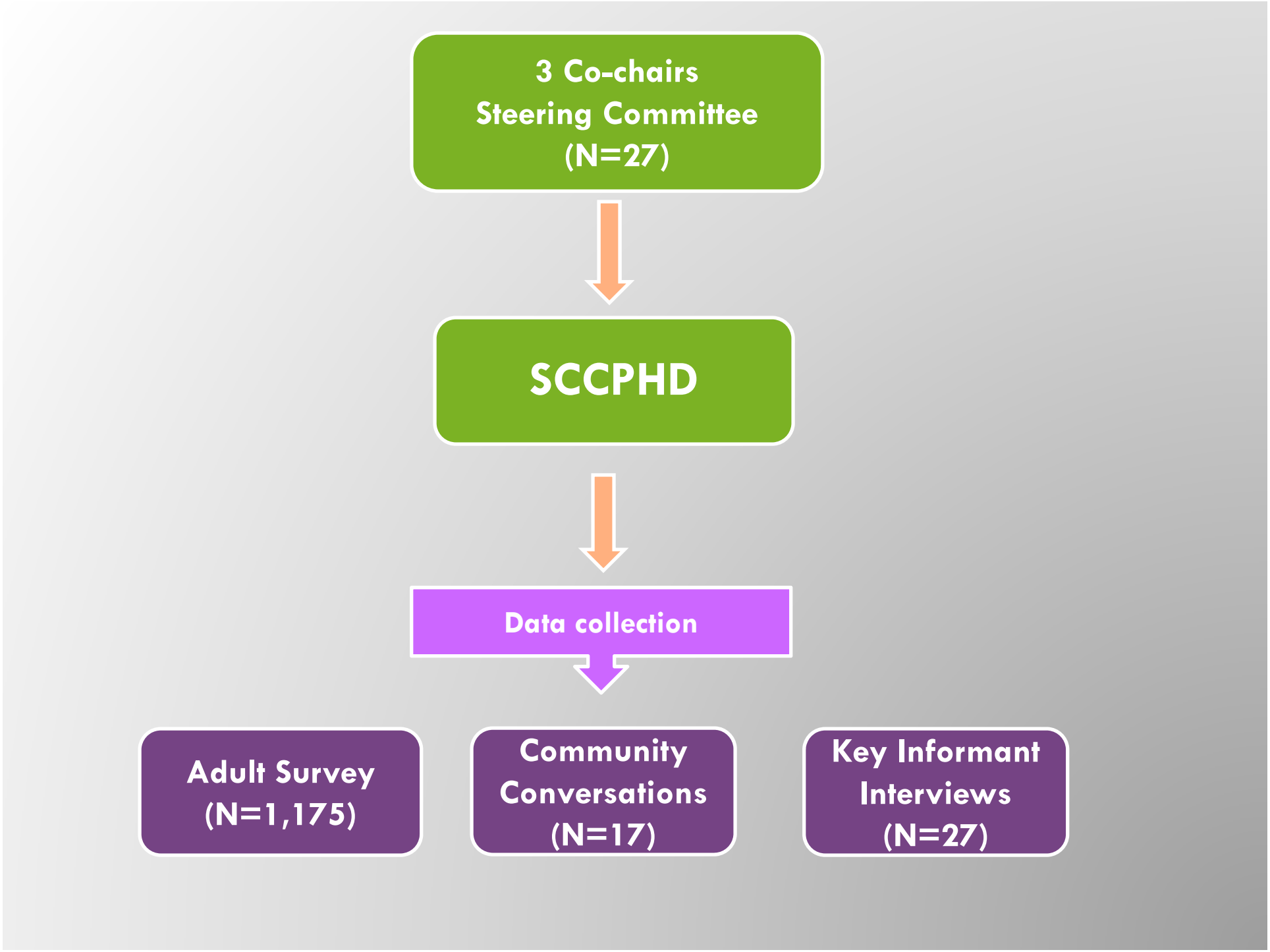
- **August 5**: First Steering Committee Meeting
- **August 17-18**: Adult paper survey administered at San Jose PRIDE
- **August 28**: Community stakeholder meeting and community conversations
- **September-October**: Online LGBTQ adult survey in English, Mandarin, Spanish & Vietnamese
- **September-November**: Key Informant Interviews and additional community conversations
- **November 14**: Community Forum (i.e. recommendations and strategy development)
- **December 20**: Final Report

Community engagement & participation

Co-chairs

PHD **RDA**

- Steering Committee Members
- Community conversations and key informant interviews
- Community forum


3 Co-chairs
Steering Committee
(N=27)
SCCPHD
Data collection
Adult Survey
(N=1,175)
Community
Conversations
(N=17)
Key Informant
Interviews
(N=27)

Community conversations

Health and social issues

- Community connectedness and social cohesion
- Discrimination and acceptance
- Health care access and discrimination
- Families
- Outness
- Substance use and abuse
- Resiliency
- Safety
- Youth
- Mental health

Additional population specific conversations identified:
Latino/a LGBTQ (in Spanish); Asian; Seniors; Lesbian; Transgender men/women; African Americans; Youth (<18)


#SanJosePride
PUBLIC HEALTH
SANJOSEPRIDE.COM
I Spoke Out!
San José
PRIDE


PUBLIC HEALTH
SANJOSEPRIDE.COM
San José


Things Start with Good
HIV Testing Today
Your Results In 20 Minu
Anonymous or Confidential


SANJOSEPRIDE.COM
#SanJosePride
I Spoke Out!
Santa Clara County
PUBLIC HEALTH

Key informant interviews

- 27 community leaders, experts, and service providers knowledge about particular issues or populations
- Similar topics as in community conversations

Community forum

SOCIODEMOGRAPHICS

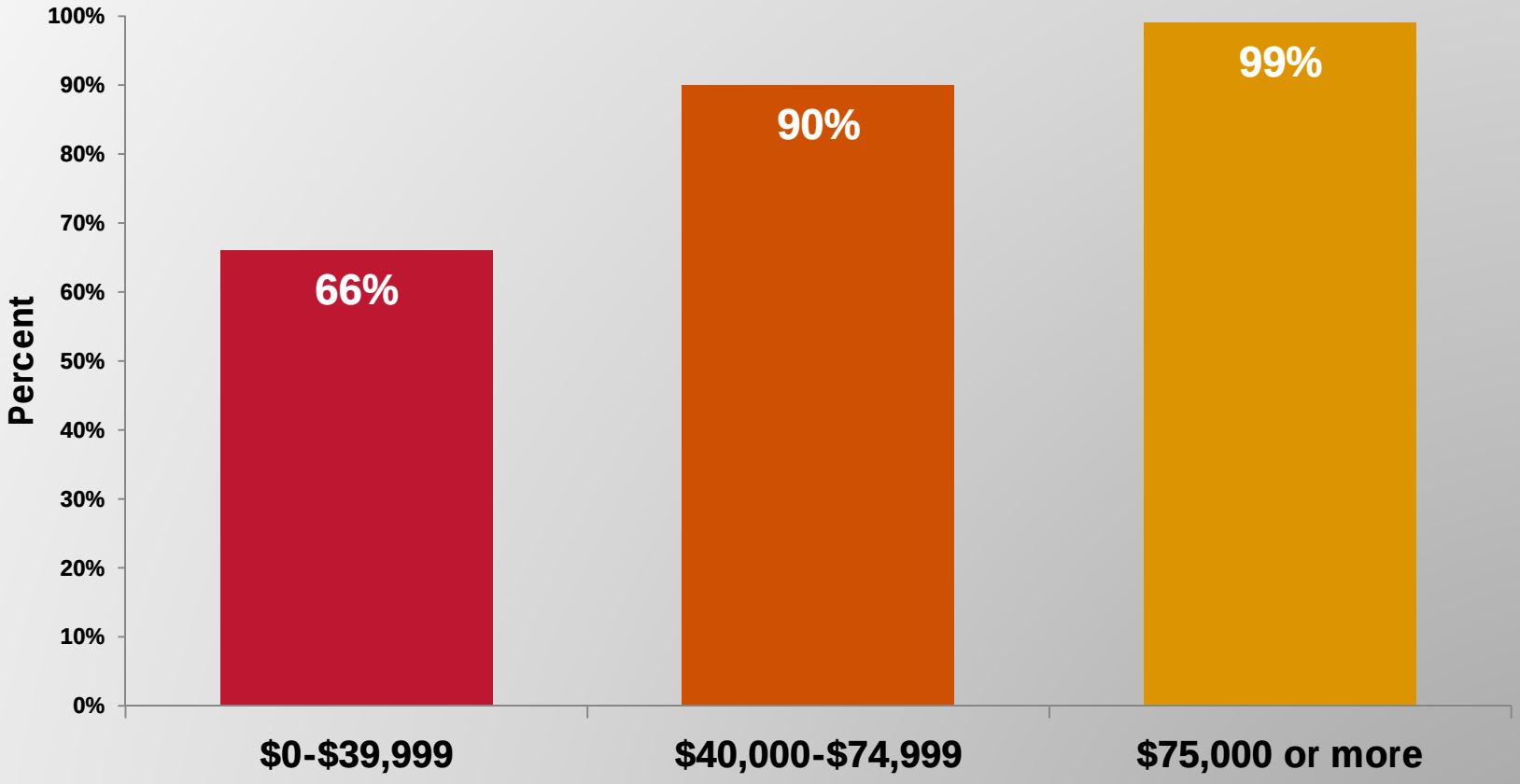
Population size and SES

- Lesbian or gay: 31,000 adults (3% of SCC adults)
- Bisexual: 16,000 adults (1% of SCC adults)
- Transgender: 3,500 adults (based on national estimates)
- Higher education than heterosexual adults but more likely to live below 200% FPL

Source: California Health Interview Survey, 2011-12

HEALTHCARE

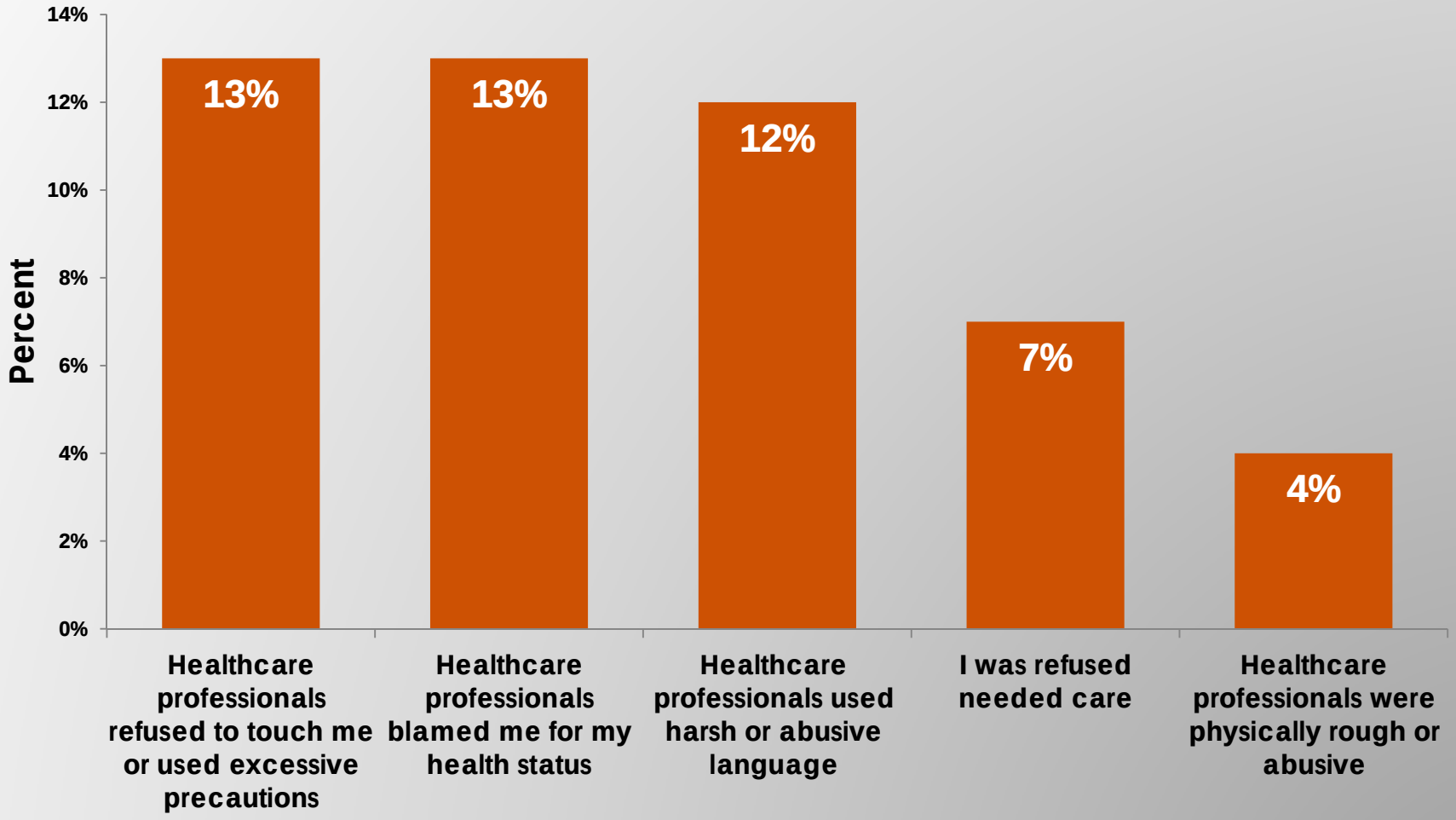
Percentage of LGBTQ survey respondents with health insurance by household income



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of LGTBQ survey respondents who have experienced healthcare discrimination in the past 5 years

14



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Out to healthcare provider

- By race/ethnicity:
  - African American: 29%
  - Asian/PI: 67%
  - Latino: 66%
  - White: 78%
- By age:
  - Ages 18-24: 56%
  - Ages 25-54: 69%
  - Ages 55+: 96%

Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their own words: Medical provider competence

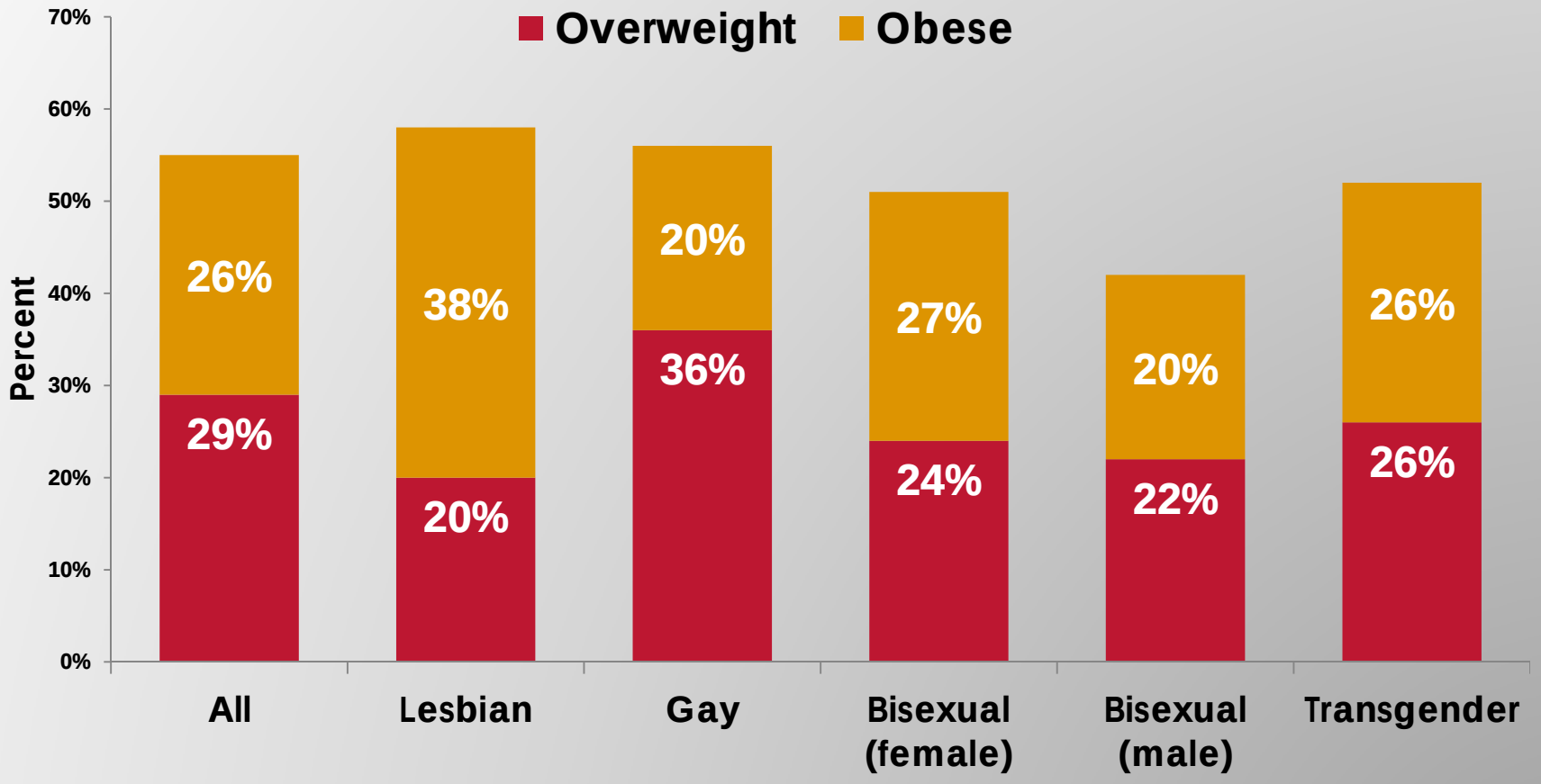
- *Being "LGBTQ friendly" is not enough; providers need to be "LGBTQ knowledgeable".*
- *"It's nice to educate our doctors [about trans issues], but I want to know that <u>they</u> know what they're doing, and not just fudging a little bit and figuring it out on us."*

Recommendations: Healthcare

- **Develop LGBTQ competency trainings** for all providers and staff in healthcare settings.
- **Educate LGBTQ healthcare consumers and providers about LGBTQ rights** and enforce existing nondiscrimination statutes.
- **Standardize medical forms** to include optional gender identity and sexual orientation questions to prevent unintentional discrimination.
- **Create an inventory** of LGBTQ-competent healthcare providers and conduct outreach around available services.

GENERAL HEALTH

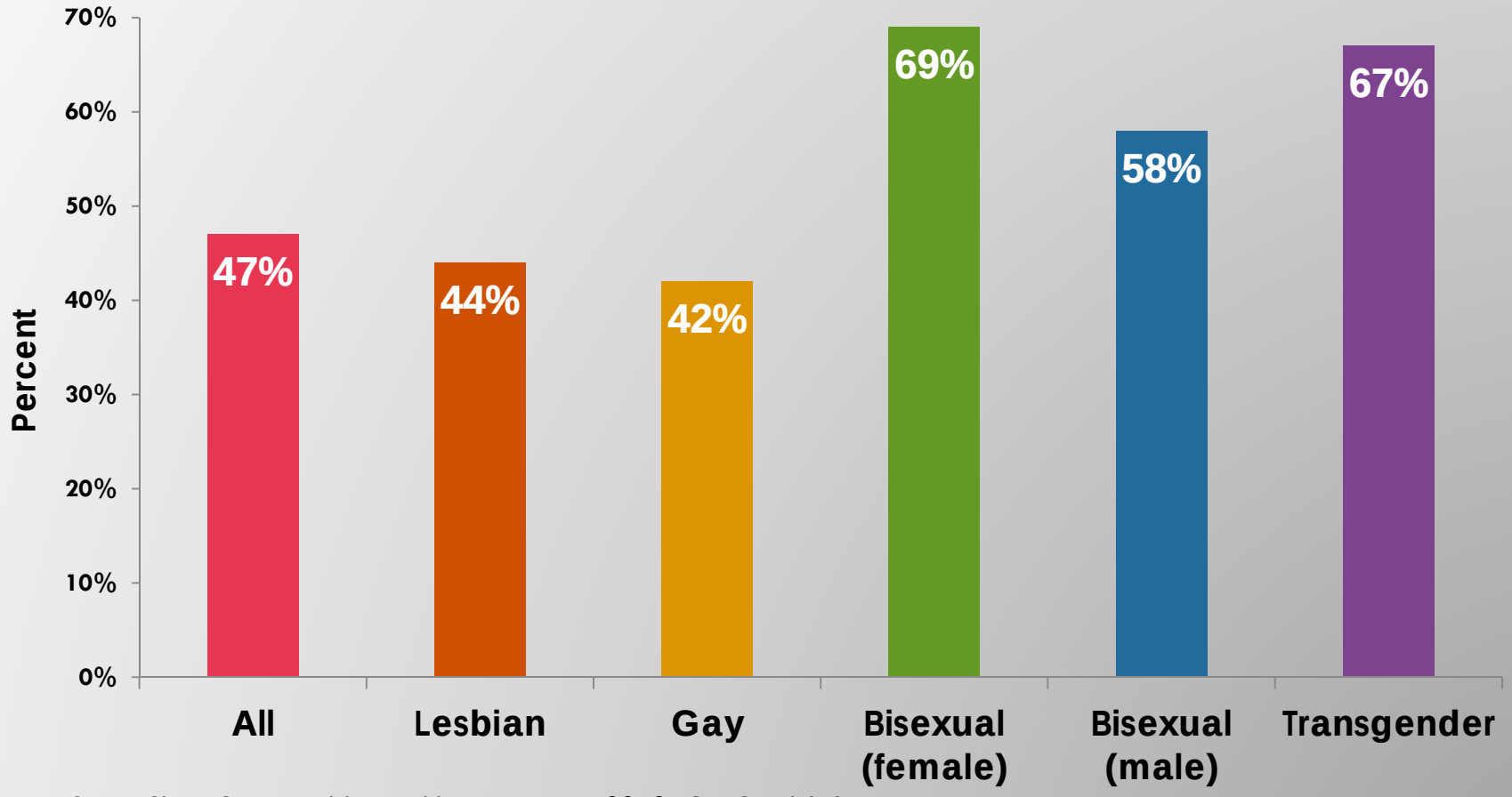
Percentage of LGBTQ survey respondents who are overweight or obese



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

MENTAL HEALTH AND SUBSTANCE USE

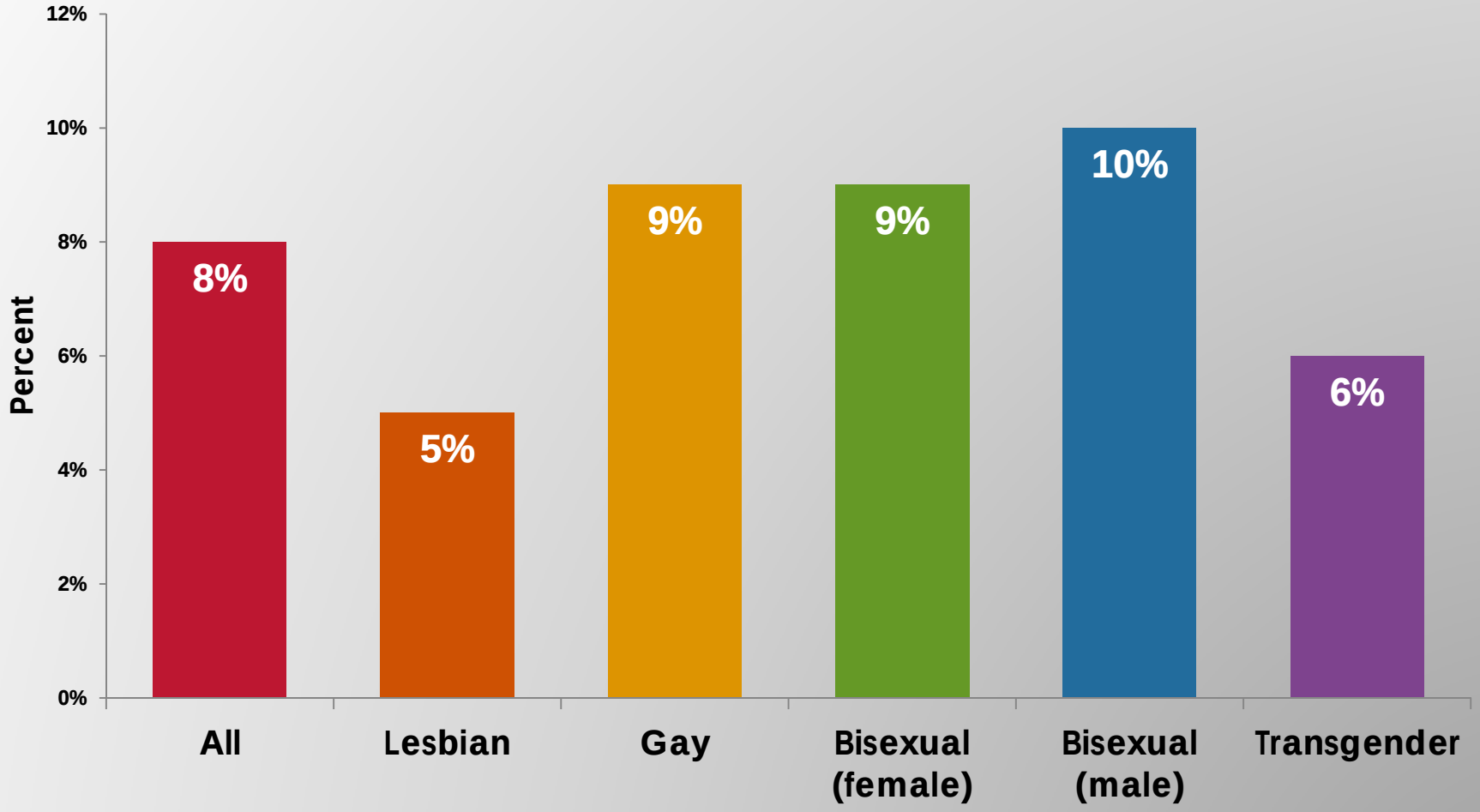
Percentage of LGBTQ survey respondents who felt that they might need to see a professional in the past 12 months because of concerns with their mental health, emotions, nerves, or use of alcohol or drugs



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of LGBTQ survey respondents who had ever shot up or injected any drugs other than those prescribed

22



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their voices: Mental health and substance use

- *Mental health and substance use among LGBTQ people are often connected to rejection, isolation from families, discrimination, and harassment.*
- *"Mental health issues are dramatically different from the straight community. Not only do you have internal struggles; there is a lot of internalized oppression and stigma."*
- *"I had two episodes where I was near suicidal - one before transition because of the stress of that, and one after because it broke up my family."*

Homelessness and LGBTQ in SCC

- LGBTQ: 29% of the homeless < age 25
- LGBTQ: 10% of the homeless ages 25+
- Transgender: 4% of homeless < age 25
- Transgender or "other": 2% of homeless ages 25+

Source: Santa Clara County Homeless Census and Survey, 2013

Affordable housing and homelessness

- *"Everybody I know who has come out [as trans] has had some family relationship that's been disrupted. For young people it impacts their ability to survive."*

- *"[As a senior] there are two choices: Maintaining my identity and being isolated or going back to the closet after being out for so many years."*

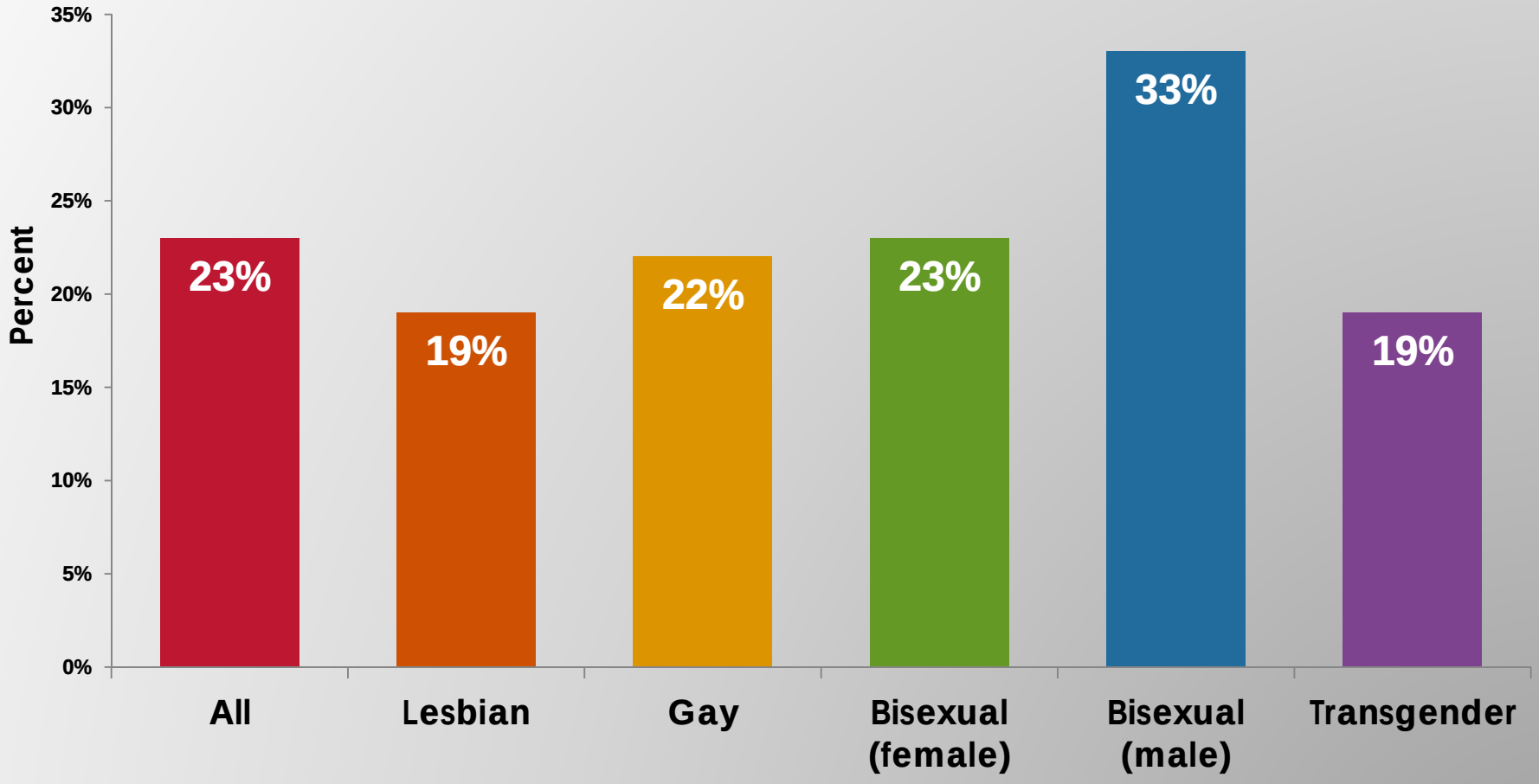
Recommendations: Mental health and substance use

- **Designate the LGBTQ population as high-risk for mental health issues** in order to prioritize services and funding.
- **Develop LGBTQ-specific mental health and substance use services** to reduce barriers and mitigate fears of discrimination.
- **Provide training to ensure an LGBTQ-competent workforce** in mental health and substance use.
- **Continue targeted outreach and education** related to mental health and substance use as well as information on available services.
- **Conduct regular tobacco cessation campaigns** that target LGBTQ populations.

TOBACCO USE

Percentage of LGBTQ survey respondents who smoked 1 or more cigarettes in the past 7 days

28



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their voices: Tobacco use

- *Some participants expressed that tobacco use in the LGBTQ community, specifically smoking, is an issues of concern that should not be overlooked.*
- *Community members cited sporadic LGBTQ public health-related tobacco education campaigns, acknowledging a need for more frequent outreach and education.*

SEXUALLY TRANSMITTED INFECTIONS AND SAFER SEX

Testing for sexually transmitted infections

Among MSM survey respondents:

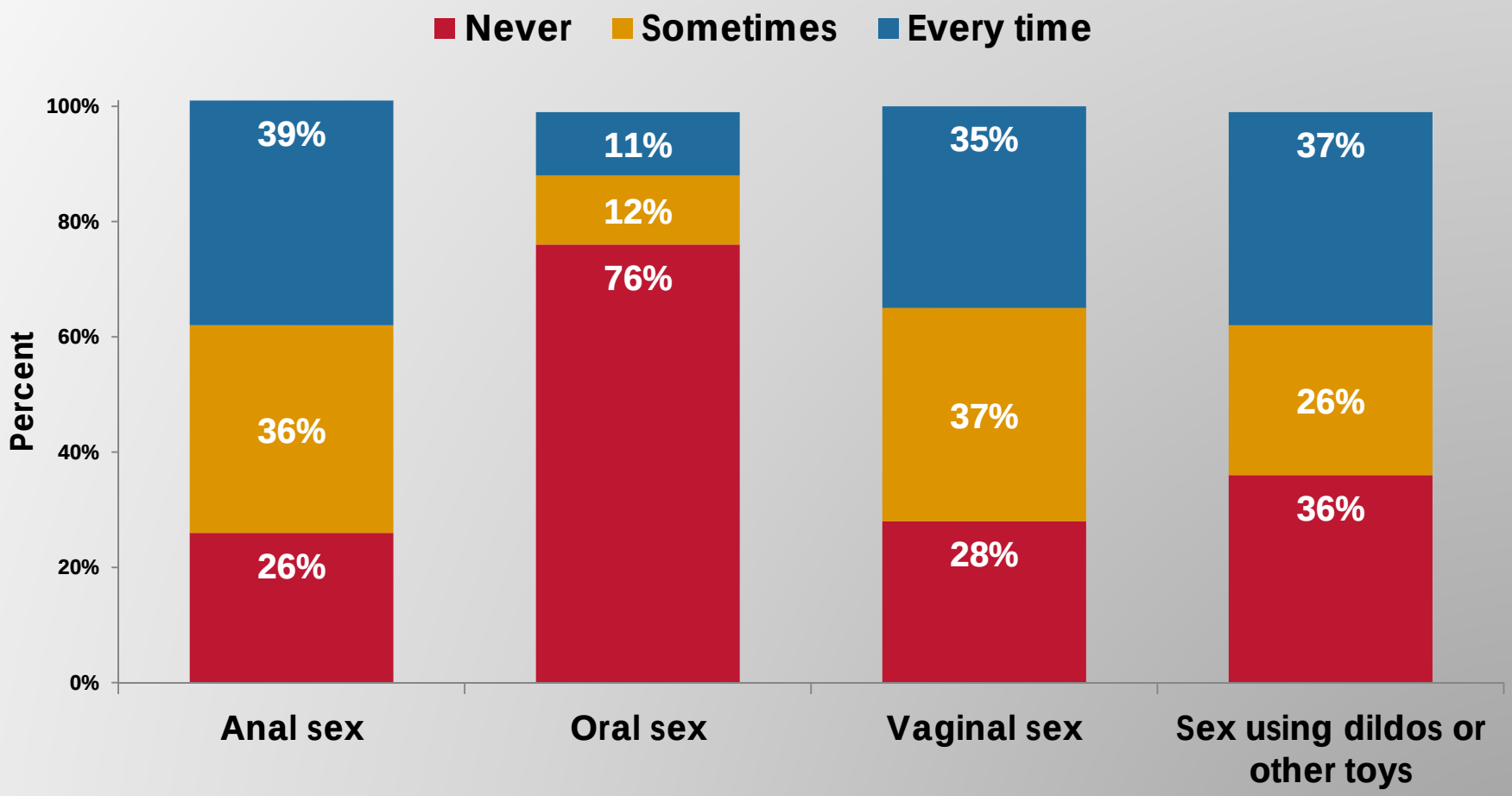
- 21% have **never been tested** for HIV
- 43% have **never been tested** for syphilis
- 38% have **never been tested** for gonorrhea

Among lesbian, bisexual women, and transgender survey respondents:

- Between 34% and 40% have **never been tested** for HIV
- Between 45% and 65% have **never been tested** for chlamydia, gonorrhea, or syphilis (transgender)

Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of MSM survey respondents who used condoms when having sex in the past 6 months



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their voices: STIs

- *Community members identified a shortage of HIV and other STI outreach and testing.*
- *Participants highlighted stereotypes about who is at risk for HIV and other STIs as a barrier to increasing access to HIV and other STI testing.*
- *"Normally, gay men go out of the county to San Francisco to get a one-stop shop service."*

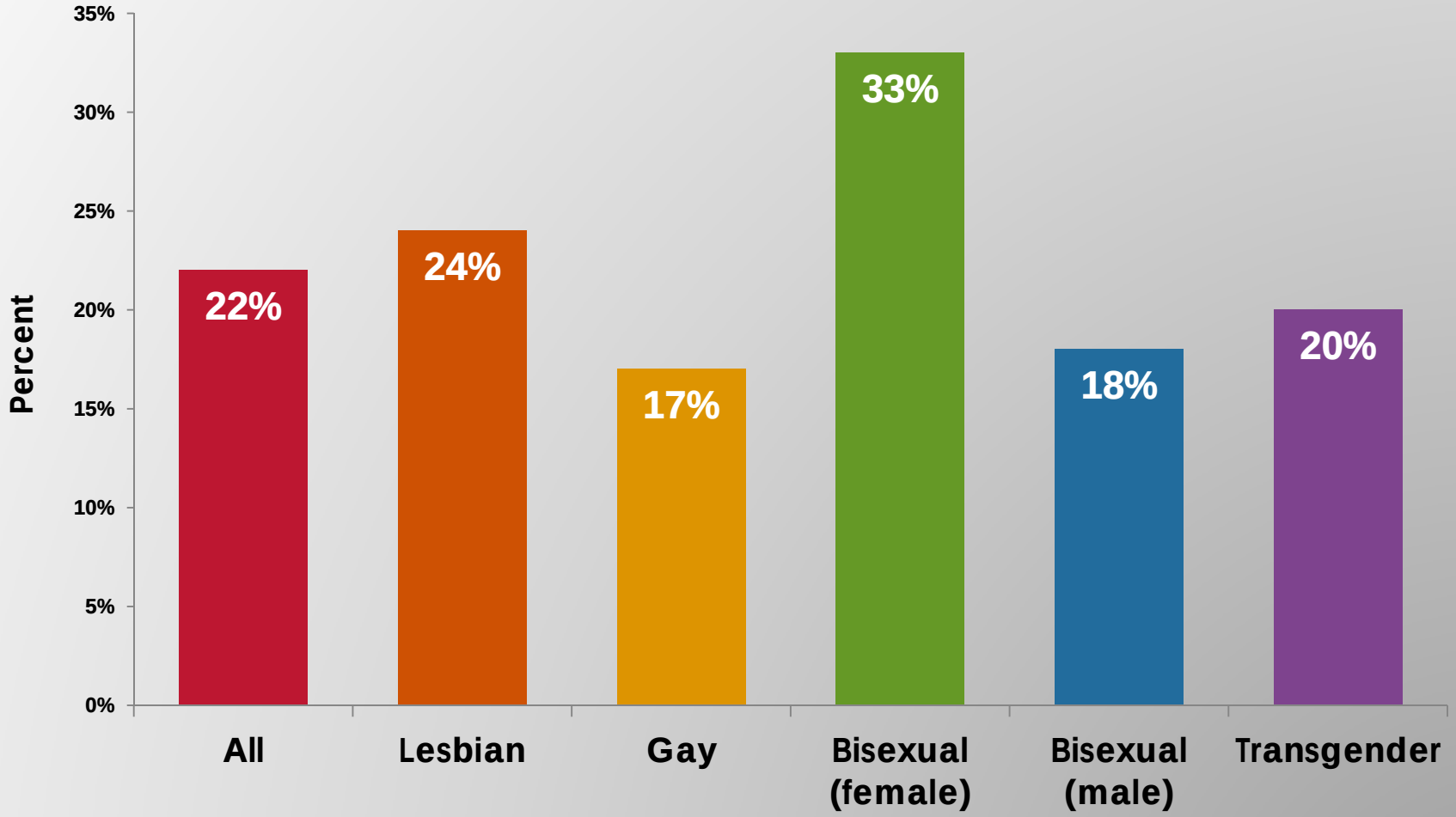
Recommendations: STIs

- **Offer free, comprehensive HIV and other STI testing.**
- **Integrate testing in community venues.**
- **Reduce barriers to testing** by offering low-cost and anonymous testing.
- **Promote and subsidize in-home HIV testing kits.**
- **Train medical providers** on how to talk to patients about STI risk, testing, and care.
- **Improve outreach for hard-to-reach groups.**
- **Raise public awareness to reduce stigma** about HIV and other STIs.
- **Mandate school-based sex education** inclusive of LGBTQ identities.

DOMESTIC VIOLENCE

Percentage of LGBTQ survey respondents ever hit, slapped, pushed, kicked, or physically hurt in any way by an intimate partner

36



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

In their own words: Domestic violence

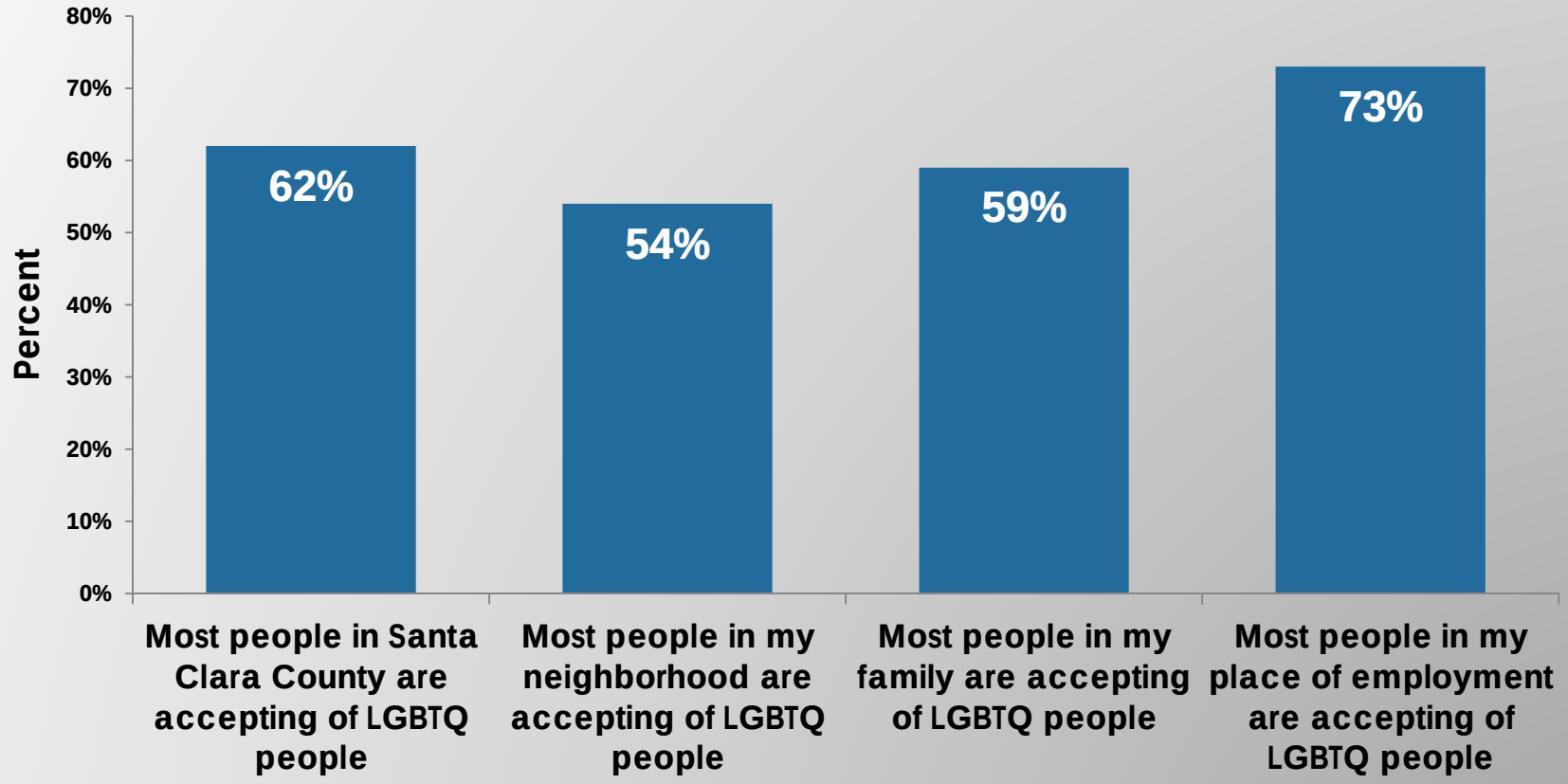
- Community members emphasized that intimate partner violence is a hidden issue in the LGBTQ community.
- Participants also cited instances of parents abusing their children for coming out.
- *"LGBT people in family violence situations often don't come forward. Domestic violence is a dirty little secret in our community."*

Recommendations: Domestic violence

- **Increase education and outreach within the LGBTQ community** to lessen stigma around intimate partner violence.
- **Develop LGBTQ-specific** intimate partner violence services, shelters, and youth crisis services.
- **Facilitate reporting** by training law enforcement agencies and courts about responding to LGBTQ intimate partner violence. Instate victims advocates trained in LGBTQ issues at local police stations.

SOCIAL ACCEPTANCE AND DISCRIMINATION

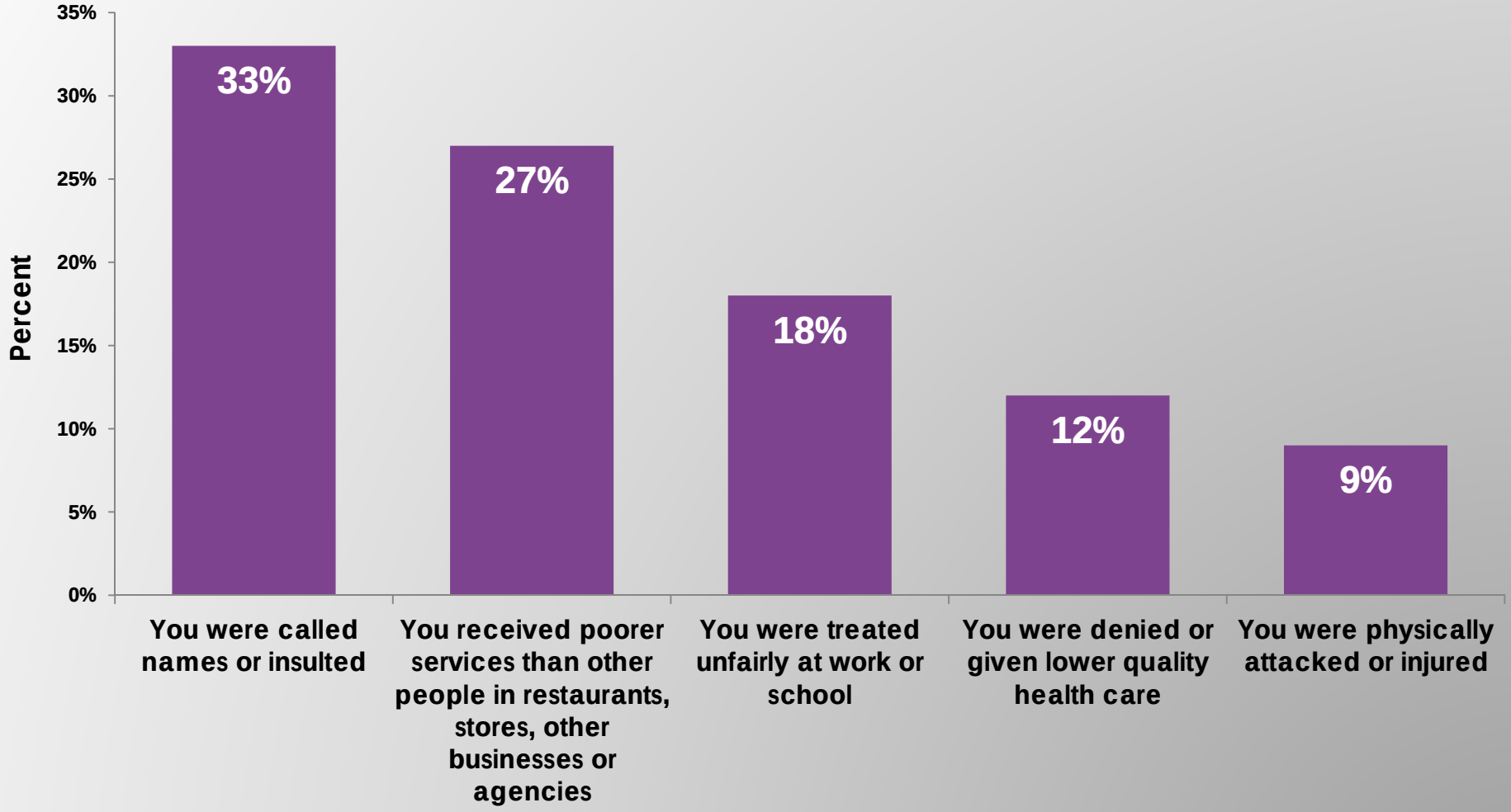
Percentage of LGBTQ survey respondents who agreed or strongly agreed with statements regarding social acceptance of LGBTQ people in Santa Clara County



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

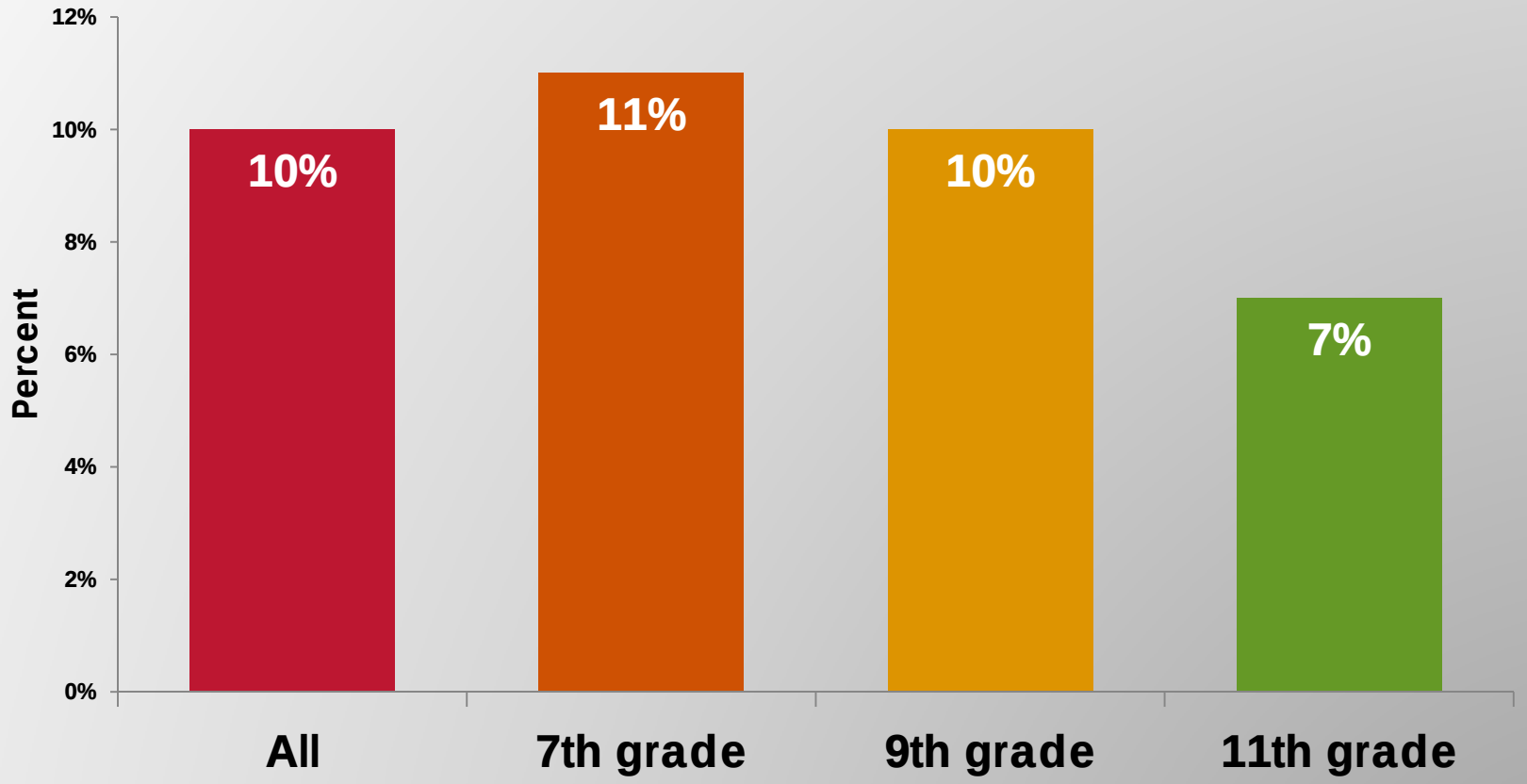
Percentage of LGBTQ survey respondents who experienced discrimination due to sexual orientation and/or gender identity in the past 12 months

41



Source: Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey

Percentage of 7th, 9th, and 11th graders who were harassed or bullied on school property in the past 12 months because they were gay or lesbian or someone thought they were



Source: California Healthy Kids Survey, 2009-10

In their voices: Social acceptance and discrimination

- *"[The trans] community as a whole recognize that walking out the door, sitting at the bus stop, going to the store, realistically can cost us our lives."*

Next steps

- Disseminate widely: report available online & print
- Data from report and recommendations from forum will help inform: community organizations, county agencies, and elected officials
- Goal: generate equitable action-oriented solutions to improve the lives of the LGBTQ community

Acknowledgements

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  - CDIP: Kris Vantornhout and staff
  - HIV/AIDS: Maharlika Aguirre and Raj Gill
  - Communications: Danica Cho, Amy Cornell and Johanna Silverthorne
- Steering Committee and community organizations
- Special thanks to the LGBTQ community of Santa Clara County


Reports - Public Health Department - County of Santa Clara - Windows Internet Explorer
http://www.sccgov.org/sites/sccphd/en-us/Partners/Data/Pages/Reports-and-Fact-Sheets.aspx
File Edit View Favorites Tools Help
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Reports - Public Health Department - County of Santa...
COUNTY OF SANTA CLARA SCCgov
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Santa Clara County PUBLIC HEALTH
Great Things Start with Good Health
En Español | Tiếng Việt
About SCCPHD
For Residents
For Partners
For Providers
For Media
Disease Search
Home > For Partners > Data and Statistics
PRINT
Reports
This section contains health status reports and fact sheets created by the Public Health Department.
Status of LGBTQ Health in Santa Clara County, 2013
Santa Clara County Public Health Department, 2013 LGBTQ Adult Survey
HIV/AIDS Report, 2012
Pertussis Report, through September 28, 2013
Previous Pertussis Reports in 2013
Child Poverty in Santa Clara County Report, 2013
Obesity, Physical Activity and Nutrition Report, 2013
Secondhand Smoke and Multi-Unit Housing in Gilroy: A Desktop HIA, 2013
Influenza Reports
Influenza Report, January 12-18, 2014
Influenza Report, January 5-11, 2014
Previous Influenza Reports
Status of Latino/Hispanic Health Santa Clara County 2012
Executive Summary (English)
Executive Summary (Spanish)
Volume 1: Latino/Hispanic Health Matters
Volume 2: Neighborhood Conditions that Affect Latino/Hispanic Health
Appendix: Methods and Tools
Additional Tables and Graphs
Presentations
Neighborhood Profiles
Leading Causes of Death for Latinos/Hispanics versus Other Racial/Ethnic Groups
External Links
Centers for Disease Control and Prevention
California Department of Public Health
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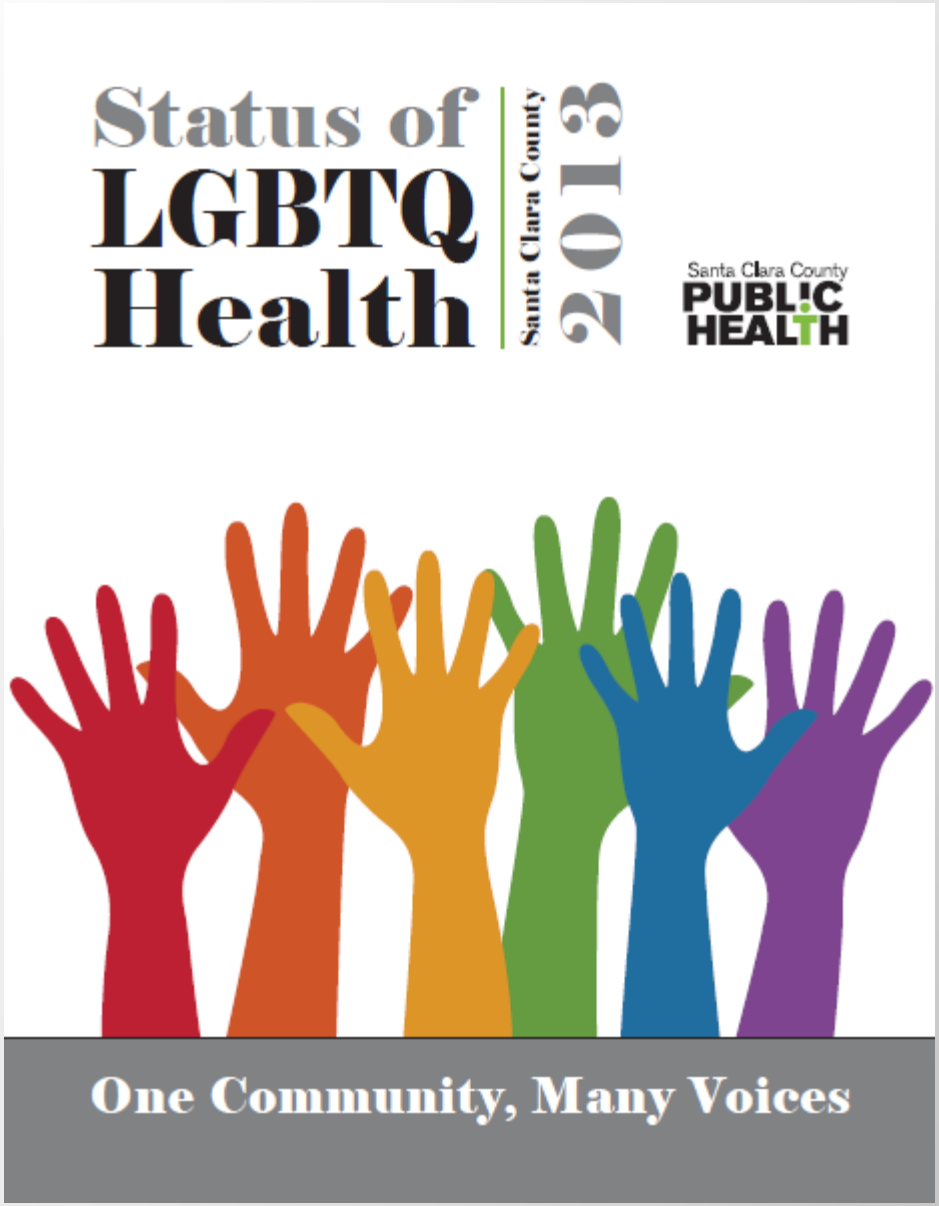

Status of
LGBTQ
Health
Santa Clara County
2013
Santa Clara County
PUBLIC
HEALTH
One Community, Many Voices

Questions?

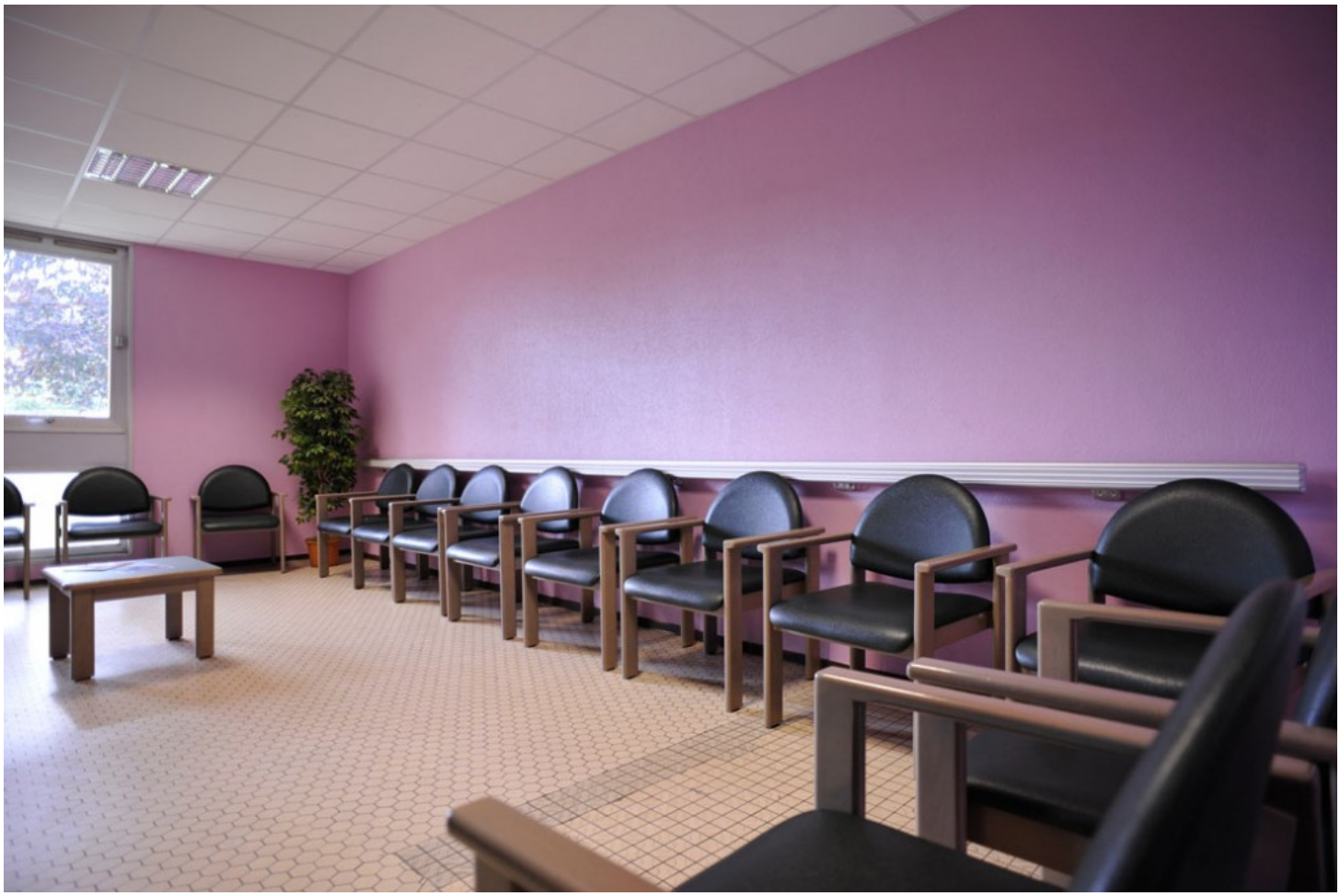
EXHIBIT 7

Center for American Progress

LGBT

Discrimination Prevents LGBTQ People from Accessing Health Care

By Shabab Ahmed Mirza and Caitlin Rooney | Posted on January 18, 2018, 9:00 am



Getty/BSIP, UIG

A waiting room, March 2015.

All people who need medical care should be able to see their doctor without worrying about being mistreated, harassed, or denied service outright. The Affordable Care Act (ACA) helped address this

issue by prohibiting health care providers and insurance companies from engaging in discrimination. As a result of several court rulings and an Obama administration rule, LGBTQ people are explicitly protected against discrimination in health care on the basis of gender identity and sex stereotypes. However, conservative forces and the Trump-Pence administration are seeking to make it easier for health care providers to discriminate against LGBTQ people and women.

Discrimination in health care settings endangers LGBTQ people's lives through delays or denials of medically necessary care. For example, after one patient with HIV disclosed to a hospital that he had sex with other men, the hospital staff refused to provide his HIV medication. In another case, a transgender teenager who was admitted to a hospital for suicidal ideation and self-inflicted injuries was repeatedly misgendered and then discharged early by hospital staff. He later committed suicide. Discrimination affects LGBTQ parents as well: In Michigan, an infant was turned away from a pediatrician's office because she had same-sex parents. Even though many states, such as Michigan, lack explicit statewide laws against LGBTQ discrimination in health care, Section 1557 of the ACA provides federal protections.

New data from a nationally representative CAP survey conducted in 2017 show that LGBTQ people experience discrimination in health care settings; that discrimination discourages them from seeking care; and that LGBTQ people may have trouble finding alternative services if they are turned away. These data underscore the importance of protecting LGBTQ people from discrimination in health care.

LGBTQ people face discrimination and mistreatment at doctors' offices

Despite existing protections, LGBTQ people face disturbing rates of health care discrimination—from harassment and humiliation by providers to being turned away by hospitals, pharmacists, and doctors. The CAP survey data show the types of discrimination that many LGBTQ people face when seeking health care.

Among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.

- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation.
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner.
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them.
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.
- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
- 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them.
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).

Discrimination discourages LGBTQ people from seeking health care

Discrimination—and even the potential for discrimination—can deter LGBTQ people from seeking care in the first place. CAP survey data show that discrimination played a role in preventing a significant number of LGBTQ people from seeking health care. In the year prior to the survey, 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. Among transgender people, 22 percent reported such avoidance. With regard to preventative screenings, 7 percent of

LGBTQ respondents reported avoiding or postponing care in the year prior to the survey, while 17 percent of LGBTQ respondents who had experienced discrimination that year and 19 percent of transgender people reporting avoidance during that period.

An earlier CAP analysis reported other findings from this survey that also indicated the effect of discrimination on LGBTQ people's willingness to seek out health care. In that analysis, 6.7 percent of LGBTQ people reported that they avoided doctor's offices in the past year out of fear of discrimination. This avoidance behavior is even more common among LGBTQ people who reported having experienced discrimination in the past year: 18.4 percent reported avoiding doctor's offices to avoid discrimination, nearly seven times the rate of LGBTQ people who had not experienced discrimination in the past year, at 2.7 percent. These CAP data are consistent with other research. The 2015 U.S. Transgender Survey found that nearly 1 in 4 transgender people (23 percent) had avoided seeking needed health care in the past year due to fear of discrimination or mistreatment due to their gender identity.

Finding another doctor is not an answer for all LGBTQ patients

The expansion of legislation, lawsuits, and administrative rule-making allowing for broad religious exemptions from providing services puts another impediment in the way of LGBTQ people receiving medical care. For those patients that do seek medical care and are turned away by providers, alternatives may not be easily accessible. This concern is exacerbated by a shortage of medical providers in key areas of treatment (such as mental health care) and geographic areas (such as rural communities).

CAP survey data show that many LGBTQ people would face significant difficulty finding an alternative provider if they were turned away by a health care provider, such as a hospital, clinic, or pharmacy.

- 18 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 17 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 8 percent of LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

LGBTQ people living outside of a metropolitan area report a high rate of difficulty accessing alternative services, which may be because such services could be further away and transportation costs have the potential to be higher.

- 41 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 31 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 17 percent of nonmetro LGBTQ people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

Transgender people also report difficulty accessing alternatives at a high rate:

- 31 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different hospital.
- 30 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.
- 16 percent of transgender people said it would be "very difficult" or "not possible" to find the same type of service at a different pharmacy.

Some people may go to LGBTQ community health centers to avoid such discrimination, but they are not widely available across the United States, and many do not provide comprehensive services. A total of 13 states—mainly those in the central United States—do not have any LGBTQ community health centers. On the U.S. Transgender Survey, 29 percent of respondents seeking transition-related care reported having to travel 25 miles or more to access such care.

Conclusion

Despite the importance of protecting people from discrimination in health care settings, current regulations are under attack. On August 23, 2016, a group of conservative religious organizations and eight states filed a lawsuit against the U.S. Department of Health and Human Services (HHS), challenging the 1557 rule. They made dubious claims that the nondiscrimination protections would require doctors to provide treatment that violated their religious beliefs, such as transition-related surgeries for transgender patients. Even though numerous courts have ruled that laws such as 1557

protect LGBTQ people, in December 2016, a single federal judge issued a nationwide injunction prohibiting HHS from enforcing the 1557 rule's prohibition on discrimination on the basis of gender identity. On May 2, 2017, the Trump-Pence administration filed a motion indicating that the 1557 rule was under review, and in August, it announced that HHS had already written a draft proposal to roll back the rule. Given the Trump-Pence administration's record on LGBTQ issues, new regulations will likely deny the existence of protections to LGBTQ people and make equal health care access and treatment more difficult to obtain for this historically marginalized community. While the administration cannot change the protections for LGBTQ people that exist under the law, a regulatory rollback would cause fear and confusion for patients and promote discrimination by providers and insurers.

Shabab Ahmed Mirza is a research assistant for the LGBT Research and Communications Project at the Center for American Progress. Caitlin Rooney is a Research Assistant for the LGBT Research and Communications Project at the Center.

Methodology

To conduct this study, CAP commissioned and designed a survey, fielded by GfK SE, which surveyed 1,864 individuals about their experiences with health insurance and health care. Among the respondents, 857 identified as lesbian, gay, bisexual, and/or transgender, queer, or asexual, while 1,007 identified as heterosexual and cisgender/nontransgender. Respondents came from all income ranges and are diverse across factors such as race, ethnicity, education, geography, disability status, and age. The survey was fielded online in English in January 2017 to coincide with the fourth open enrollment period through the health insurance marketplaces and the beginning of the first full year of federal rules that specifically protect LGBTQ people from discrimination in health insurance coverage and health care. The data are nationally representative and weighted according to U.S. population characteristics. Metro is defined as a metropolitan core-based statistical area and nonmetro is defined as anything else, including micropolitan core-based statistical areas and locations outside of a core-based statistical area.

Additional information about study methods and materials are available in prior analyses and from the authors. Results reported in this column may differ slightly (two-tenths of 1 percent) but not substantively from other analyses of these data due to the statistical program employed.

The authors would like to thank Sharita Gruberg, Frank Bewkes, and Laura E. Durso from the Center for American Progress as well as Harper Jean Tobin, Katie Keith, and Kellan Baker for their contributions to this column.

Center for American Progress

EXHIBIT 8

Lesbian, Gay, Bisexual, and Transgender Health *New*

Goal

Improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.

Overview

LGBT individuals encompass all races and ethnicities, religions, and social classes. Sexual orientation and gender identity questions are not asked on most national or State surveys, making it difficult to estimate the number of LGBT individuals and their health needs.

Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT persons has been associated with high rates of psychiatric disorders,[1] substance abuse,[2, 3] and suicide.[4] Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community.[5] Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals.[6]

The LGBT companion document to Healthy People 2010[7] highlighted the need for more research to document, understand, and address the environmental factors that contribute to health disparities in the LGBT community. As part of this work, we need to increase the number of nationally-representative health-related surveys that collect information on sexual orientation and gender identity (SOGI).

View HP2020 Data for:
▶ Lesbian Gay Bisexual and Transgender Health

Midcourse Review Data Are In!

Check out our interactive infographic to see progress toward the Lesbian Gay Bisexual and Transgender Health objectives and other Healthy People topic areas.

Why Is LGBT Health Important?

Eliminating LGBT health disparities and enhancing efforts to improve LGBT health are necessary to ensure that LGBT individuals can lead long, healthy lives. The many benefits of addressing health concerns and reducing disparities include:

- Reductions in disease transmission and progression
- Increased mental and physical well-being
- Reduced health care costs
- Increased longevity

Efforts to improve LGBT health include:

- Collecting SOGI data in health-related surveys and health records in order to identify LGBT health disparities [8]
- Appropriately inquiring about and being supportive of a patient's sexual orientation and gender identity to enhance the patient-provider interaction and regular use of care[9]
- Providing medical students with training to increase provision of culturally competent care[10]
- Implementing antibullying policies in schools[11]
- Providing supportive social services to reduce suicide and homelessness among youth[11]

- Curbing human immunodeficiency virus (HIV)/sexually transmitted infections (STIs) with interventions that work[12]

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Related Topic Areas

- Access to Health Services
- Adolescent Health
- Cancer
- Early and Middle Childhood
- Educational and Community-Based Programs

More

Understanding LGBT Health

In order to effectively address LGBT health issues, we need to securely and consistently collect SOGI information in national surveys and health records. This will allow researchers and policy makers to accurately characterize LGBT health and disparities.

Understanding LGBT health starts with understanding the history of oppression and discrimination that these communities have faced. For example, in part because bars and clubs were often the only safe places where LGBT individuals could gather, alcohol abuse has been an ongoing problem.[14]

Social determinants affecting the health of LGBT individuals largely relate to oppression and discrimination. Examples include:

- Legal discrimination in access to health insurance, employment, housing, marriage, adoption, and retirement benefits
- Lack of laws protecting against bullying in schools
- Lack of social programs targeted to and/or appropriate for LGBT youth, adults, and elders
- Shortage of health care providers who are knowledgeable and culturally competent in LGBT health

The physical environment that contributes to healthy LGBT individuals includes:

- Safe schools, neighborhoods, and housing
- Access to recreational facilities and activities
- Availability of safe meeting places
- Access to health services

LGBT health requires specific attention from health care and public health professionals to address a number of disparities, including:

- LGBT youth are 2 to 3 times more likely to attempt suicide.[15]
- LGBT youth are more likely to be homeless.[16, 17, 18]
- Lesbians are less likely to get preventive services for cancer.[19, 20]
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.[21]
- Lesbians and bisexual females are more likely to be overweight or obese.[22]
- Transgender individuals have a high prevalence of HIV/STDs,[23] victimization,[24] mental health issues,[25] and suicide[26] and are less likely to have health insurance than heterosexual or LGB individuals.[27]
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.[28]
- LGBT populations have the highest rates of tobacco,[29, 30] alcohol,[30, 31] and other drug use.[30, 32, 33]

Continuing Issues in LGBT Health

A number of issues will need to continue to be evaluated and addressed over the coming decade, including:

- Nationally representative data on LGBT Americans
- Prevention of violence and homicide toward the LGB community, and especially the transgender population
- Resiliency in LGBT communities
- LGBT parenting issues throughout the life course
- Elder health and well-being
- Exploration of sexual/gender identity among youth
- Need for a LGBT wellness model
- Recognition of transgender health needs as medically necessary

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Learn More

- Centers for Medicare & Medicaid Services: Final Rule on Changes to Hospital Conditions of Participation to Ensure Visitation Rights for All Patients
- HealthCare.gov: Health Care Coverage Options for Same Sex Couples
- www.stopbullying.gov
- U.S. Department of Health and Human Services: Health and Well-Being for Lesbian, Gay, Bisexual and Transgender Americans
- National Clearinghouse on Family and Youth: Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

More ▶

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March 27, 2018

HUMAN RIGHTS WATCH
HRW.org

Secretary Alex Azar
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW., Room 445-G
Washington, DC 20201

RE: Proposed Rule on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority

Dear Secretary Azar,

Human Rights Watch opposes the Proposed Rule on Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (83 Fed. Reg. 3880). The proposed rule would dramatically expand the discretion that religious or moral objectors have to refuse care in healthcare settings without any meaningful safeguards to ensure that the rights and health of others are protected. The rule would function not only as a shield for people asserting objections on religious or moral grounds but also as a sword that permits them to withhold care from women; lesbian, gay, bisexual, and transgender (LGBT) people; and others.

The proposed rule fails to appreciate the significant barriers that women, LGBT people, and others already face when attempting to access health care that meets their needs, and the likelihood that the rule would exacerbate those barriers and prevent people from accessing care. The rule codifies vague, open-ended definitions that would permit unfettered discrimination in healthcare settings. And it breaks from a long tradition of religious or moral exemptions under domestic and international law by providing blanket protection for religious exercise without any mechanism to ensure that the rights and health of others are not jeopardized as a result.

I. Women and LGBT People Already Face Barriers to Care

Under Executive Order 13563, the Department of Health and Human Services may only propose a rule where it has made a reasoned determination that the rule's benefits outweigh its costs and it is

tailored to impose "the least burden on society."[1] However, the proposed rule fails to incorporate an understanding of the barriers that women and LGBT people already face in accessing care and the ways in which the proposed rule could exacerbate health disparities.

Women face significant barriers in access to health care, particularly reproductive health services. Despite significant increases in the number of women with health insurance as a result of the Affordable Care Act, women are less likely than men to be insured through an employer and more likely to be insured as a dependent of another family member.[2] This leaves women more vulnerable to a loss of insurance if they become widowed or divorced, or if their spouses lose insurance. One in ten women have no health insurance, and uninsured women have poorer access to care and lower rates of use of important preventative services, such as mammograms, pap smears, and contraceptive services.[3] Low-income women, women of color, and immigrant women are at greatest risk of being uninsured.[4] An estimated 1.1 million women in states that have not expanded Medicaid under the Affordable Care Act fall into the "coverage gap" between being eligible for Medicaid and qualifying for subsidies for private insurance. Another 1.5 million undocumented women are uninsured and ineligible for either Medicaid or private insurance coverage.[5]

For women who do have health insurance, the Affordable Care Act prohibits discrimination by healthcare and insurance providers on the basis of sex, and requires coverage for key women's health services, such as preventative screenings for breast and cervical cancer, contraception, maternity care, and breastfeeding support services.[6] The proposed rule fails to indicate how the anti-discrimination and substantive coverage provisions of the ACA would be balanced against claims for religious or moral exemptions. This creates a dangerous ambiguity that could undermine the ACA's anti-discrimination provisions.

There are also significant challenges in access to constitutionally-protected abortion services, particularly for low-income women and women of color. Poor women are five times more likely than higher income women to have an unintended pregnancy, and rates of unintended pregnancy among women of color are more than twice the

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rates for white women; the federal ban on funding for Medicaid coverage for abortions contributes significantly to these disparities.[7] Current US law provides extensive grounds for religious and conscience-based objection to abortion and abortion related services, including the Church Amendment, the Coats-Snowe Amendment, the Weldon Amendment, the Medicaid or Medicare Conscience Protections, and the Affordable Care Act Conscience and Religious Exemption Laws.[8] Rule proponents have produced no compelling evidence of the necessity of supplementing these provisions. Furthermore, the proposed rule may risk further limiting access to abortion services and exacerbate existing racial and socio-economic health disparities. It does not appear that these possible harms have been seriously considered in formulating the rule.

LGBT people also face significant disparities in access to health care, with LGBT individuals twice as likely to be uninsured than their non-LGBT counterparts.[9] Moreover, discrimination in healthcare settings is problematic; in 2010, more than half of LGBT people surveyed by Lambda Legal reported a discriminatory experience while seeking healthcare services.[10] Transgender individuals in particular experience high levels of discrimination. In a 2017 survey, nearly 1 in 3 reported denial of health care on the basis of their gender identity.[11]

Congress has not enacted explicit federal non-discrimination protections for LGBT people, and fewer than half of the states offer such protection. In this environment, broad and vaguely worded religious exemption laws threaten to increase discrimination on the basis of sexual orientation and gender identity. In numerous states that have recently passed religious exemption laws without adequate protection against discrimination, Human Rights Watch has documented discriminatory denials of health care and services to LGBT people.[12] According to

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[7] American Public Health Association, "Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention," November 3, 2015, https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights (accessed March 26, 2018).

[8] 42 USC 300-a(7); 42 USC 238(n); Consolidated Appropriations Act, 2017, Pub. L. 115-31, Div. H, Tit. V, sec. 507(d); 42 U.S.C. 18023(c)(2)(A)(i)-(iii), (b)(1)(A) and (b)(4); 42 U.S.C. 1395w-22(j)(3)(B) and 1396u-2(b)(3)(B).

[9] Kellan Baker and Laura E. Durso, "Why Repealing the Affordable Care Act is Bad Medicine for LGBT Communities," Center for American Progress, March 22, 2017, https://www.americanprogress.org/issues/lgbt/news/2017/03/22/428970/repealing-affordable-care-act-bad-medicine-lgbt-communities/ (accessed March 26, 2017).

[10] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV*, 2010, https://www.lambdalegal.org/publications/when-health-care-isnt-caring (accessed March 26, 2018).

[11] Shabab Ahmed Mirza & Caitlin Rooney, "Discrimination Prevents LGBTQ People from Accessing Health Care," Center for American Progress, January 18, 2018, https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ (accessed March 26, 2018).

[12] Human Rights Watch, "*All We Want is Equality": Religious Exemptions and Discrimination against LGBT People in the United States*, February 19, 2018, https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

Lambda Legal: "In the health care field, where patients are especially vulnerable, religion-based harassment and refusals of medically necessary care have been a persistent, profoundly harmful problem."[13] People living with HIV also continue to face discrimination in healthcare settings; as recently as December 2017 the Department of Justice reached a settlement under the Americans with Disabilities Act against a surgeon in Ohio who refused care on the basis of the claimant's HIV status.[14] In many of the countries where HHS implements global HIV/AIDS programs, many of the patients served already face numerous barriers to care, including a broad and harmful refusal provision contained within the statute governing such programs.[15] The proposed rule lacks consideration of existing anti-LGBT and HIV-related discrimination in health care and contains no mechanism for avoiding or reducing potential harm.

The complaints received by the Office of Civil Rights (OCR) suggest that civil rights violations in health care are far more common than religious liberty violations. Between November 2016 and January 2018, OCR received 34 complaints alleging violations of federal laws permitting religious refusals; from the fall of 2016 to the fall of 2017, OCR received more than 30,000 complaints alleging HIPAA or civil rights violations.[16] While Human Rights Watch recognizes that violations of religious freedom are a significant and valid concern, HHS has not demonstrated that existing safeguards are insufficient to protect religious objectors; that the benefits of broader exemptions outweigh the costs they will impose; or that the proposed rule is tailored to impose the least burden on society.

As detailed below, Human Rights Watch believes the proposed rule would embolden providers to discriminate against women, LGBT people, and others based on their religious beliefs. Worse, it would do so at a time when HHS has weakened access to contraceptive services under the Affordable Care Act (ACA);[17] removed online

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[13] Lambda Legal, "Trump Administration Plan to Expand Religious Refusal Rights of Health Professionals: Legal Issues and Concerns," https://www.lambdalegal.org/health-care-analysis (accessed March 26, 2018).

[14] Settlement Agreement between the United States of America and Advanced Plastic Surgery Solutions under the Americans with Disabilities Act, December 6, 2017, https://www.ada.gov/adv_plastic_surgery_sa.html (accessed March 26, 2018).

[15] See Henry J. Kaiser Family Foundation, "The Mexico City Policy: An Explainer," June 1, 2017, https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/ (accessed March 26, 2018).

[16] US Department of Health and Human Services, "FY 2019 Budget in Brief," February 19, 2018, https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf (accessed March 26, 2018) p. 124.

[17] Human Rights Watch, "Human Rights Watch Comment on Interim Final Rule on Moral Exemptions and Accommodations Under the ACA," December 5, 2017, https://www.hrw.org/news/2017/12/05/human-rights-watch-comment-interim-final-rule-moral-exemptions-and-accommodations-0.

resources for lesbian and bisexual women;[18] and intends to roll back protections for transgender people under Section 1557 of the ACA.[19]

II. The Proposed Rule Represents a Troubling Expansion of the Scope of Religious and Moral Exemptions

While the proposed rule purports to clarify federal law, it redefines key terms in ways that would significantly broaden the scope of religious and moral exemptions. In the absence of any protections that might mitigate harm, these redefinitions risk greatly exacerbating the discrimination and barriers to access women and LGBT people already experience. Among the definitions that give cause for concern are the following:

- The proposed rule broadens the definition of the term "entity" to encompass the definition of "person" in 1 U.S.C. 1, which includes "corporations, companies, associations, firms, partnerships, societies, and joint stock companies, as well as individuals."[20]
- The proposed rule broadens the definition of the term "health care entity" with an illustrative, non-exhaustive list of providers, leaving little clarity about the scope of the exemptions that could be claimed under the proposed rule and providing little guidance for providers and patients alike.[21]
- The proposed rule broadens what it means to "assist in the performance of" a healthcare service, permitting anyone with an "articulable connection" to the healthcare service they consider objectionable – instead of a "direct connection" – to decline to participate. The expanded definition would allow objectors, including administrative or technical personnel, to refuse to perform a task because they can identify some connection, no matter how attenuated, to a service they consider objectionable.[22] For example, a hospital room scheduler could refuse to book a room or a technician could refuse to clean surgical instruments for procedures they consider objectionable.
- The proposed rule allows exemptions from a broad range of referral requirements, defining "referral" or "refer for" to include the provision of basic information about a healthcare service, activity, or procedure.[23]

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[18] Dan Diamond, "HHS Strips Lesbian, Bisexual Health Content from Women's Health Website," *Politico*, March 21, 2018, https://www.politico.com/story/2018/03/21/hhs-strips-lesbian-bisexual-health-content-from-womens-health-website-430123 (accessed March 26, 2018).

[19] National Center for Transgender Equality, "Trump Administration Says It Will Try to Legalize Anti-Transgender Discrimination in Health Care," May 2, 2017, https://transequality.org/press/releases/trump-administration-says-it-will-try-to-legalize-anti-transgender-discrimination-in (accessed March 26, 2018).

[20] Rule at 56. For the broader definition of "person," see 1 U.S.C. 1.

[21] Rule at 58-59.

[22] Rule at 52.

[23] Rule at 63-66.

At the same time, the proposed rule does not define key terms like "religious beliefs," "moral convictions," or "moral or religious grounds." This gives objectors virtually unfettered discretion to couch any refusal in moral or religious terms.

These drastic expansions of existing law could come at a cost to patients, and the rule fails to consider this. Human Rights Watch research has documented how recent religious exemptions jeopardize the health of women and LGBT people.[24] In some instances, these exemptions are invoked to justify discrimination and refuse service to individuals seeking care. Even before refusals occur, however, sweeping religious or moral exemptions put women and LGBT people on notice that they may be turned away or discriminated against, deterring them from seeking care at all.

III. The Proposed Rule Lacks Safeguards to Protect Patients

The prevalence of discrimination against women and LGBT people in health care and the sheer breadth of the proposed rule put the rights of patients at risk. These harms are exacerbated by the lack of safeguards in the proposed rule, which breaks from the US' traditional approach towards religious exemptions.

The proposed rule fails to account for the adverse impact that religious or moral refusals may have on the state's interests or the rights of others – something that has generally been a core element of religious and moral exemptions under US law.

Under international law, religious freedom protections have distinguished between the freedom of religious belief, which is inviolable, and the freedom of religious exercise, which may be limited when it infringes upon the rights of others or the state's interests. While federal law frequently collapses the distinction between religious belief and religious exercise, exemptions have typically contained some mechanism to balance protections for conscience with the state's interests, including its protection of the rights of other people.[25] The proposed rule not only fails to distinguish between belief and exercise, but does not give any explicit weight whatsoever to the rights of others or state interests.

In addition, the proposed rule does not include safeguards to minimize the harm inflicted on those who are denied service or turned away. It does not require healthcare facilities to ensure that, when a provider has an objection, a non-

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[24] Human Rights Watch, *"All We Want is Equality": Religious Exemptions and Discrimination against LGBT People in the United States*, February 19, 2018, https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[25] See, for example, Title VII, which requires employers to reasonably accommodate employees' religious beliefs – including in healthcare settings – unless the accommodation would impose an 'undue hardship' on the employer. The Religious Freedom Restoration Act, which prohibits the government from substantially burdening religious exercise but allows such restrictions where the burden is the least restrictive means necessary to advance a compelling governmental interest. 42 U.S.C. 2000bb et seq.

objecting provider is available to offer the service in their stead. It does not require healthcare facilities to refer patients to another healthcare facility where they can obtain the treatment or services they seek or provide information about their options.

IV. Rights at Stake

a. Right to Health

Under international law, everyone has the right "to the enjoyment of the highest attainable standard of physical and mental health" without discrimination on the basis of sex, age, or other prohibited grounds.[26] The right to health is also inextricably linked to provisions on the right to life and the right to non-discrimination that are included in the International Covenant on Civil and Political Rights (ICCPR), which the US has ratified.[27]

The Committee on Economic, Social and Cultural Rights, the body charged with interpreting and monitoring the implementation of the ICESCR, has identified four essential components to the right to health: availability, accessibility, acceptability and quality.[28] Even though the US is not a party to the ICESCR, the Committee's interpretation represents a useful and authoritative guide to the steps governments should take to realize and protect the right to health and other human rights. The proposed rule will reduce the availability and accessibility of healthcare services, particularly sexual and reproductive healthcare services, in communities across the US.

Sexual and reproductive health and rights are addressed specifically in a number of international treaties and other authoritative sources.[29] Article 12 of the Convention

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[26] The US has signed, but not ratified, the ICESCR and as such is not legally bound by its provisions. It does, however, have an obligation not to take actions that would undermine the object and purpose of the treaty. International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, art. 12(1).

[27] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, art. 10.

[28] Committee on Economic, Social and Cultural Rights (CESCR), "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), http://www.refworld.org/pdfid/4538838do.pdf (accessed March 26, 2018), para. 12.

[29] In the 1994 Cairo Programme of Action on Population and Development, delegates from governments around the world pledged to eliminate all practices that discriminate against women and to assist women to "establish and realize their rights, including those that relate to reproductive and sexual health." In the 1995 Beijing Declaration and Platform for Action, delegates from governments around the world recognized that women's human rights include their right to have control over and decide freely and responsibly on matters related to their sexuality free of coercion, discrimination, and violence. See United Nations, *Programme of Action of the United Nations International Conference on Population and Development* (New York: United Nations Publications, 1994),

on the Elimination of Discrimination Against Women (CEDAW) provides that "[s]tates parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services […]."[30] The US has signed, but not ratified, CEDAW. The CEDAW Committee in its General Recommendation 24 affirmed states parties' obligation to respect women's access to reproductive health services and to "refrain from obstructing action taken by women in pursuit of their health goals."[31] As with the ICESCR, even though the US is not a party to CEDAW, the Committee's interpretation represents a useful and authoritative guide to the steps governments should take to realize and protect the range of human rights addressed under the Convention.

b. Right to Information

The right to information is set forth in numerous human rights treaties.[32] CEDAW asserts that states should provide women "[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[33] The ICESCR obliges state parties to provide complete and accurate information necessary for the protection and promotion of rights, including the right to health.[34] Furthermore, the CESCR Committee in its General Comment 14 has stated that the right to health includes the right to health-related education and information, including on sexual and reproductive health.[35] The CEDAW Committee has also noted that, under article 10(h) of CEDAW, women must have access to information about contraceptive measures, sex education and family-planning services in order to make informed decisions.[36]

The proposed rule expands existing protections to allow providers to decline to provide information they deem morally or religiously objectionable to their patients, while doing nothing to ensure that those patients have reliable alternative routes to secure that information. Denying medically accurate information to patients leaves

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A/CONF.171/13, 18 October 1994, para. 4.4(c) and United Nations, *Beijing Declaration and Platform for Action* (New York: United Nations Publications, 1995), A/CONF.177/20, 17 October 1995, para. 223.

[30] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, art. 12.

[31] CEDAW Committee, "General Recommendation 24, Women and Health (Article 12)," U.N. Doc. No. A/54/38/Rev.1 (1999), para. 14.

[32] ICCPR, art. 19(2); American Convention on Human Rights, art. 13(1). See also Inter-American Court, Claude-Reyes and others Case, Judgment of September 19, 2006 Inter-Am Ct.H.R., Series C. No. 151, para. 264.

[33] CEDAW, art. 16(e).

[34] See ICESCR, article 2(2). See also CESCR, "General Comment No. 14, The Right to the Highest Attainable Standard of Health," U.N. Doc. E/C.12/2000/4 (2000), paras. 12(b), 18, 19.

[35] Ibid., para. 11.

[36] CEDAW Committee, "General Recommendation no. 21, on equality in marriage and family relations," HRI/GEN/1/Rev.9 (Vol. II), para. 22.

them in the dark about their treatment options and prevents them from making an informed choice about which options to pursue.

c. The Right to Non-Discrimination

Non-discrimination is a central principle of international human rights law.[37] As a party to the ICCPR, the US is obligated to guarantee effective protection against discrimination, including discrimination based on sex, sexual orientation, and gender identity.[38] CEDAW mandates that state parties take action to "eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to healthcare services."[39]

The UN Human Rights Committee, which provides authoritative guidance on the ICCPR, has clarified that the freedom of thought, conscience, and religion does not protect religiously motivated discrimination against women, or racial and religious minorities.[40] It has urged states considering restrictions on the manifestation of religion or belief to "proceed from the need to protect all rights guaranteed under the Covenant, including the right to equality and non-discrimination."[41]

As Human Rights Watch has documented, recent religious exemptions at the state level have emboldened service providers to discriminate against women and LGBT people. Indeed, there is substantial evidence that permitting such discrimination is the primary motivation for some of these exemptions.[42] By granting virtually unfettered discretion to religious objectors who refuse to meet the healthcare needs

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[37] International protections for the right to non-discrimination include: ICCPR, arts. 2, 4, 26; ICESCR art.2(2); CEDAW, art. 2; International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on October 21, 1994, art. 5; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Migrant Workers Convention), adopted December 18, 1990, G.A. Res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990), entered into force July 1, 2003., art. 1(1), art. 7.

[38] ICCPR, art. 26.

[39] CEDAW, art. 12.

[40] See Human Rights Committee, General Comment 28, "Article 3 (The Equality of Rights Between Men and Women)," March 29, 2000, UN Doc. CCPR/C/21/Rev.1/Add.10, para. 21 ("Article 18 may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience, and religion."); Human Rights Committee, General Comment 22, "Article 18: Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies," 1994, UN Doc. HRI/GEN/1/Rev.1, para. 2 ("The committee therefore views with concern any tendency to discriminate against any religion or belief for any reason, including the fact that they are newly established, or represent religious minorities that may be the subject of hostility on the part of a predominant religious community."); Ibid., at 7 (noting that "no manifestation of religion or belief may amount to … advocacy of national, racial, or religious hatred that constitutes incitement to discrimination" and that "States parties are under the obligation to enact laws to prohibit such acts.").

[41] Human Rights Committee, General Comment 22, "Article 18: Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies," para. 8.

[42] Human Rights Watch, "*All We Want is Equality": Religious Exemptions and Discrimination against LGBT People in the United States*, February 19, 2018, https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people; Letter from Sen. Patty Murray to Secretary Alex Azar on March 23, 2018, https://twitter.com/dominicholden/status/977276347532890114.

of women and LGBT people – and declining to provide any safeguards to mitigate the harm that such refusals inflict – the proposed rule likely fails to satisfy the US's obligations under international law.

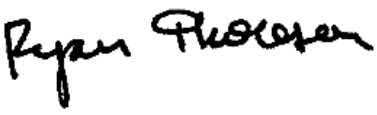
V. Conclusion

While religious freedom is an important human right, the proposed rule fails to advance that right in a responsible and rights-respecting manner. It fails to appreciate the effectiveness of existing protections for conscience and the worrying prevalence of discrimination against women and LGBT people in the United States. It broadens existing protections for conscience in ways that jeopardize access to healthcare and risk exacerbating discrimination and mistreatment against women and LGBT people. It gives little to no regard to those whose rights are jeopardized by blanket religious exemptions and breaks with a long tradition of religious exemptions that seek to ensure that the rights of all are respected. In these ways, it jeopardizes the right to health, the right to information, and the principle of non-discrimination under international law. For all of these reasons, Human Rights Watch calls on HHS to reject the proposed rule.

Sincerely,

Amanda Klasing
Senior Researcher, Women's Rights Division
Human Rights Watch

Megan McLemore
Senior Researcher, Health and Human Rights Division
Human Rights Watch



Ryan Thoreson
Researcher, LGBT Rights Program
Human Rights Watch

HRC Cmt.

March 27, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Human Rights Campaign Public Comment in Response to the Proposed Regulation, Protecting Statutory Conscience Rights in Health Care RIN (0945-ZA03)

To Whom It May Concern:

On behalf of the Human Rights Campaign's more than three million members and supporters nationwide, I write in response to the request for public comment regarding the proposed rule entitled, "Protecting Statutory Conscience Rights in Health Care" published January 26. As the nation's largest organization working on behalf of lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, we are deeply troubled by the likely impact of the proposed regulation on LGBTQ people—who already face significant barriers to accessing quality healthcare. The proposed regulation sets forth a problematic standard that prioritizes individual providers' beliefs ahead of patient health and well-being. As proposed, this regulation adopts an overly expansive interpretation of existing conscience protections that will undoubtedly empower healthcare providers to deny life-saving care to some of the most vulnerable patients.

The Proposed Regulation is Overly Broad and Fails to Address the Impact on Vulnerable Health Minorities, Including LGBTQ People.

Discrimination against LGBTQ People is Real and Causes Irreparable Harm.

LGBTQ patients face an increased risk of discrimination at the hands of healthcare providers. Numerous surveys, studies, and reports have documented the widespread extent of the discrimination faced by LGBT individuals and their families in the health care system. One

nationwide study found that 56 percent of lesbian, gay, and bisexual (LGB) respondents and 70 percent of transgender respondents reported experiencing discrimination by health care providers, including providers being physically rough or abusive, using harsh or abusive language, or refusing to touch them.[1] In the same study, 8 percent of LGB respondents and 27 percent of transgender respondents reported being refused necessary medical care outright.[2] Similarly, the 2015 National Transgender Discrimination Survey found that 33 percent of respondents had negative experiences when seeing a health care provider in the past year.[3] The survey also found that respondents were three times more likely to have to travel more than 50 miles for transgender-related care than for routine care.[4]

Beyond each of these numbers is an individual story – and too often a nightmare. The Human Rights Campaign gathered over 13,000 individual comments and stories in response to the Department's request for public comment regarding the proposed regulation implementing Section 1557 of the Affordable Care Act. Thousands of our members shared personal, heartbreaking stories of discrimination and denial when seeking healthcare. Our members recounted incidents of hostility including homophobic statements, intrusive and unnecessary questioning, and unwarranted physical removal of a same-sex partner from a doctor's visit. One of the most common stories of hostility and harassment reported by our members in their public comments included unwanted proselytizing by hospital or clinic staff. Unwanted proselytizing is a distinct form of bullying. It undermines patient care and can prevent individuals from seeking much needed care in the future.

Amongst the thousands of stories we received, many members shared stories of outright denial of care. For example, a nurse assigned to care for an elderly gay man in an assisted living facility refused to bath him or provide the necessary day-to-day care that he needed and deserved simply because he was gay. We have also received calls from individuals who have been denied access to treatment because they are in a same-sex couple. In one particular instance two nurses serving in the military and stationed in Missouri had been denied fertility treatment by every local clinic and by the military hospital because of their sexual orientation. The couple was forced to drive five hours round trip to a clinic in another city to receive treatment. This denial of care was not only a threat to their dignity, but required a costly and time-consuming alternative.

HHS has Consistently Found LGBTQ People to be Vulnerable to Discrimination

For almost a decade HHS has consistently considered LGBTQ people to be a health disparity population for purposes of HHS-funded programs and services. Healthy People 2020 provides

[1] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People*
[2] *Id.*
[3] S.E. James, C. Brown, & I. Wilson, *2015 U.S. Transgender Survey*, 97 (National Center for Transgender Equality 2017).
[4] *Id.* at 98.

that, "Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[5] The Healthy People report provides science-based national objectives designed to improve the health of every American.[6] One of the five core missions detailed by the initiative is to identify critical research areas and data collection needs and opportunities.[7] Healthy People 2020 specifically provides that recognizing the impact of social determinants on health – which include factors like sexual orientation and gender identity – is essential to improving the health and well-being of the nation.[8]

The National Institutes of Health has also formally designated sexual and gender minorities as a health disparity population for purposes of NIH research.[9] The term "sexual and gender minorities" includes lesbian, gay, bisexual, transgender, and queer people.[10] This designation recognizes the devastating health disparities facing LGBTQ people across the nation and the need for a concerted federal research response. In announcing this designation NIH provided that, "mounting evidence indicates that SGM populations have less access to health care and higher burdens of certain diseases, such as depression, cancer, and HIV/AIDS."[11]

The proposed rule is silent as to how hospitals should navigate the impact of the proposed "protections" on patient care, including the anticipated increase in discriminatory denials. The absence of any protections for vulnerable populations, including those who are LGBTQ, is a marked departure from longstanding HHS policies regarding patient care and access.

LGBTQ People will be Disparately Impacted by the Proposed Regulation's Expansive Interpretation of Conscience Laws

The regulation purports, among other things, to clarify current "religious refusal clauses" related to abortion and sterilization in three federal statutes. Each of these statutes refers to specific, limited circumstances in which health care providers or health care entities may not be required to participate in abortion and sterilization procedures. The regulation, however, creates ambiguity about these limited circumstances and encourages an overly broad interpretation that

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[5] Healthy People 2020, *Disparities*, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited Mar. 26, 2017).
[6] Healthy People 2020, *About Healthy People*, https://www.healthypeople.gov/2020/About-Healthy-People (last visited Mar. 26, 2017).
[7] *Id.*
[8] *Disparities*, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited Mar. 26, 2017).
[9] Eliseo J. Pérez-Stable, M.D., *Director's Message: Sexual and Gender Minorities Formally Designated as a Health Disparity Population for Research Purposes*, National Institute on Minority Health and Health Disparities (Oct. 6, 2016) https://www.nimhd.nih.gov/about/directors-corner/message.html.
[10] *Id.*
[11] *Id.*

goes far beyond what longstanding legal tradition and public policy understanding have understood the statutes permit.

For example, section (d) of the Church Amendments refers to circumstances when a person may refuse to participate in any part of a health service program or research activity that "would be contrary to his religious beliefs or moral convictions."[12] Even though longstanding legal interpretation has applied this section singularly to participation in abortion and sterilization procedures, the proposed rule does not make this limitation clear. This ambiguity can encourage an overly broad interpretation of the statute that empowers a provider to refuse to provide *any* health care service or information for a religious or moral reason—potentially including not just sterilization and abortion procedures, but also Pre-Exposure Prophylaxis (PrEP), infertility care, treatments related to gender dysphoria, and even HIV treatment. Some providers may try to claim even broader refusal abilities, as a recent analysis of complaints to HHS showed that transgender patients are most often discriminated against simply for being who they are rather than for the medical care they are seeking.[13]

Doctors may be misled into believing they may refuse to administer an HIV test or prescribe PrEP to a gay or bisexual man, or refuse screening for a urinary tract infection for a transgender man.[14] In fact, medical staff may interpret the regulation to indicate that they can not only refuse, but decline to tell the patient where he would be able to obtain these lifesaving services or even inform patients of their treatment options. This puts the health of the patient, and potentially that of others, at risk. The regulation could lead a physician to refuse to provide fertility treatments to a same-sex couple, or a pharmacist to refuse to fill a prescription for hormone replacement therapy for a transgender customer. In addition, by unlawfully redefining the statutory term "assisting in the performance" of a procedure, the rule could encourage health care workers to obstruct or delay access to a health care service even when they have only a tangential connection to delivering that service, such as scheduling a procedure or running lab tests to monitor side-effects of a medication. The extension and broadening of this clause will impair LGBTQ patients' access to care services if interpreted—as the proposed rule improperly appears to do—to permit providers to choose patients based upon sexual orientation, gender identity, or family structure.

We are particularly concerned that the proposed rule will be used to refuse medically necessary care to transgender patients. We are concerned that the rule's sweeping terms and HHS's troubling discussions of a case involving a transgender patient will encourage the mistaken belief that treatments that have an incidental impact on fertility, such as some procedures used to treat

[12] 42 U.S. Code § 300a–7(d).
[13] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (Mar. 7, 2018) https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.
[14] *Id.*

gender dysphoria, are sterilization procedures. Treatments for serious medical conditions may have the incidental effect of causing or contributing to infertility: for example, a hysterectomy to treat gender dysphoria, chemotherapy to treat cancer, and a wide range of medications can have the incidental effect of temporarily or permanently causing infertility. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. If religious or moral exemptions related to sterilization are misinterpreted to include treatments that have simply an incidental effect on fertility—as the vague and sweeping language of this rule encourages—it can lead to refusals that go even further beyond what federal law allows and unlawfully encourages individuals and institutions to refuse a dangerously broad range of medically needed treatments.

The Regulation Lacks Safeguards to Protect Patients from Harmful Refusals of Care.

The proposed regulation is dangerously silent in regards to the needs of patients and the impact that expanding religious refusals can have on their health. The proposed regulation includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensure that they receive medically warranted treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

The expanded religious exemptions in the proposed regulations also conflict with many patient protections in federal laws like the Affordable Care Act and the Emergency Medical Treatment and Active Labor Act. While protections under these laws are subject to religious exemptions provided under federal statute, they are not subject to exemptions whose scope goes beyond federal law—including many of the exemptions expanded in this rule. Additionally, the proposed regulation's approach to religious exemptions—which appears to allow for no limitations even when those exemptions unjustifiably harm patients or employers—conflict with the well-established standard under other federal laws, like Title VII of the Civil Rights Act.

The Proposed Regulation Will Undermine Hospital and Provider Autonomy as Centers of Care and as Private Employers.

Over the past decade, many hospitals and health systems have followed the recommendations of major accrediting bodies including the Joint Commission and have taken significant steps to ensure that LGBTQ patients receive consistent, quality, culturally competent care. Hospitals and health systems have trained staff, developed nondiscrimination patient and personnel policies, and have made other structural changes to ensure that facilities are welcoming. However, the proposed regulation could cause these hospitals and organizations to feel restricted in their ability to create inclusive and welcoming environments for both their staff, as well as their patients. The proposed regulation may empower staff to deny to provide services beyond the scope of existing law. Many hospitals facing the threat of a costly federal complaint and

investigation process may acquiesce to even unnecessary denials in order to avoid an investigation regardless of the merit of the complaint.

The proposed regulation also interferes with hospital and health systems' personnel decisions. Title VII requires employers to reasonably accommodate the sincerely-held religious beliefs, observances, and practices of its applicants and employees, when requested, unless the accommodation would impose an undue hardship on business operations.[15] This is defined as more than a de minimis cost. The proposed regulation fails to mention Title VII and the balancing of employee rights and provider hardships. The Equal Employment Opportunity Commission (EEOC) addressed this problematic intersection in its public comment in response to the 2008 regulation that had the substantively identical legal problem, noting that "Introducing another standard under the Provider Conscience Regulation for some workplace discrimination and accommodation complaints would disrupt this judicially-approved balance and raise challenging questions about the proper scope of workplace accommodation for religious, moral or ethical beliefs."[16] In this public comment the EEOC concluded that, "Title VII should continue to provide the legal standards for deciding all workplace religious accommodation complaints. HHS's mandate to protect the conscience rights of health care professionals could be met through coordination between EEOC and HHS's Office for Civil Rights, which have had a process for coordinating religious discrimination complaints under Title VII for over 25 years."[17]

Conditions for Federal Healthcare Funding Must be Grounded in Promoting Health Outcomes

"Enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services."[18] This is the mission statement that HHS asserts drives its programs, policies, and in turn this regulation. Conditions of receipt of funding for participation in HHS programs are routinely patient centered. The Conditions of Participation (CoPs) that guide the Medicare and Medicaid programs directly address patient care including infection control, nurse-bed ratios, and staffing requirements. Grant programs operated through HHS condition funding on beneficiary well-being and service delivery. For example, organizations receiving funding to serve runaway and homeless youth must certify that they are appropriately training staff to best meet the needs of youth. Domestic violence shelters receiving HHS grants must take steps to keep their delivery of services confidential to protect survivors. Patients and

[15] Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e.
[16] Letter in response to request for public comment from Reed L. Russell, Legal Counsel, EEOC, to Brenda Destro, Department of Health and Human Services (Sept. 24, 2008) https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.
[17] *Id.*
[18] Department of Health and Human Services, *Mission Statement*, https://www.hhs.gov/about/strategic-plan/introduction/index.html (last visited Mar. 26, 2017).

beneficiaries are at the center of these conditions. Holding organizations and hospitals accountable for delivering quality, accessible services and care is essential.

The proposed regulation offers no quantifiable description of a direct patient benefit. In fact, of the 216 page proposed rule, HHS dedicates a mere three paragraphs to what it describes as "ancillary" benefits to patients.[19] Webster's Dictionary defines "ancillary" as "subordinate," or "placed in or occupying a lower class, rank, or position: inferior."[20] We believe this description to be troublingly accurate. One of these inferior patient benefits includes the ability to seek health care providers who share a patient's deepest held beliefs—asserting that this will strengthen the doctor-patient relationship. The proposed regulation provides that "open communication in the doctor-patient relationship will foster better over-all care for patients. . . Facilitating open communication between providers and their patients also helps to eliminate barriers to care, particularly for minorities."[21] We could not agree more. However, as proposed the regulation does nothing to improve communication between patients and doctors, and will in fact dramatically undermine the relationship for any patient wary of discrimination. While the insertion of a physician's personal religious belief within the healthcare relationship might be welcome by some, it will come at a devastating cost to a myriad of vulnerable and traditionally underserved communities.

Studies already show that fear of discrimination causes LGBTQ people to delay or wholly avoid necessary care – even in an emergency. The proposed regulation requires that entire facilities be put on notice that a range of health care workers can deny care based on their own moral or religious beliefs. As a result, the proposed regulation also puts many patients on notice that if they are honest and open about critical clinical factors including their medical history, behavior, and even marital status and family structure that they can be turned away from care. For communities with long histories of discrimination, like the LGBTQ community, the proposed regulation's so-called "protections" will do nothing to promote open doctor-patient relationships. Instead, they provide a concrete, federally sanctioned requirement that may necessitate that they hide their own identities to get critical care.

The proposed regulation boldly asserts that it will "generate benefits by securing a public good—a society free from discrimination, which permits more personal freedom and removes unfairness."[22] The Human Rights Campaign and our members work every day to create such a society. This is why we must oppose this regulation in its entirety.

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[19] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. 18, 3916 (proposed Jan. 26, 2018).
[20] *Ancillary*, Merriam-Webster.com. Accessed March 26, 2018. https://www.merriam-webster.com/dictionary/ancillary.
[21] Protecting Statutory Conscience Rights in Health Care, 83 Fed. Reg. at 3917.
[22] *Id.* at 3916.

Lambda Cmt.

Lambda Legal
making the case for equality

March 27, 2018

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Public Comment in Response to the Proposed Rule, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03

To Whom It May Concern:

Lambda Legal Defense and Education Fund, Inc. ("Lambda Legal") appreciates the opportunity provided by the Department of Health and Human Services ("HHS" or the "Department") to offer comments in response to the Proposed Rule, Protecting Statutory Conscience Rights in Health Care RIN 0945-ZA03 ("Proposed Rule" or "Rule"), published in the Federal Register on January 26, 2018.[1] As described herein, the Proposed Rule both exceeds its statutory authority and contravenes this Department's mission, the legal rights of patients, the ethical obligations of health professionals, and the legal rights and responsibilities of institutional health care providers. It should be withdrawn.

Lambda Legal is the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, and transgender ("LGBT") people and everyone living with HIV through impact litigation, policy advocacy, and public education. For decades, Lambda Legal has been a leader in the fight to ensure access to quality health care for our vulnerable communities. In recent years, Lambda Legal has submitted a series of comments to HHS regarding the importance of reducing discrimination against LGBT people in health care services, the fact that current law already protects health worker conscience rights appropriately, and the ways that conscience-based exemptions to health standards endanger LGBT people and others.[2] Recently, Lambda Legal also has opposed an HHS proposal to expand

[1] 83 Fed. Reg. 3880 *et seq*. (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88).

[2] *Lambda Legal Comments on Proposed Rule 1557 Re: Nondiscrimination in Health Programs and Activities, 1557 NPRM (RIN 0945-AA02)* (submitted Nov. 9, 2015) ("Lambda Legal 1557 Comments"), https://www.lambdalegal.org/in-court/legal-docs/hhs_dc_20151117_letter-re-1557; *Lambda Legal Comments on Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities (RIN 0945-AA02 & 0945-ZA01)* (submitted Sept. 30, 2013) ("Lambda Legal Nondiscrimination Comments"), https://www.lambdalegal.org/in-court/legal-docs/ltr_hhs_20130930_discrimination-in-health-services. *See also* Brief of Amici Curiae Lambda Legal et al., *Zubik v. Burwell*, 136 S. Ct. 1557

the ability of religiously-affiliated health care institutions and individuals to impose their religious beliefs on workers and on patients, cautioning in detail about the likely harmful consequences of any such expansions for LGBT people and people living with HIV.[3]

As to the Proposed Rule now under consideration, Lambda Legal emphatically recommends its withdrawal because:

(1) It improperly expands statutory religious exemptions in multiple ways, including by:

(a) permitting workers to refuse job duties that cannot reasonably be understood as "assisting" with an objected-to procedure, [4] and instead have merely an "articulable" connection to the procedure[5];

(b) expanding who may assert religious objections from employees performing or assisting in specified procedures to any member of the workforce[6];

(c) using an improperly expanded definition of "referral"[7] that includes providing any information or directions that could assist a patient in pursuing care; and

(d) defining "discrimination" to focus on protecting the interests of health care providers in continuing to receive favorable financial, licensing or other treatment, rather than on patients' interest in receiving medically appropriate care[8]; and

(e) defining health care entity to include health insurance plans, plan sponsors, and third-party administrators.[9]

(2016) (Nos. 14-1418, 14-1453, 14-1505, 15-35, 15-105, 15-119, 15-191), http://www.lambdalegal.org/in-court/legal-docs/zubik_us_20160217_amicus.

[3] *See, e.g., Lambda Legal Comments on Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (RIN 0938-AT46)* (submitted Dec. 5, 2017), https://www.lambdalegal.org/in-court/legal-docs/dc_20171205_aca-moral-exemptions-and-accommodations; *Lambda Legal Comments on Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act (RIN 0938-AT20)* (submitted Dec. 5, 2017), https://www.lambdalegal.org/in-court/legal-docs/dc_20171205_aca-religious-exemptions-and-accommodations.

[4] 42 U.S.C.A. § 300a-7(b) and (d).

[5] Section 88.2, 83 Fed. Reg. at 3923.

[6] Section 88.2, 83 Fed. Reg. at 3924.

[7] *Id*.

[8] *Id*.

[9] *Id*.

(2) It encourages workers and institutions to refuse care and does not acknowledge the rights of patients, such as the right against sex discrimination provided by Section 1557 of the Affordable Care Act.[10]

(3) It encourages workers and institutions to refuse care and does not acknowledge the legal rights and duties of health care providers, such as those under Title VII of the Civil Rights Act of 1964,[11] or health professionals' ethical obligations to patients.

(4) Using broad, vague language, it addresses a purported "problem" of health workers being pressed to violate their conscience, suggesting that workers should have broad religious rights to decline care and refuse other work of any sort in any context, going far beyond the narrow contexts specified in the authorizing statutes.

(5) Its proposed enforcement mechanisms are draconian, threatening the loss of federal funding and even the potential of funding "claw backs," with limited if any due process protections, all of which would skew health systems improperly in favor of religious refusals and against patient care.

(6) The heavy-handed enforcement mechanisms inevitably would invite discrimination and aggravate existing health disparities and barriers to health care faced by LGBT people and others, contrary to the mission of HHS and, in particular, its Office for Civil Rights.

(7) It is the result of a rushed, truncated process inconsistent with procedural requirements including the Administrative Procedure Act.[12]

In sum, the role of the HHS Office for Civil Rights ("OCR") described in the Proposed Rule is not to promote access to health care and to safeguard patients against discrimination, but instead to impose vague, overbroad *restraints* on health care provision, as a practical matter elevating "conscience" objections of workers over the needs of patients. In so doing, the Proposed Rule turns the mission of HHS/OCR on its head. Freedom of religion is a core American value, which is why it is already protected by the First Amendment of the Constitution. But, that freedom does not and must not allow anyone to impose their beliefs on others or to discriminate. This basic principle is nowhere more important than in medical contexts where religion-based refusals can cost patients their health and even worse.

[10] 42 U.S.C.A. § 18116.

[11] Civil Rights Act of 1964 § 7, 42 U.S.C.A. § 2000e *et seq.* (1964).

[12] 5 U.S.C.A. § 500 *et seq*.

I. The Proposed Rule Improperly Expands Statutory Religious Exemptions.

The Proposed Rule improperly expands statutory religious exemptions beyond their narrow, specific parameters in numerous ways. It includes definitions that would broaden the exemptions in the Church Amendments, which currently allow health workers to decline to assist in an abortion or sterilization procedure if doing so "would be contrary to [their] religious beliefs or moral convictions."[13] The Proposed Rule reinterprets what it means to "assist in the performance" of a procedure from participating in "any activity with a *reasonable* connection" to a procedure [14] to "any … activity with an *articulable* connection" to an objected-to procedure.[15] In other words, any connection that can be described, no matter how tenuous, potentially could suffice. Confirming the potentially indefinite expansion of *what* can be deemed "assistance" is a broad definition of *who* may object. From the prior common language understanding of who might be involved in a medical procedure, the new definition appears to authorize any member of the workforce to object to performing their job duties.[16]

The Proposed Rule also includes an aggressive expansion of the concept of "referral" from the common understanding of actively connecting a patient with an alternate source of a particular service to the provision of any information or directions that could possibly assist a patient who might be pursuing a form of care to which the employee objects.[17] This goes far beyond a reasonable understanding of what the underlying statute justifies.

Similarly, where the statute authorizes "health care entities" to assert religious objections, the Proposed Rule grossly expands the entities covered by that term to include health insurance plans, plan sponsors, and third-party administrators.[18] It also adds a definition of "discrimination" that focuses not on patients' interest in receiving equal, medically appropriate services, but rather on protecting health care providers' interests in continuing to receive favorable financial, licensing or other treatment while refusing on religious or moral objections to provide care despite medical standards, nondiscrimination rules, or other requirements.[19]

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[13] 42 U.S.C.A. § 300a-7.

[14] 45 C.F.R. § 88.2 (2008) (emphasis added).

[15] Proposed Rule, 83 Fed. Reg. at 3923 (emphasis added).

[16] Section 88.2, 83 Fed. Reg. at 3924.

[17] Section 88.2, 83 Fed. Reg. at 3924.

[18] Section 88.2, 83 Fed. Reg. at 3924.

[19] Section 88.2, 83 Fed. Reg. at 3924.

In numerous places, the Proposed Rule seems to indicate that HHS is adopting interpretations that would extend the Amendments' reach beyond current understanding that the exemptions only concern abortion and sterilization and follow the common medical understanding of those terms.[20] As one example, it seems likely that the "sterilization" references within the Proposed Rule could be applied to deny health care to transgender patients because the Rule itself, at footnote 36, cites *Minton v. Dignity Health* approvingly.[21] *Minton* addresses whether a Catholic hospital was legally justified when it blocked a surgeon from performing a hysterectomy for a transgender man as part of the prescribed treatment for gender dysphoria. The hospital defended on religious freedom grounds, arguing that it was bound "to follow well-known rules laid down by the United States Conference of Catholic Bishops," including rules prohibiting "direct sterilization."[22]

But, to equate hysterectomy to treat gender dysphoria with direct sterilization is medically inaccurate. Sterilization procedures undertaken for the *purpose* of sterilization are fundamentally different from procedures undertaken for other medical purposes that incidentally affect reproductive functions. Regardless of whether the United States Conference of Catholic Bishops considers gender transition-related care to be sterilization as a religious matter, were the federal government to approve a religious rationale as grounds for stretching a federal statute and permitting denial of medically necessary care would be problematic for both statutory interpretation and Establishment Clause reasons.

The Proposed Rule's apparent embrace of the Bishops' view poses an overtly discriminatory and unacceptable threat to transgender patients. This concern is not speculative. The Proposed Rule's footnote referencing *Minton* supports the following statement: "Many religious health care personnel and faith-based medical entities have further alleged that health care personnel are being targeted for their religious beliefs."[23] For the Proposed Rule to equate a transgender patient expecting to receive medically necessary care from health care personnel with those personnel "being targeted for their religious beliefs" is a chilling indicator of the direction the Proposed Rule would take health care in this country. Not only would health providers be invited to turn away transgender patients, but those that abide by their obligation to

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[20] *Compare* cases describing statute's applicability to provision or refusal provide abortions or sterilization, *e.g.*, *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695 (2d Cir. 2010), *and Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974), *with Geneva Coll. v. Sebelius*, 929 F. Supp. 2d 402 (W.D. Pa. 2013), *on reconsideration in part* (May 8, 2013) (statute does not apply to provision of emergency contraception, which is not abortion or sterilization).

[21] No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017).

[22] Defendant Dignity Health's Reply Brief in Support of Demurrer to Verified Complaint, *Minton v. Dignity Health*, No. 17-558259, at 2 (Calif. Super. Ct. Apr. 19, 2017) (filed Aug. 8, 2017), https://www.aclusocal.org/sites/default/files/brf.sup_.080817_defendant_dignity_healths_reply_in_support_of_demurrer_to_verified_complaint.pdf.

[23] Proposed Rule, 83 Fed. Reg. at 3888 n. 36.

provide nondiscriminatory care and require their employees to act accordingly could be stripped of federal funding if equal treatment of those patients offended any workers' personal beliefs.

The overbroad definitions and suggestive language all contribute to the alarming overall theme of the Proposed Rule—that it addresses a purported problem of health workers ostensibly being pressed wrongfully to act against their rights of conscience. The Proposed Rule's suggested cure appears to be that workers should have broad religious rights to decline care of any sort in any context. This theme starts with the broad language stating the Proposed Rule's purpose and runs throughout the rule.[24] It creates at least a serious concern that, for example, language long understood to be bounded by its statutory context only to concern abortion and sterilization could be misconstrued as authorizing health care providers to refuse to participate in *any* part of *any* health service program or research activity "contrary to [their] religious beliefs or moral convictions."[25] While such an interpretation obviously could be challenged legally, many patients have neither the knowledge nor the means to resist such improper care refusals and would simply suffer the delay or complete denial of medically needed treatments.

II. The Proposed Rule Invites Workers And Institutions To Refuse Care And Does Not Acknowledge The Rights Of Patients.

By issuing the Proposed Rule, HHS invites health workers and institutions to refuse to provide medical care for religious reasons, without acknowledging that patients often have countervailing rights. Yet, all federal agencies, including HHS, must comply with the federal statutes that protect LGBT people and others from discrimination, such as Section 1557 of the Affordable Care Act, which bars discrimination based on sex in federally funded health services and programs.[26] Properly understood, Section 1557 protects transgender patients from discriminatory denials of care based on their gender identity or transgender status.[27] It also protects lesbian, gay, and bisexual patients.[28] Even if it were not contrary to the mission of OCR

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[24] *See, e.g.*, Section 88.1 (Purpose); Appendix A (required notice to employees) to 45 C.F.R., 83 Fed. Reg. at 3931 (declaring broad right to accommodation for any religious or moral belief); 83 Fed. Reg. at 3881, 3887-89, 3903 (addressing "problem" of workers being required to meet patient needs despite their personal beliefs).

[25] 42 U.S.C.A. § 300a-7(d). See cases cited *supra* note 20.

[26] 42 U.S.C.A. § 18116.

[27] *Rumble v. Fairview Health Services*, 2015 WL 1197415 (D. Minn. March 16, 2015) (Affordable Care Act, Section 1557). *See also Whitaker v. Kenosha Unified School District No. 1 Board of Education, 858 F.3d 1034 (7th Cir. 2017*) (analogous protection against sex discrimination in Title IX protects transgender students); *EEOC v. R.G. v. G.R. Harris Funeral Homes, Inc.*, __ F.3d __, 2018 WL 1177669 (6th Cir. March 7, 2018) (analogous protection against sex discrimination in Title VII protects transgender workers).

[28] *Cf. Zarda v. Altitude Express, Inc.*, 883 F.3d 100 (2d Cir. 2018) (sexual orientation discrimination is sex discrimination under Title VII); *Hively v. Ivy Tech Comm'ty College*, 853 F.3d 339 (7th Cir. 2017) (same).

to undermine patient protections against discrimination, the agency lacks the authority to reduce the protections provided to patients by separate statutes.

The ACA also includes patient protections to ensure access to essential health services, including reproductive health services. Yet, the Proposed Rule's aggressive approach to advancing conscience rights offers nothing to explain how those refusal rights are to coexist with patients' rights under the ACA. As to these conflicts, Lambda Legal joins the comments submitted by the National Health Law Program.

Moreover, the Proposed Rule also is inconsistent with several core constitutional guarantees: (1) each of us is entitled to equal protection under law; (2) the Establishment Clause forbids our government from elevating the religious wishes of some above the needs of others to be protected from harm, including the harms of discrimination; and (3) congressional spending powers have limits. On the latter point, the Proposed Rule references the spending powers of Congress as grounds for the new enforcement powers created for HHS to condition federal funding upon health care providers' acquiescence in religious refusal demands of their workers.[29] However, as well-established by *South Dakota v. Dole*[30] and its progeny, Congress's spending powers are limited. Any exertion of power must be in pursuit of the general welfare; must not infringe upon states' abilities "to exercise their choice knowingly, cognizant of the consequences of their participation"; must be related "'to the federal interest in particular national projects or programs;'" and must be otherwise constitutionally permissible.[31]

Multiple Equal Protection and Establishment Clause concerns implicate the final prong of the *South Dakota v. Dole* test for unconstitutional conditions on federal funds. But the first prong deserves immediate focus because it obviously does not serve the general welfare to use severe de-funding threats to intimidate medical facilities into deviating from medical practice standards in favor of religious interests in secular settings, to the detriment of individual and public health.

In addition, with its explicit intention to enforce federal "conscience" rights despite contrary state and local protections for patients, the Proposed Rule further implicates federalism concerns. It states: "Congress has exercised the broad authority afforded to it under the Spending Clause to attach conditions on Federal funds for respect of conscience, and such conscience conditions supersede conflicting provisions of State law[.]"[32] It then asserts that it "does not impose substantial direct effects on States," "does not alter or have any substantial direct effects on the relationship between the Federal government and the States," and "does not implicate" federalism concerns under Executive Order 13132.[33] Yet, by inviting health professionals and

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[29] Proposed Rule, 83 Fed. Reg. at 3889.

[30] 483 U.S. 203 (1987).

[31] *Id*. at 207-08.

[32] Proposed Rule, 83 Fed. Reg. at 3889.

[33] *Id.* at 3918-19.

other workers to turn away patients and refuse job duties in such a sweeping way, the Proposed Rule directly conflicts with state and local nondiscrimination laws and other patient protections. Its assertions to the contrary are patently inaccurate.

III. The Proposed Rule Invites Workers To Refuse Care And Does Not Acknowledge The Legal Rights And Duties, And Ethical Obligations, Of Health Care Providers.

The Proposed Rule aims improperly to empower workers to object to job duties without addressing the impacts on employers and coworkers left somehow to try to ensure that patient needs are met by others, with whatever increased costs, workload, and other burdens it may entail. The proposed approach fails to acknowledge that the federal employment nondiscrimination law, Title VII of the Civil Rights Act of 1964, limits the extent to which employers are to be burdened by employee demands for religious accommodation.[34] Undue burdens on employers could include objections by coworkers to unfair additional job duties or to coworker proselytizing. Likewise, it certainly would impose unjustifiable burdens to require employers to hire duplicate staff simply to ensure patient needs are met by employees willing to perform basic job functions. Indeed, courts have confirmed that when denial of a requested accommodation is "reasonably necessary to the normal operation of the particular business or enterprise,"[35] employers, including health care employers,[36] need only show that they "offered a reasonable accommodation *or* that a reasonable accommodation would be an undue burden."[37]

Such limitations on employee religious rights are essential to ensure that health care employers can hire those who will perform the essential functions of their jobs, and will comply with all statutory obligations including prohibitions against discrimination. If instead, employees who claim "conscience" objections to providing the health care services to LGBT people or people living with HIV are empowered by the Proposed Rule to threaten their employees with loss of federal funding if they do not allow such discrimination, employers will face logistical

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[34] 42 U.S.C.A. § 2000e *et seq. See, e.g., See, e.g., Bruff v. North Miss. Health Servs., Inc.*, 244 F.3d 495, 497-98 (5th Cir. 2001) (Title VII duty to accommodate employees' religious concerns did not require employer to accommodate employee's requests to be excused from counseling patients about non-marital relationships, which meant "she would not perform some aspects of the position itself"); *Berry v. Dep't of Social Servs.*, 447 F.3d 642 (9th Cir. 2006) (employer entitled to prohibit employee from discussing religion with clients).

[35] 42 U.S.C.A. § 2000e-2(e).

[36] *See, e.g., Grant v. Fairview Hosp. & Healthcare Servs.*, No. Civ. 02-4232JNEJGL, 2004 WL 326694 (D. Minn. Feb. 18, 2004) (hospital wasn't required to accommodate employee's request to be able to proselytize or provide pastoral counseling to patients to try to persuade them not to have abortions); *Robinson v. Children's Hosp. Boston*, Civil Action No. 14-10263-DJC, 2016 WL 1337255 (D. Mass. Apr. 5, 2016) (granting hospital employee's request to forgo flu shot would have been an undue hardship for hospital).

[37] *See, e.g., Sánchez-Rodríguez v. AT & T Mobility P. R., Inc.*, 673 F.3d 1, 8 (1st Cir. 2012).

nightmares and the employees without such beliefs will be unfairly subjected to increased workloads.

This seems like an inevitable repercussion particularly in light of the Proposed Rule's explanation in its definition of prohibited "discrimination" that "religious individuals or institutions [must] be allowed a level playing field, and that their beliefs not be held to disqualify them from participation in a program or benefit."[38] This definition lacks any qualifying language confirming that employers may condition employment on willingness to perform essential parts of a job. The likely effects would include increased burnout among those staff who have additional work delegated to them when religious exemptions are claimed. The Proposed Rule also would drain institutional resources as employers must respond (with management time and legal fees) to complaints filed by overburdened workers and by those who file implausible "conscience" objections upon receiving negative work evaluations. The waste of essential health care resources in service of improper denials of medical care cannot be justified.

Moreover, the Proposed Rule similarly ignores that health professionals are bound by ethical standards to do no harm and to put patient needs first. Concerning the application of this point to ensuring patients' reproductive health needs are not improperly subordinated to others' religious concerns, Lambda Legal endorses the comments submitted by the National Health Law Program. Concerning patients' needs to be treated equally regardless of gender identity, sexual orientation, and other irrelevant personal characteristics, the Joint Commission's accreditation standards and the ethical rules of the American Medical Association and other leading medical associations all impose a duty of nondiscrimination. For example, AMA Ethical Rule E-9.12 prohibits discrimination against patients and Ethical Rule E-10.05 provides that health professionals' rights of conscience must not be exercised in a discriminatory manner.[39] But that is precisely what results when, for example, a medically necessarily hysterectomy is denied to a patient because it is needed as treatment for gender dysphoria, and is provided to other patients as treatment for fibroids, endometriosis, or cancer.[40]

The Tennessee Counseling Association has expressed the bottom line cogently. Like many medical associations across the country, the TCA has codified the "do no harm" mandate and issued a formal statement opposing legislation proposing to allow denials of medical care through religious exemptions in that state: "When we choose health care as a profession, we

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[38] Proposed Rule, 83 Fed. Reg. at 3892.

[39] AMA ethical rule E-9.12, "Patient-Physician Relationship: Respect for Law and Human Rights," E-10.05, "Potential Patients."

[40] See discussion of Proposed Rule reference to *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. Apr. 19, 2017), at page 5, footnote 22. *See also Conforti v. St. Joseph's Healthcare Sys.* (D. N.J. filed Jan. 5, 2017), case documents at https://www.lambdalegal.org/in-court/cases/nj-conforti-v-st-josephs; Amy Littlefield, *Catholic Hospital Denies Transgender Man a Hysterectomy on Religious Grounds*, Rewire.News, Aug. 31, 2016, https://rewire.news/article/2016/08/31/catholic-hospital-denies-transgender-man-hysterectomy-on-religious-grounds/.

choose to treat all people who need help, not just the ones who have goals and values that mirror our own."[41]

IV. The Proposed Rule's Enforcement Mechanisms Are Draconian And Would Skew Health Systems In Favor Of Religious Refusals And Against Patient Care.

The Proposed Rule's enforcement mechanisms include aggressive investigation, require medical facilities to subject themselves to an extensive scheme of regulatory surveillance by HHS, and allocate authority to OCR "to handle complaints, perform compliance reviews, investigate, and seek appropriate action."[42] The Proposed Rule even "make[s] explicit the Department's authority to investigate and handle violations and conduct compliance reviews *whether or not a formal complaint has been filed*."[43] In addition to conditioning federal funding on prospective pledges to comply with broad, vague requirements, penalties can include not just the loss of future federal funding but even the potential of funding "claw backs,"[44] all with limited if any due process protections.

For many major medical providers, the threat of loss of federal funding is a threat to the facilities' very existence. It is nearly unfathomable that the government intends to force medical facilities either to forego their ethical obligations not to harm their patients or to close their doors. But, that easily could be the effect of the Proposed Rule in many instances. More often, the likely result would be simply to skew health systems dangerously in favor of religious refusals and against patient care. Doing so would both invite discrimination and aggravate existing health disparities and barriers to health care faced by LGBT people and others, contrary to the mission of HHS and, in particular, its Office for Civil Rights.

V. The Proposed Rule Inevitably Would Invite Discrimination And Worsen Health Disparities Affecting LGBT People And Others.

Discrimination and related health disparities already are widespread problems for LGBT people and people living with HIV.[45] In 2010, Lambda Legal conducted the first-ever national

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[41] *See* Emma Green, *When Doctors Refuse to Treat LGBT Patients*, The Atlantic, April 19, 2016, https://www.theatlantic.com/health/archive/2016/04/medical-religious-exemptions-doctors-therapists-mississippi-tennessee/478797/, citing Tenn. Counseling Assoc., *TCA Opposes HB 1840* (2016), http://www.tncounselors.org/wp-content/uploads/2016/03/TCA-Opposes-HB-1840-3.9.16.pdf.

[42] Proposed Rule, 83 Fed. Reg. at 3898.

[43] *Id*. (emphasis added).

[44] *Id*.

[45] *See, e.g.*, Inst. of Med., *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011) ("IOM Report") (undertaken at the request of the National Institutes of Health, and providing an overview of the public health research concerning health disparities for LGBT people and the adverse health consequences of anti-LGBT attitudes),

survey to examine the refusals of care and other barriers to health care confronting LGBT people and people living with HIV, *When Health Care Isn't Caring: Survey on Discrimination Against LGBT People and People Living with HIV*.[46] Of the nearly 5,000 respondents, more than half reported that they had experienced at least one of the following types of discrimination in care:

- Health care providers refusing to touch them or using excessive precautions;
- Health care providers using harsh or abusive language;
- Health care providers being physically rough or abusive;
- Health care providers blaming them for their health status.[47]

Almost 56 percent of lesbian, gay, or bisexual (LGB) respondents had at least one of these experiences; 70 percent of transgender and gender-nonconforming respondents had one or more of these experiences; and almost 63 percent of respondents living with HIV experienced one or more of these types of discrimination in health care.[48] Almost 8 percent of LGB respondents reported having been denied needed care because of their sexual orientation,[49] and 19 percent of respondents living with HIV reported being denied care because of their HIV status.[50] The picture was even more disturbing for transgender and gender-nonconforming respondents, who reported the highest rates of being refused care (nearly 27 percent), being subjected to harsh language (nearly 21 percent), and even being abused physically (nearly 8 percent).[51]

Respondents of color and low-income respondents reported much higher rates of hostile treatment and denials of care. Nearly half of low-income respondents living with HIV reported that medical personnel refused to touch them, while the overall rate among those with HIV was

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https://www.ncbi.nlm.nih.gov/books/NBK64806; Sandy E. James et al., Nat'l Ctr. For Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 93-129 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf; Lambda Legal, Health Care; Shabab Ahmed Mirza & Caitlin Rooney, Ctr. For Am. Progress, *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.

[46] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010) ("Lambda Legal, Health Care"), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

[47] *Id*. at 5, 9-10.

[48] *Id*.

[49] *Id*. at 5, 10.

[50] *Id*.

[51] *Id*. at 10-11.

nearly 36 percent.[52] And while transgender respondents as a whole reported a care-refusal rate of almost 27 percent, low-income transgender respondents reported a rate of nearly 33 percent.[53] People of color living with HIV and LGB people of color were at least twice as likely as whites to report experiencing physically rough or abusive treatment by medical professionals.[54]

Also detailed in the report are particular types of discrimination in health care based on gender identity, sex discrimination against LGB people, and discrimination against people living with HIV. Such discrimination can take many forms, from verbal abuse and humiliation to refusals of care;[55] to refusal to recognize same-sex family relationships in health care settings to the point of keeping LGBT people from going to the bedsides of their dying partners;[56] to lack of understanding and respect for LGBT people.[57] The resulting harms are manifold, from transgender patients denied care postponing, delaying, or being afraid to seek medical treatment, sometimes with severe health consequences, or resorting out of desperation to harmful self-treatment;[58] to the mental and physical harms of stigma;[59] to other immediate physical harms from being denied medical care.

As described, the discriminatory treatment of LGBT people too often occurs in the name of religion. When it does, that religious reinforcement of anti-LGBT bias often increases the mental health impacts of discrimination.[60]

Since the 2010 Lambda Legal survey, other studies have similarly documented the disparities faced by LGBT people seeking health care. For example, *The Report of the 2015 U.S. Transgender Survey*, a survey of nearly 28,000 transgender adults nationwide, found that 33 percent "of respondents who had seen a health care provider in the past year reported having at least one negative experience related to being transgender, such as verbal harassment, refusal of treatment, or having to teach the health care provider about transgender people to receive

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[52] *Id*. at 11.

[53] *Id*.

[54] *Id*. at 12.

[55] *Id*. at 5-6.

[56] *Id*. at 15-16.

[57] *Id*. at 12-13.

[58] *Id.* at 6, 8, 12-13.

[59] *Id*. at 2.

[60] Ilan H. Meyer et al., *The Role of Help-Seeking in Preventing Suicide Attempts among Lesbians, Gay Men, and Bisexuals*, Suicide & Life Threatening Behavior, 8 (2014), http://www.columbia.edu/~im15/papers/meyer-2014-suicide-and-life.pdf ("[A]lthough religion and spirituality can be helpful to LGB people, negative attitudes toward homosexuality in religious settings can lead to adverse health effects") (internal citations omitted).

appropriate care" and that "23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person[.]"[61]

The Center for American Progress in 2017 conducted another nationally representative survey with similar results about LGBT health disparities, including findings that:

> Among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:
>
> > 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation.
> >
> > 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation.
> >
> > 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner.
> >
> > 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them.
> >
> > 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[62]
>
> Among transgender people who had visited a doctor or health care providers' office in the past year:
>
> > 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity.
> >
> > 12 percent said a doctor or other health care provider refused to give them health care related to gender transition.
> >
> > 23 percent said a doctor or other health care provider intentionally misgendered them or used the wrong name.

[61] James et al., *supra* n. 45, at 93.

[62] Mirza & Rooney, *supra* n. 45.

> 21 percent said a doctor or other health care provider used harsh or abusive language when treating them.
>
> 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[63]

Independently of our own and others' research studies, Lambda Legal has become distressingly aware of the nature and scope of the discrimination problem from our legal work and requests for assistance received by our Legal Help Desks. We have repeatedly submitted information about the pattern of religion-based refusals of medical care to LGBT people in response to HHS requests. For example, in our 2013 response to the Request For Information for Section 1557 of the ACA, we documented numerous cases in which health professionals had denied medical care or otherwise discriminated against LGBT people and/or people living with HIV, based on the professionals' personal religious views, including:

> • Guadalupe "Lupita" Benitez was referred for infertility care to North Coast Women's Care Medical Group, a for-profit clinic that had an exclusive contract with Benitez's insurance plan. After eleven months of preparatory treatments, including medication and unwarranted surgery, Lupita's doctors finally admitted they would not perform donor insemination for her because she is a lesbian. The doctors claimed a right not to comply with California's public accommodations law due to their fundamentalist Christian views against treating lesbian patients as they treat others. In a unanimous decision, the California Supreme Court held that religious liberty protections do not authorize doctors to violate the civil rights of lesbian patients. *North Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court (Benitez)*, 189 P.3d 959 (Cal. 2008)
>
> • Counseling student's objections to providing relationship counseling to same-sex couples. *Keeton v. Anderson-Wiley*, 664 F.3d 865 (11th Cir. 2011) (finding student unlikely to prevail on free speech and religious liberty claims challenging her expulsion from counseling program due to her religiously based refusal to counsel same-sex couples, contrary to professional standards requiring nonjudgmental, nondiscriminatory treatment of all patients).
>
> • Physician's objection to working with an LGB person. *Hyman v. City of Louisville*, 132 F. Supp. 2d 528, 539-540 (W.D. Ky. 2001) (physician's religious beliefs did not exempt him from law prohibiting employment discrimination based on sexual orientation or gender identity), *vacated on other grounds by* 53 Fed. Appx. 740 (6th Cir. 2002).

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[63] *Id.*

> • Proselytizing to patients concerning religious condemnation of homosexuality. *Knight v. Connecticut Dep't of Pub. Health*, 275 F.3d 156 (2d Cir. 2001) (rejecting free exercise wrongful termination claim of visiting nurse fired for antigay proselytizing to home-bound AIDS patient).
>
> • Refusal to process lab specimens from persons with HIV. *Stepp v. Review Bd. of Indiana Emp. Sec. Div.*, 521 N.E.2d 350, 352 (Ind. 1988) (rejecting religious discrimination claim of lab technician fired for refusing to do tests on specimens labeled with HIV warning because he believed "AIDS is God's plague on man and performing the tests would go against God's will").[64]

In addition, testimonies received in Lambda Legal's health survey describe similar encounters with health professionals who felt free to express their religiously grounded bias toward LGBT patients:

> • Kara in Philadelphia, PA: "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?'"[65]
>
> • Joe in Minneapolis, MN: "I was 36 years old at the time of this story, an out gay man, and was depressed after the breakup of an eight-year relationship. 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."[66]

Lambda Legal documented additional recent examples of health care denials or discriminatory treatment in its amicus brief to the Supreme Court in *Masterpiece Cakeshop v. Colorado Civil Rights Commission*,[67] including the following two Lambda Legal cases:

- Lambda Legal client Naya Taylor, a transgender woman in Mattoon, Illinois, who sought hormone replacement therapy (HRT), a treatment for gender dysphoria, from the health clinic where she had received care for more than a decade. When her primary care physician refused her this standard treatment, clinic staff told her that, because of

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[64] Lambda Legal Nondiscrimination Comments (citations partially omitted).

[65] *Id.*

[66] *Id.*

[67] *See* Brief of Amici Curiae Lambda Legal et al., *Masterpiece Cakeshop Ltd. v. Colorado Civil Rights Comm'n*, No. 16-111, at 11-14, 17-18, 26, 30 (filed Oct. 30, 2017), https://www.lambdalegal.org/in-court/cases/masterpiece-cakes-v-co-civil-rights-commission.

the religious beliefs of the clinic's doctors, they do not have to treat "people like you."[68]

- Lambda Legal client Jionni Conforti, who was refused a medically necessary hysterectomy despite his treating physician's desire to perform the surgery. The hospital where the surgeon had admitting privileges was religiously affiliated and withholds permission for all gender transition-related care.[69]

These examples are just a tip of the iceberg, a few of many incidents across the country in which religion has been used to justify denial of health care or other discrimination against LGBT people and people living with HIV. Although courts consistently have rejected such reliance on religion to excuse discrimination, examples of religion-based discrimination in health care continue to occur with regularity.[70] This mistreatment contributes to persistent health disparities, including elevated rates of stress-related conditions.[71]

Given this landscape, Lambda Legal is deeply concerned that this Proposed Rule, designed to protect and even encourage religious refusals of health care, inevitably will facilitate further discrimination by health professionals in contexts involving sexual orientation, gender identity, or HIV status. As a result, the health of patients across the country, as well as others, would be at risk, and "conscience" claims could too easily become a way for providers to turn away LGBT patients. The past examples of religiously-based discrimination indicate there is significant likelihood that too-many individual and institutional care providers will demand exemptions from rules and standards designed to ensure that patients receive proper treatment regarding the following needs:

- Treatment of patients who need counseling, hormone replacement therapy, gender confirmation surgeries, or other treatments for gender dysphoria.
- For patients with a same-sex spouse or who are in a same-sex relationship, bereavement counseling after the loss of a same-sex partner or other mental health care that requires

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[68] In April 2014, Lambda Legal filed a claim of sex discrimination on Ms. Taylor's behalf under Section 1557 of the ACA; however, Ms. Taylor subsequently passed away and her case was voluntarily dismissed. *See* Complaint, *Taylor v. Lystila*, 2:14-cv-02072-CSB-DGB (C.D. Ill., Apr. 15, 2014), *available at* https://www.lambdalegal.org/in-court/legal-docs/taylor_il_20140416_complaint.

[69] *See Conforti v. St. Joseph's Healthcare Sys.* (D. N.J. filed Jan. 5, 2017) case documents at https://www.lambdalegal.org/in-court/cases/nj-conforti-v-st-josephs. *See also* Amy Littlefield, *Catholic Hospital Denies Transgender Man a Hysterectomy on Religious Grounds*, Rewire.News, Aug. 31, 2016, https://rewire.news/article/2016/08/31/catholic-hospital-denies-transgender-man-hysterectomy-on-religious-grounds/.

[70] *See* Lambda Legal 1557 Comments; Brief of Amici Curiae Lambda Legal et al., *Zubik v. Burwell*, 136 S. Ct. 1557 (2016).

[71] *See* Mark Hatzenbuehler, *Structural Stigma: Research Evidence and Implications for Psychological Science*, 71 AM. PSYCHOLOGIST, 742, 742–51 (2016), http://dx.doi.org/10.1037/amp0000068; IOM Report, *supra* n. 45.

respectful acknowledgment of a person's sexual orientation or gender identity.

- Care for patients living with HIV, including the option of pre-exposure prophylaxis (PrEP), a highly effective medication that dramatically reduces the risk of HIV infection among those who are otherwise at high risk, including people who are in a sexual relationship with a partner who is living with HIV.
- Treatment of patients who are unmarried or in a same-sex relationship and require infertility treatment or other medical services related to pregnancy, childbirth or pediatric needs.

In addition, the Proposed Rule threatens to undermine the community's trust in health care providers. Although there may be health care facilities that remain safer places for patients who face increased risk of discrimination in health care facilities, those facilities that are more welcoming of LGBT patients and patients seeking HIV care and willing to provide them with full health care access will become overburdened and increasingly unable to meet the needs of all who come through their doors.

If the number of health care facilities that LGBT people can feel comfortable going to, knowing they won't be turned away is reduced as the inevitable result of this Proposed Rule, access to health care will become harder, and nearly impossible for some, who, for example, are low income[72] or who live in remote areas and cannot travel long distances for medical care. Patients seeking more specialized care such as infertility treatments or HIV treatment or prevention are already often hours away from the closest facility. The Proposed Rule threatens to build even greater barriers between those who are most vulnerable and the health care they need.

For the Proposed Rule to transform the role of HHS from an agency focused on ensuring nondiscriminatory provision of health care to one that facilitates refusals of care is a disturbing about-face contrary to the Department's mission and authorizing statutes. Its failure to explain how the enhanced powers of health care providers to refuse patient care in the name of "conscience" should be reconciled with the protections for patients under the ACA and other statutes, and for employers under Title VII, make clear that this proposal is legally untenable as well as unjustifiably dangerous as a matter of federal health policy.

VI. The Proposed Rule Is The Result Of A Rushed, Truncated Process Contrary To The Department's Mission And Inconsistent With Procedural Requirements.

Considering the well-recognized health disparities and difficulty obtaining nondiscriminatory care that already confront the LGBT community, the Proposed Rule's apparent goal of inviting more discrimination and care denials to LGBT people and is peculiar

[72] Contrary to some misperceptions, LGBT people and people living with HIV are disproportionately economically disadvantaged. *See, e.g.*, M.V. Lee Badgett et al., *New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community*, WILLIAMS INST. (June 2013), https://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/lgbt-poverty-update-june-2013.

and alarming. Indeed, the lack of concern for the Proposed Rule's inevitable impacts is especially shocking because this Department itself has conducted studies revealing disparities in LGBT health outcomes. As reported in the 2014 National Health Statistics Reports:

> [R]ecent studies have examined the health and health care of lesbian, gay, and bisexual (LGB) populations and have found clear disparities among sexual minority groups (i.e., gay or lesbian and bisexual) and between sexual minorities and straight populations. These disparities appear to be broad-ranging, with differences identified for various health conditions (e.g., asthma, diabetes, cardiovascular disease, or disability) … health behaviors such as smoking and heavy drinking … and health care access and service utilization …. Across most of these outcomes, sexual minorities tend to fare worse than their nonminority counterparts.[73]

Thus, in addition to the legal and ethical conflicts it would generate, the Proposed Rule also would undermine HHS's national and local efforts to reduce LGBT health disparities. For example, this Department's "Healthy People 2020 initiative" and the Institute of Medicine have called for steps to be taken to address LGBT health disparities"[74]; medical associations including the American Medical Association, the Association of American Medical Colleges, the American College of Physicians, the American Psychiatric Association, and others are committed to improving medical care for LGBT people through education and cultural competency training; and legislation is increasingly being considered and passed to improve LGBT health access and reduce health disparities.[75] The Proposed Rule endangers the important progress made on this front.

With this Department's past focus on addressing LGBT health disparities, it would be a bizarre and disturbing reversal of course for HHS now to become an active participant in the very denials of health care and discriminatory treatment that cause these disparities. Years of careful study and deliberation went into framing the protections against discrimination implemented pursuant to Section 1557 of the ACA, including the explicit protections against gender identity discrimination and other forms of sex discrimination and the accompanying

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[73] Brian W. Ward et al., *Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013*, Nat'l Health Statistics Report No. 77, 1, (July 15, 2014), https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf.

[74] Dep't of Health & Human Servs., *Healthy People 2020: LGBT Health Topic Area* (2015), http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health; IOM Report.

[75] *See* Timothy Wang et al., The Fenway Inst., *The Current Wave of Anti-LGBT Legislation: Historic Context and Implications for LGBT Health* at 6, 8-9 (June 2016), http://fenwayhealth.org/wp-content/uploads/The-Fenway-Institute-Religious-Exemption-Brief-June-2016.pdf.

value statement that "HHS supports prohibiting sexual orientation discrimination as a matter of policy[.]"[76]

In addition, the Proposed Rule has been issued without adequate time spent considering the thousands of comments submitted on related proposals. It lacks acknowledgment of countervailing interests of patients and many health provider institutions, let alone any explanation of how those interests are to be reconciled with the proposed aggressive enforcement of inconsistent religious interests. All in all, the Department's process has been arbitrary, capricious, and dangerous.[77] Consequently, along with its numerous other legal infirmities, it also violates the Administrative Procedure Act.[78]

VII. Conclusion

The Proposed Rule would have a chilling effect on the full and unbiased provision of health care, including to members of the LGBT community and everyone living with HIV, in a manner that conflicts with ethical, legal, and constitutional standards. While freedom of religion is a fundamental right protected by our Constitution and federal laws, it does not give anyone the right to use religious or moral beliefs as grounds for violating the rights of others. Instead, the Constitution commands that any religious or moral accommodation must be "measured so that it does not override other significant interests" or "impose unjustified burdens on other[s]."[79] Indeed, when the Supreme Court addressed the related question in *Burwell v. Hobby Lobby Stores, Inc.*, it explained that a religious accommodation should be provided in that case because the impact on third parties would be "precisely zero."[80]

Here, the Proposed Rule conflicts with statutory rights of health care providers to operate with reasonable efficiency and cost, and within their ethical obligations to care for patients according to professional standards. Most importantly, it also conflicts with legal and ethical protections for patients, potentially putting their health and even lives at risk. It is ill conceived and has no place in federal health policy.

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[76] Press Release, U.S. Dep't of Health & Human Servs., HHS Finalizes Rule to Improve Health Equity Under the Affordable Care Act (May 13, 2016), https://wayback.archive-it.org/3926/20170127191750/https://www.hhs.gov/about/news/2016/05/13/hhs-finalizes-rule-to-improve-health-equity-under-affordable-care-act.html.

[77] 5 U.S.C.A. § 706(2)(a).

[78] 5 U.S.C.A. § 500 *et seq*.

[79] *Cutter v. Wilkinson*, 544 U.S. 709, 722, 726 (2005).

[80] 134 S. Ct. 2751, 2760 (2014). Indeed, every member of the Court, whether in the majority or in dissent, reaffirmed that the burdens on third parties must be considered. *See id* at 2781 n. 37; *id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790, 2790 n. 8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting).

For the foregoing reasons, we emphatically recommend that the Department set aside this Proposed Rule.

Most respectfully,

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.

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March 26, 2018

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Conscience NPRM, RIN 0945-ZA03
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Protecting Statutory Conscience Rights in Health Care (RIN 0945-ZA03)

The National Center for Lesbian Rights (NCLR) writes to urge that the above-referenced Proposed Rule be withdrawn in its entirety, as it would endanger patient health and encourage widespread discrimination in health care delivery.

NCLR is a non-profit, public interest law firm that litigates precedent-setting cases at the trial and appellate court levels, advocates for equitable public policies affecting the lesbian, gay, bisexual, and transgender (LGBT) community, provides free legal assistance to LGBT people and their advocates, and conducts community education on LGBT issues. NCLR has been advancing the civil and human rights of LGBT people and their families across the United States through litigation, legislation, policy, and public education since its founding in 1977. We also seek to empower individuals and communities to assert their own legal rights and to increase public support for LGBT equality through community and public education. NCLR recognizes the critical importance of access to affordable health care for all people, and is concerned about the increasing use of religious exemptions to undercut civil rights protections and access to services for our community.

Our overarching objections to this Proposed Rule are twofold. First, it strays far from the primary mission of the Department of Health & Human Services. Our nation's premier public health agency should always maintain a focus on protecting the health of all, rather than seeking to empower health care providers to withhold care, in contravention of the core principles of informed consent and adherence to accepted standard of care. Second, it exceeds the agency's authority and was promulgated in violation of the Administrative Procedure Act. We provide further detail below.

I. The Proposed Rule disregards HHS's core mission

The Proposed Rule disregards the health care needs of patients and the core mission of the Department of Health & Human Services (HHS). The purpose of our nation's health care delivery system is to deliver health care to the people of this country. As the nation's largest public health agency, and one that is charged with furthering the health of all Americans, HHS is primarily charged with assisting patients in accessing care and health care providers in

delivering high-quality, culturally-competent care to everyone. Access to care, rather than denials of care, should be the goal. This Proposed Rule, in addition to being on questionable legal ground, focuses exclusively on purported rights of health care providers to turn patients away, with virtually no mention of the impact on patient health and well-being or on how access to care will be ensured. The priorities reflected in the Rule represent a sharp departure from the missions of HHS and its Office for Civil Rights (OCR) and should be withdrawn.

A. HHS should be trying to broaden access, not encourage denials of care

The HHS web site states: "It is the mission of the U.S. Department of Health & Human Services (HHS) to enhance and protect the health and well-being of all Americans. We fulfill that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services" (emphasis added).[1] The Proposed Rule departs significantly from that vision as well as the Office for Civil Rights (OCR's) mission to address health disparities and discrimination that harm patients.[2] Instead, the Proposed Rule appropriates language from civil rights statutes and regulations that were intended to improve access to health care and applies that language to situations for which it was not intended, proposing a regulatory scheme that would be affirmatively harmful to many patients seeking care.

HHS, through OCR, has an important role to play in ensuring equal opportunity to access health care and ending discriminatory practices that contribute to poor health outcomes and health disparities.[3] If finalized, however, the Proposed Rule will undermine HHS's mission of combating discrimination, protecting patient access to care, and eliminating health disparities. Through enforcement of civil rights laws, OCR has in the past worked to reduce discrimination in health care by ending discriminatory practices such as segregation in health care facilities based on race or disability, categorical insurance coverage denials of care for transition-related care, and insurance benefit designs that discriminate against people who are HIV positive, among other things.[4]

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[1] *See* https://www.hhs.gov/about/index.html.

[2] *OCR's Mission and Vision*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/ocr/about-us/leadership/mission-and-vision/index.html ("The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination; and to protect the privacy and security of health information in accordance with applicable law.").

[3] As one of its first official acts in 1967, the Office of Equal Health Opportunity undertook the massive effort of inspecting 3,000 hospitals to ensure they were complying with Title VI's prohibition against discrimination on the basis of race, color, or national origin. 42. U.S.C. § 2000d (1964). After this auspicious start, the Office of Equal Health Opportunity, which would eventually become OCR, would go on to ensure that health programs and activities it regulated complied with key anti-discrimination laws, including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 (1972), the Age Discrimination Act of 1976, 42 U.S.C. § 6101 (1976), and Section 1557 of the Affordable Care Act, 42 U.S.C. §18116 (2010), among others. Through robust enforcement of these laws, OCR has in the past worked to reduce discrimination in health care.

[4] *See, e.g., Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; *Protecting the Civil Rights and Health Information Privacy*

Despite this past progress, there is still much work to be done, and the Proposed Rule would divert limited resources away from ending discrimination. De facto segregation, for example, continues to contribute to poorer health outcomes for Black people. According to one study, over half of the racial disparity in survival for heart attack patients can be attributed to the lower performance of hospitals that serve predominantly people of color.[5] Black women are three to four times more likely than are white women to die during or after childbirth.[6] And the disparity in maternal mortality is growing rather than decreasing,[7] which in part may be due to the reality that women have long been the subject of discrimination in health care and the resultant health disparities. Lesbian, gay, bisexual, and transgender individuals also encounter high rates of discrimination in health care (we discuss this further below).

There is an urgent need for OCR to address these disparities, yet the Proposed Rule seeks instead to prioritize the expansion of existing religious refusal laws beyond their statutory requirements to create new religious exemptions. The Proposed Rule will harm patient care and is antithetical to OCR's mission—to eliminate discriminatory practices that contribute to persistent health inequality.

B. The evidence does not support the existence of the problem the Proposed Rule purports to address

Rather than focusing on the overarching aim of ensuring that all people in this country have access to the health care they need, the Proposed Rule seeks to empower health care providers, whose very jobs are to deliver health care, to instead deny not only health care services but even information about services to which they might personally object. It would create additional barriers to care in a health care system already replete with obstacles, particularly for people with limited incomes or those who are LGBT.

Through prior rulemaking in this area, HHS has already created mechanisms by which any provider who believes they have been subject to discrimination in violation of any of the federal health care refusal statutes may file a complaint with OCR and seek redress. Complaints have been filed and resolved through this process. And HHS has the ability to decline to fund entities that engage in violations of these laws. Individual health care providers who wish to exercise a conscientious objection to participating in certain health care services have the ability to do so and HHS, through OCR, already has the tools it needs to protect those rights. Rather than seeking to engage in a sweeping new rulemaking effort that would inappropriately

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Rights of People Living with HIV/AIDS, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/hiv/index.html; *National Origin Discrimination*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/national-origin/index.html; *Health Disparities*, DEP'T OF HEALTH AND HUMAN SERVS. (2018), https://www.hhs.gov/civil-rights/for-individuals/special-topics/health-disparities/index.html.

[5] *See* Skinner et al., *Mortality after Acute Myocardial Infarction in Hospitals that Disproportionately Treat African-Americans*, NAT'L INSTIT. OF HEALTH 1 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1626584/pdf/nihms13060.pdf.

[6] *See* Nina Martin, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 2017), https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why.

[7] *See id.*

shift the balance too far in the direction of care denial, the agency should instead devote its resources to expanding access to health care for all.

1. Discrimination against LGBT people in health care is pervasive

LGBT people, women, and other vulnerable groups already face significant barriers to getting the care they need.[8] The Proposed Rule will compound the barriers to care that LGBT individuals face, particularly the effects of ongoing and pervasive discrimination, by inviting providers to refuse to provide services and information vital to LGBT health.

As a civil rights organization that has been advocating for the LGBT community for over four decades, we at NCLR see firsthand the negative effects of stigma and discrimination on LGBT people seeking care. Despite significant gains in societal acceptance and legal protections, we still face hostility and ill treatment simply for being who we are, and sometimes the consequences are fatal. For example, NLCR currently represents the parents of a transgender youth who died by suicide after being denied appropriate care and discharged prematurely by a hospital in southern California.[9]

LGBT people of all ages continue to face discrimination in health care on the basis of their sexual orientation and gender identity. The Department's Healthy People 2020 initiative recognizes that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[10] This surfaces in a wide variety of contexts, including physical and mental health care services.[11] In a recent study published in *Health Affairs*, researchers examined the intersection of gender identity, sexual orientation, race, and economic factors in health care access.[12] They concluded that discrimination, as well as insensitivity or disrespect on the part of health care providers, were key barriers to health care access.[13]

There is a growing body of research documenting how LGBT people encounter barriers in the health care system and suffer disproportionately from a variety of conditions due to health care

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[8] *See, e.g.,* Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care; Sandy E. James et al., *The Report of the U.S. Transgender Survey* 93–126 (2016), www.ustranssurvey.org/report; Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx; Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), http://www.lambdalegal.org/publications/when-health-care-isnt-caring.

[9] *See* http://www.nclrights.org/cases-and-policy/cases-and-advocacy/case-prescott-v-rchsd/.

[10] *Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health*, U.S. DEPT. HEALTH & HUMAN SERV., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health, (last accessed on Mar. 8, 2018).

[11] HUMAN RIGHTS WATCH, *All We want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States*, (Feb. 2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[12] Ning Hsieh and Matt Ruther, HEALTH AFFAIRS, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities In Access To Care* (Oct. 2017) 1786–1794.

[13] *Id*.

access issues compounded by stigma and discrimination. In 2010, Lambda Legal found that fifty-six percent of lesbian, gay, and bisexual survey respondents (out of 4,916 total respondents) experienced health-care discrimination in forms such as refusal of health care, excessive precautions used by health-care professionals, and physically rough or abusive behavior by health-care professionals. Seventy percent of transgender and gender nonconforming respondents experienced the same, and sixty-three percent of respondents living with HIV/AIDS had experienced health-care discrimination. In addition, low-income LGBT people and LGBT people of color experienced increased barriers to health care. Approximately seventeen percent of low-income lesbian, gay, and bisexual respondents and twenty-eight percent of low-income transgender respondents reported harsh language from health-care providers compared to under eleven percent of LGB respondents and twenty-one percent of transgender respondents, overall.[14] The 2015 U.S. Transgender Survey found that 23 percent respondents did not see a provider for needed health care because of fears of mistreatment or discrimination.[15]

A recent survey conducted by the Center for American Progress found that among lesbian, gay, bisexual, and queer (LGBQ) respondents who had visited a doctor or health care provider in the year before the survey:

- 8 percent said that a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation;
- 6 percent said that a doctor or other health care provider refused to give them health care related to their actual or perceived sexual orientation;
- 7 percent said that a doctor or other health care provider refused to recognize their family, including a child or a same-sex spouse or partner;
- 9 percent said that a doctor or other health care provider used harsh or abusive language when treating them;
- 7 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[16]

Among transgender people who had visited a doctor or health care providers' office in the past year:

- 29 percent said a doctor or other health care provider refused to see them because of their actual or perceived gender identity;

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[14] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination against LGBT People and People with HIV*, 2010, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isntcaring.pdf.

[15] NAT'L CTR. FOR TRANSGENDER EQUALITY, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[16] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

- 12 percent said a doctor or other health care provider refused to give them health care related to gender transition;
- 23 percent said a doctor or other health care provider intentionally used the wrong name;
- 21 percent said a doctor or other health care provider used harsh or abusive language when treating them;
- 29 percent said that they experienced unwanted physical contact from a doctor or other health care provider (such as fondling, sexual assault, or rape).[17]

When LGBT patients are turned away or refused treatment, it is much harder—and sometimes simply not possible—for them to find a viable alternative. In the CAP study, nearly one in five LGBT people, including 31% of transgender people, said that it would be very difficult or impossible to get the health care they need at another hospital if they were turned away. That rate was substantially higher for LGBT people living in non-metropolitan areas, with 41% reporting that it would be very difficult or impossible to find an alternative provider.[18] For these patients, being turned away by a medical provider is not just an inconvenience: it often means being denied care entirely with nowhere else to go.

Health-care disparities in general are often more pronounced in rural areas in the United States, and this is further compounded for LGBT individuals, often due to a lack of cultural competency. This hinders physical and mental health providers from meeting the health needs of rural communities.[19] The lack of connection to positive, affirming resources also isolates LGBT youth, making them more susceptible to self-destructive behavior patterns.[20] Isolation continues into adulthood, when LGBT populations are more likely to experience depression and engage in high-risk behaviors.[21]

NCLR has been holding convenings of LGBT people in rural communities for the past several years, and we hear consistently about difficulties in accessing adequate health care. The challenges our community faces in these rural settings include having few providers with LGBT competency, difficulty maintaining health insurance coverage due to employment challenges, transportation difficulties to get to what medical providers there are, food deserts, and specific health conditions that are often more prevalent among LGBT people because of having to live with discrimination and social isolation, including poor eating habits, smoking, and substance abuse.

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[17] *Id*.
[18] *Id*.
[19] Cathleen E. Willging, Melina Salvador, and Miria Kano, "Pragmatic Help Seeking: How Sexual and Gender Minority Groups Access Mental Health Care in a Rural State," *Psychiatric Services* 57, no. 6 (June 2006): 871–4, http://doi.org/10.1176/ps.2006.57.6.871.
[20] Colleen S. Poon and Elizabeth M. Saewyc, "Out Yonder: Sexual-Minority Adolescents in Rural Communities in British Columbia," *American Journal of Public Health* 99, no. 1 (January 2009): 118–24, http://doi.org/10.2105/AJPH.2007.122945.
[21] Trish Williams et al., "Peer Victimization, Social Support, and Psychosocial Adjustment of Sexual Minority Adolescents," *Journal of Youth and Adolescence* 34, no. 5 (October 2005): 471–82, https://doi.org/10.1007/s10964-005-7264-x.

In rural areas, if care is denied for religious reasons, there may be no other sources of health and life-preserving medical care.[22] The ability to refuse care to patients would therefore leave many individuals in rural communities with no health care options. Medically underserved areas already exist in every state,[23] with over 75 percent of chief executive officers of rural hospitals reporting physician shortages.[24] Many rural communities experience a wide array of mental health, dental health, and primary care health professional shortages, leaving individuals in rural communities with less access to care that is close, affordable, and high quality, than their urban counterparts.[25]

In addition to geographic challenges, the problems for patients presented by the expansion of refusal provisions in both federal and state law have been exacerbated by the growth in health care systems owned and operated by religious orders. Mergers between Catholic and nonsectarian hospitals have continued as hospital consolidation has intensified. Catholic hospitals and health systems must follow the church's Ethical and Religious Directives for Catholic Health Care Services ("Directives"), which prohibit a wide range of reproductive health services, such as contraception, sterilization, abortion care, and other needed health care.[26] Nonsectarian hospitals must often agree to comply with these Directives in order to merge with Catholic hospitals.[27]

Providers in one 2008 study disclosed that they could not provide the standard of care for managing miscarriages at Catholic hospitals, and as a result, women's care was delayed or they were transferred to other facilities at great risk to their health.[28] The reach of this type of religious refusal of care is growing with the proliferation of religiously affiliated entities that provide health care and related services.[29] New research shows that women of color in many states disproportionately receive their care at Catholic hospitals. In nineteen states, women of color are more likely than are white women to give birth in Catholic hospitals.[30]

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[22] Since 2010, eighty-three rural hospitals have closed. *See Rural Hospital Closures: January 2010 – Present*, THE CECIL G. SHEPS CTR FOR HEALTH SERVS. RES. (2018), http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[23] Health Res. & Serv. Admin, *Quick Maps – Medically Underserved Areas/Populations*, U.S. DEP'T OF HEALTH & HUM. SERV., https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=MUA, (last visited Mar. 21, 2018).

[24] M. MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483/.

[25] Carol Jones et al., *Health Status and Health Care Access of Farm and Rural Populations*, ECON. RESEARCH SERV. (2009), *available at* https://www.ers.usda.gov/publications/pub-details/?pubid=44427.

[26] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf.

[27] Elizabeth B. Deutsch, *Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act's Nondiscrimination Mandate*, 124 Yale L. J. 2470, 2488 (2015).

[28] Lori R. Freedman, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/.

[29] *See, e.g.*, *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, AM. CIVIL LIBERTIES UNION & MERGER WATCH (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[30] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 12 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

Refusals in the context of reproductive health care sometimes run in both directions – they prevent access to contraception and abortion, but also to assisted reproductive technologies (ART) to enable pregnancy. Not only does this infringe on individuals' right to information and care, for those with certain medical conditions it directly contravenes the standard of care. For individuals with cancer, for example, the standard of care includes education and informed consent around fertility preservation, according to the American Society for Clinical Oncology and the Oncology Nursing Society.[31] Refusals to educate patients about or to provide ART, or to facilitate ART when requested, are contrary to the standard of care.

While religiously-based objections to contraception and abortion are well known and have posed access barriers for years, less evident is how these types of refusals can also affect the LGBT community. Not only are LGBT people affected by denials of reproductive health care, other types of medically necessary care, such a transition-related care, are also frequently refused.

Many religious health care providers are opposed to infertility treatments altogether or are opposed to providing it to certain groups of people such as members of the LGBT community.[32] Health care providers have even sought exemptions from state antidiscrimination laws to avoid providing reproductive services to lesbian parents.[33] For example, in one case, an infertility practice group subjected a woman to a year of invasive and costly treatments only to ultimately deny her the infertility treatment that she needed because she is a lesbian.[34] When doctors at the practice group recognized that the woman needed in vitro fertilization to become pregnant, every doctor in the practice refused, claiming that their religious beliefs prevented them from performing the procedure for a lesbian.[35] Because this was the only clinic covered by her health insurance plan, the woman had to pay out-of-pocket for the treatment at another clinic, which subjected her to serious financial harm.

The lack of clarity in the Proposed Rule could lead a hospital or an individual provider to refuse to provide ART to same-sex couples based on religious belief. For some couples, this

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[31] Alison W. Loren et al., *Fertility Preservation for Patients With Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update*, 31 J. CLINICAL ONCOLOGY 2500-10 (July 1, 2013); Ethics Committee of the American Society for Reproductive Medicine, *Fertility preservation and reproduction in patients facing gonadotoxic therapies: a committee opinion*, 100 AM. SOC'Y REPROD. MED. 1224-31 (Nov. 2013), http://www.allianceforfertilitypreservation.org/_assets/pdf/ASRMGuidelines2014.pdf; Joanne Frankel Kelvin, *Fertility Preservation Before Cancer Treatment: Options, Strategies, and Resources*, 20 CLINICAL J. ONCOLOGY NURSING 44-51 (Feb. 2016).

[32] U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH SERVICES 25 (5th ed. 2009), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf. (Directive 41 of the Ethical and Religious Directives for Catholic Health Care states: "Homologous artificial fertilization is prohibited when it separates procreation from the marital act in its unitive significance.")

[33] Douglas Nejaime et al., *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 Yale L.J. 2516, 2518 (2015). *See*, e.g., *N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty. Superior Court*, 189 P.3d 959 (Cal. 2008) (on the potential impact of healthcare refusal laws on same-sex couples).

[34] *Benitez v. N. Coast Women's Care Med. Grp., Inc.*, 106 Cal. App. 4th 978 (2003); *see also* LAMBDA LEGAL, BENITEZ V. NORTH COAST MEDICAL GROUP (Jul. 1, 2001), http://www.lambdalegal.org/in-court/cases/benitez-v-north-coast-womens-care-medical-group.

[35] *Id.*

discrimination would increase the cost and emotional toll of family building. In some parts of the country, however, these refusals would be a complete barrier to parenthood. More broadly, these refusals deny patients the human right and dignity to be able to decide to have children, and cause psychological harm to patients who are already vulnerable because of their health status or their experience of health disparities.

Religiously-based refusals can also result in the denial of other medically necessary care to LGBT people, particularly those who are transgender and in need of gender-affirming services. The following is one example that we learned about through a call to our Legal Help Line:

- Carl,[36] a transgender man, needed to undergo a hysterectomy and oophorectomy as part of his medically-supervised transition. Working with his healthcare providers, Carl obtained insurance coverage for the procedure. His surgeon, who had privileges at several hospitals in the area, scheduled the procedure at the hospital that was nearest to Carl and the surgeon. That hospital happened to be a religiously-affiliated facility. A few days before the procedure was scheduled to occur, Carl was informed that he could not have the procedure done at the hospital. According to the surgeon, the decision was made by the hospital's Ethics Committee. The reason Carl was given for the decision was that "the hospital does not perform that type of hysterectomy." Due to the short notice of the cancellation, the surgeon was unable to get the procedure moved to another hospital.

The foregoing barriers and challenges are evident in the stories we are hearing from NCLR supporters who are alarmed by the prospect of this Rule, including the following comments that have been submitted already to HHS:[37]

- I and many of my community members struggle to afford healthcare as it is, even with full time jobs. I live in a rural area and even if you do have health insurance, access to healthcare is very difficult. I do not see how my sexual orientation, religion, or other parts of me that one might disagree with at a personal level has anything to do with my right to receive healthcare. This regulation, whatever its intentions, will give those who are discriminatory the ability to act on this in a way that can harm the community and disproportionately provide support based on personal differences. I fear this will only further drive people apart.

- As a retired nurse educator I find this proposed rule unethical, immoral, unconscionable & inhumane. All health professionals essentially take an oath to treat & or take care of any person regardless of their race/religion/age/sexual orientation/ethnic background. And women have a right to choose their own reproduction health care. I strongly oppose this rule which promotes discrimination & urge HHS to withdraw it.

[36] This incident was reported to NCLR Legal Help Line attorneys; the name has been changed to protect the caller's privacy.
[37] Some have been edited slightly for length and clarity.

- If this rule is allowed to exist, it will allow emergency room staff to turn away people maimed by car accidents, mass shootings and terrorist attacks. Do you really want to be waiting for life saving care as you are interviewed (interrogated) to determine that you are the "right" sort of person who aligns with a hospital staff member's religious beliefs? You could easily die as you try to prove that you are "worthy" of their care.

- I happen to be a health care provider and I see LGBT people in my practice regularly. I understand the disadvantages they face every day as they go to work, to school, and even at home in their families and communities. Access to health care is a critical problem for many people, and HHS should not be making the problem worse by inviting health care institutions and providers to turn people away based on religious or moral reasons.

- I am a US citizen, I am also Romani Hindu. I am an intersex female and lesbian. I greatly oppose any rules or laws that would allow any person to establish their personal religious views as a means to hold others as a lesser person. This archaic way of thinking does not create a peaceful and free nation. I live in America that is said to be a free nation. Yet I am not free simply because of who I am. I have a difficult time finding the heath care I need because of discrimination. I am a senior citizen of America and have been denied medical care. Giving any person the right to discriminate for any purpose does great harm to an entire country.

- I am an LBGTX woman, married and the mother of two adult children. I travel frequently for work and have paid into my company's health insurance system for over 40 years. While I'm fairly confident that wouldn't be refused treatment locally, the thought that I might be refused treatment during an emergency while I'm traveling because I am a gay woman is both appalling and frightening.

- I am a 75 year-old lesbian living in San Francisco. As an R.N. and an LCSW, I have worked in the healthcare field for my entire adult life. The proposed rule entitled "Protecting Statutory Conscience Rights in Health Care" would give permission to mistreat or not treat an entire group of citizens. This is outrageous! This would be against any oath that a healthcare provider has taken to provide healthcare to all - without exception. An individual's personal opinions or biases have no place in the healthcare field. HHS should not promote discrimination of any kind. I am sure this proposed rule would prove to be unconstitutional if tested in our courts - and it surely would be. This proposed rule should be withdrawn immediately! It's shocking that it's even been suggested.

- In many small communities there is a limited number of health care providers. Allowing this kind of bigotry and prejudice could be life-threatening to any number of people. I know of no religion that preaches withholding life-saving care from anyone. The whole idea of government sponsored bigotry is outrageous and about as un-American as you can get.

- In the last year alone, I had to be taken by ambulance to Emergency Rooms in Northern and Southern California due to a heart issue. I also had to go to an Emergency Room in

Rochester, NY. I dare to think what might have happened to me if the health care providers refused service because my same sex spouse was with me and they "objected" to our relationship.

- I fear we will return to the days where we could be refused health care because of who we love. In 2008, I had to carry legal papers with me to the emergency room so that my partner, before marriage was legal, could be informed about my illness and be involved in making decisions. We were lucky to have a nurse who was also lesbian and while she was on duty I had excellent care. One of my care givers was not happy that I had a female partner and excused himself from the room to send in another therapist a few hours later. We cannot go back, lives are at stake.

- I have personally known people who have come within inches of death from complications due to HIV/AIDS because of the neglect of a doctor based on that doctor's personal beliefs. Discrimination and personal beliefs should not factor in to medical treatment, ever.

- In our community there is a shortage of health care providers to begin with, and if you reduce the number of providers that LGBT people can use, people will die.

- My children (one of whom is still a minor) are part of the LGBTQ community, and your rule would allow physicians to deny them lifesaving medical treatment, should they fall ill or have a medical emergency, such as a car accident or appendicitis, because they are gay or trans. They could die in the waiting area of the ER while someone who would be willing to treat them is located, and brought to the hospital, or in transit to a hospital where someone would treat them. It would allow doctors providing preventative care like pap smears to turn away my trans son, so that he wouldn't be able to find out if he had ovarian cancer until it was too late. Or to deny them vaccines for preventable diseases, or even just the flu. It would allow pharmacists to deny my children a prescription for antibiotics, because they feel morally or religiously opposed to their "lifestyle choices." It could have allowed one of my best friends to die from the heart attack he had a few years ago, because he's married to another man - because he was taken to a Catholic hospital by the ambulance crew. If it happened again, and your rule is in place, that hospital, one of the largest and most comprehensive in coverage in our area, could start turning people away en mass, for simply not being Catholic. In a predominantly Mormon state, that means about half the population.

The fear expressed throughout these comments is palpable. LGBT people are all too familiar with discrimination and hostile treatment, including in health care settings, and inviting health care institutions and providers to turn away people and deny them care would exacerbate the widespread mistreatment experienced by many LGBT people in the health care system today.

2. The Proposed Rule fits a troubling pattern at HHS

We are concerned that this overemphasis on the right to deny care rather than the right to receive it reflects a broader orientation on the part of the agency. In 2017, HHS adopted rules – with no prior public comment – vastly expanding existing religious exemptions from the

ACA's requirement of birth control coverage. This was followed by a Request for Information (RFI) regarding supposed barriers to participation in health care by religious entities, a puzzling choice given the proliferation of religiously affiliated health care systems in this country. The FY 2018 – 2022 HHS Strategic Plan also overemphasized accommodating religious beliefs and moral convictions of health care providers, while failing to mention key populations (like LGBT people) or include any measurable goals, as such a document is supposed to do. Taken together, these issuances from HHS signal an alarming approach to public health, one that elevates the personal religious beliefs of some health care providers far above patients' well-being.

C. The Proposed Rule fails completely to address its impact on patients

The Proposed Rule is silent with regard to the needs of patients and the impact that expanding religious refusals can have on their health. It includes no limitations to its sweeping exemptions that would protect patients' rights under the law and ensure that they receive medically necessary treatment. Any extension of religious accommodation should always be accompanied by equally extensive protections for patients to ensure that their medical needs remain paramount, and that they are able to receive both accurate information and quality health services.

Existing refusals of care based on personal beliefs already undermine open communication between providers and patients, interfere with providers' ability to provide care according to medical standards, and ignore the reality that many providers want to provide comprehensive care.[38] The Proposed Rule would exacerbate these problems by emboldening health care entities and institutions to bind the hands of providers and attempt to limit the types of care they can provide. This has profound implications for the core medical ethical precept of informed consent, and for the ability of health care providers to follow accepted standards of care for their patients.

1. Informed consent

The Proposed Rule threatens informed consent, a necessary principle of patient-centered decision-making. Informed consent relies on disclosure of medically accurate information by providers so that patients can competently and voluntarily make decisions about their medical treatment.[39] This right relies on two factors: access to relevant and medically-accurate information about treatment choices and alternatives, and provider guidance based on generally

[38] *See, e.g.*, Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf; *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/; Julia Kaye, et al., *Health Care Denied*, AM. CIVIL LIBERTIES UNION 1 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf; Catherine Weiss, et al., *Religious Refusals and Reproductive* Rights, AM. CIVIL LIBERTIES UNION (2002), https://www.aclu.org/report/religious-refusals-and-reproductive-rights-report;.

[39] TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); CHARLES LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY (1984).

accepted standards of practice. Both factors make trust between patients and health care professionals a critical component of quality care.

According to the American Medical Association: "The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."[40]The American Nursing Association similarly maintains that patient autonomy and self-determination are core ethical tenets of nursing. "Patients have the moral and legal right to determine what will be done with their own persons; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens and available options in their treatment."[41] Pharmacists are also expected to respect the autonomy and dignity of each patient.[42]

The Proposed Rule purports to improve communication between patients and providers,[43] but in reality it will have the opposite effect, deterring open, honest conversations that are vital to ensuring that a patient is able to be in control of their medical circumstances. Informed consent is intended to address the unequal balance of power between health providers and patients and ensure patient-centered decision-making. Moreover, consent is not a "yes or no" question but rather is dependent upon the patient's understanding of the procedure that is to be conducted and the full range of treatment options for a patient's medical condition. [44] Without informed consent, patients will be unable to make medical decisions that are grounded in agency, their beliefs and preferences, and that meet their personal needs. This is particularly problematic as many communities, including women of color and women living with disabilities, have disproportionately experienced abuse and trauma at the hands of providers and institutions.[45]

In order to ensure that patient decisions are based on free will, informed consent is essential to the patient-provider relationship. The Proposed Rule threatens this principle by inviting

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[40] *The AMA Code of Medical Ethics' Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), http://journalofethics.ama-assn.org/2012/07/coet1-1207.html.
[41] *Code of ethics for nurses with interpretive statements, Provision 1.4 The right to self-determination*, AM. NURSES ASS'N (2001), https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html.
[42] *Code of Ethics for Pharmacists*, AM. PHARMACISTS ASS'N (1994).
[43] 83 Fed. Reg. 3917.
[44] BEAUCHAMP & CHILDRESS, *supra* note 39; Robert Zussman, *Sociological perspectives on medical ethics and decision-making*, 23 ANN. REV. SOC. 171-89 (1997).
[45] Gutierrez, E. R. *Fertile Matters: The Politics of Mexican Origin Women's* Reproduction, 35-54 (2008) (discussing coercive sterilization of Mexican-origin women in Los Angeles); Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 411-12 (2000) (referencing one 1974 study indicating that Indian Health Services would have coercively sterilized approximately 25,000 Native American Women by 1975); Alexandra Minna Stern, *Sterilized in the Name of Public Health*, 95 AM. J. PUB. H. 1128, 1134 (July 2005) (discussing African-American women forced to choose between sterilization and medical care or welfare benefits and Mexican women forcibly sterilized). *See also Buck v. Bell*, 274 U.S. 200, 207 (1927) (upholding state statute permitting compulsory sterilization of "feeble-minded" persons); Vanessa Volz, *A Matter of Choice: Women With Disabilities, Sterilization, and Reproductive Autonomy in the Twenty-First Century*, 27 WOMEN RTS. L. REP. 203 (2006) (discussing sterilization reform statutes that permit sterilization with judicial authorization).

institutions and individual providers to withhold information about services to which they personally object, without regard for the patient's needs or wishes.

2. Standards of care

The Proposed Rule also disregards standards of care established by the medical community by allowing providers to opt out of providing medical care. Medical practice guidelines and standards of care establish the boundaries of medical services that patients can expect to receive and that providers should be expected to deliver. Yet, the Proposed Rule seeks to allow providers and institutions to ignore standards of care, particularly surrounding reproductive and sexual health. Information, counseling, referral and provision of contraceptive and abortion services are not only important services in their own right, they are also part of the standard of care for a range of common medical conditions including heart disease, diabetes, epilepsy, lupus, obesity, and cancer.[46] Allowing providers to flout established medical guidelines and deny medically accurate, evidence-based care to patients harms them and impairs their ability to make the health care decision that is right for them. It is alarming that a public health agency would actively encourage compromising patient health by facilitating departures from accepted standards of care.

A 2007 survey of physicians working at religiously-affiliated hospitals found that nearly one in five (19 percent) experienced a clinical conflict with the religiously-based policies of the hospital.[47] While some of these physicians might refer their patients to another provider who could provide the necessary care, another survey found that as many as one-third of patients (nearly 100 million people) may be receiving care from physicians who do not believe they have any obligations to refer their patients to other providers.[48] Meanwhile, the number of Catholic hospitals in the United States has increased by 22 percent since 2001, and they now control one in six hospital beds across the country.[49] The increase of Catholic hospitals poses a danger for women seeking reliable access to medical services, many of whom do not understand the full range of services that may be denied them. One public opinion survey found

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[46] For example, according to the guidelines of the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Recommendations for women with diabetes of childbearing potential include the following: the incorporation of preconception counseling into routine diabetes care for all adolescents of childbearing potential, discussion of family planning, and the prescription and use of effective contraception by a woman until she is ready to become pregnant. AM. DIABETES ASS'N, STANDARDS OF MEDICAL CARE IN DIABETES-2017, 40 DIABETES CARE § 114-15, S117 (2017), available at http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics guidelines state that the risks to the woman from persistent severe pre-eclampsia are such that delivery (abortion) is usually suggested regardless of fetal age or potential for survival. AM. ACAD. OF PEDIATRICS & AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 232 (7th ed. 2012).

[47] Debra B. Stulberg M.D. M.A., et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, J. GEN. INTERN. MED. 725-30 (2010) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970/.

[48] Farr A. Curlin M.D., et al., *Religion, Conscience, and Controversial Clinical Practices*, NEW ENG. J. MED. 593–600 (2007) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2867473/.

[49] Julia Kaye et al., *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIVIL LIBERTIES UNION 22 (2017), *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.

that, among the less than one-third of women who understood that a Catholic hospital might limit care, only 43 percent expected limited access to contraception, and a mere 6 percent expected limited access to the morning-after pill.[50]

As outlined below, there are significant questions regarding the authority of HHS to enforce the statutes cited in the Proposed Rule in the manner suggested. But even if the types of care denials this rule encourages are ultimately found to contravene federal law, we have grave concerns that the very promulgation of this Rule in its current form will encourage some health care providers and institutions to improperly restrict access to care for LGBT people, those seeking reproductive health care, and others, with harmful consequences. The ability to seek legal redress at a later date is cold comfort to a patient denied essential, even life-saving, care.

II. HHS has failed to establish its authority to issue the Proposed Rule

It is incumbent upon HHS to set forth with specificity the source of its purported authority to engage in this rulemaking, through which it seeks to reinterpret the scope of over two dozen federal statutes by, among other things, redefining key terms and adopting a wider array of enforcement tools. Absent such a detailed showing, the Proposed Rule should be withdrawn because, in addition to representing misguided and dangerous public health policy, it goes well beyond the authority of HHS and is therefore unlawful.

A. HHS has exceeded its rulemaking authority

The Proposed Rule exceeds HHS's authority under the various federal refusal statutes it references and seeks to enforce. An agency may not promulgate regulations that purport to have the force of law without delegated authority from Congress.[51] Yet none of the 25 statutory provisions cited by the Proposed Rule delegates authority to HHS to engage in rulemaking as contemplated in the Proposed Rule. Specifically, nothing within the 25 statutes cited by the Proposed Rule gives HHS the authority to require healthcare entities to provide assurances or certifications, to post the extensive notice included as Appendix A of the Proposed Rule, or to keep and make records available for review.[52] Nor does it give HHS the authority to conduct periodic compliance reviews or to subject healthcare entities to the full investigative process described in Section 88.7 of the Proposed Rule.[53]

The Department draws this purported authority not from the cited statutes but from its desire to implement a regulatory scheme "comparable to the regulatory schemes implementing other civil rights laws."[54] This desire arises from HHS's belief that the 25 cited statutes provide rights

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[50] Nadia Sawicki, *Mandating Disclosure Of Conscience-Based Limitations On Medical Practice*, 42 AM. J. OF LAW & MED. 85-128 (2016) *available at* http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.
[51] *Gonzales v. Oregon*, 546 U.S. 243, 274–75 (2006); *United States v. Mead*, 533 U.S. 218, 229–30 (2001); *Motion Picture Ass'n of Am., Inc. v. FCC*, 309 F.3d 796, 801 (D.C. Cir. 2002); *Amalgamated Transit Union v. Skinner*, 894 F.2d 1362, 1371 (D.C. Cir. 1990)*Pharm. Research & Mfrs. of Am. v. U.S. Dep't of Health & Human Servs.*, 43 F. Supp. 3d 28, 39–40 (D.D.C. 2014).
[52] *See* 83 Fed. Reg. at 3928–30.
[53] *Id.* at 3930–31.
[54] 83 Fed. Reg. 3904.

"akin to other civil rights to be free from discrimination on the basis of race, national origin, disability, etc."[55] Both the plain text and legislative history of these "other civil rights laws" distinguish them from the 25 statutes cited by the Proposed Rule, however. Each of the "other civil rights laws" cited by the Proposed Rule expressly authorizes HHS to promulgate regulations for their uniform implementation.

Title VI of the Civil Rights Act of 1964,[56] for example, which prohibits discrimination on the basis of race, color, or national origin in federal funding, states that "[e]ach Federal department and agency which is empowered to extend Federal financial assistance to any program or activity . . . is authorized and directed to effectuate the provisions of [Title VI] with respect to such program or activity by issuing rules, regulations, or orders of general applicability."[57] Title VI soon became the model for other nondiscrimination laws.[58]

Most recently, in Section 1557 of the Patient Protection and Affordable Care Act of 2009 (ACA), Congress clarified that the protections of Title VI, Title IX, the Age Discrimination Act, and Section 504 of the Rehabilitation Act of 1973 apply to all health programs or activities that receive federal financial assistance.[59] Congress explicitly granted HHS the authority to promulgate regulations to implement Section 1557.[60] Section 1553 of the ACA, which contains one of the refusal provisions cited by the Proposed Rule, does *not* contain such a grant.[61] Rather, Section 1553 gives HHS the authority to "receive complaints of discrimination" based on its provisions.[62] When Congress has explicitly granted an agency rulemaking authority in one section of a statute, the lack of such a grant in another section of the statute clearly indicates that Congress did not intend the agency to exercise rulemaking authority over that section.[63] The ACA conforms to the pattern Congress has followed for the past half-century: When it intends to grant HHS the kind of rulemaking authority claimed by the Proposed Rule, it does so expressly. The lack of such an explicit grant in any of the 25 cited statutes is

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[55] *Id.* at 3903.

[56] 42 U.S.C. 2000d *et seq*.

[57] Pub. L. No. 88-352, Title VI, § 602, 78 Stat. 252 (1964) (codified at 42 U.S.C. § 2000d-1).

[58] Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990, both of which prohibit disability discrimination, explicitly refer to Title VI's enforcement provisions. *See* 29 U.S.C. § 794a(a)(2) (Section 504); 42 U.S.C. § 12133 (ADA). The Age Discrimination Act of 1975 not only permitted but required the Department to promulgate regulations to carry out its nondiscrimination provisions. 42 U.S.C. § 6103(a)(1). Title IX of the Education Amendments Act of 1972, which prohibits sex discrimination in education, contained delegation language that exactly mirrors that of Title VI. 20 U.S.C. § 1682.

[59] *See* Pub. L. 111-148, Title I, § 1557 (2010) (codified at 42 U.S.C. § 18116(a)). Congress did not include conscience protections in Section 1557, strongly implying that it does not see them as being "akin to," 83 Fed. Reg. at 3904, or "on an equal basis" with "other civil rights laws," *id*. at 3896. See *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 600 (2004) (noting that relationship with other federal statutes can be useful in statutory interpretation).

[60] 42 U.S.C. § 18116(c). The Department did so on May 18, 2016. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (to be codified at 45 C.F.R. part 92). The final rule contains no mention of conscience protections.

[61] *See* 42 U.S.C. § 18113.

[62] *Id*.

[63] *See Amalgamated Transit Union*, 894 F.2d at 1371 ("[O]n the few occasions when Congress intended to give UMTA broad rulemaking authority . . . it did so expressly.").

therefore clear evidence that HHS does not have congressional authority to promulgate the Proposed Rule.

B. The Proposed Rule violates the Administrative Procedure Act

Even if HHS could promulgate a rule such as this based on its general authority to engage in rulemaking, that authority is not without limits. Under the Administrative Procedure Act (APA), "agency action, findings, and conclusions found to be… arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," "contrary to a constitutional right," or "in excess of statutory jurisdiction, authority, or limitations" shall be held unlawful and set aside.[64] An agency must provide "adequate reasons" for its rulemaking, in part by "examin[ing] the relevant data and articulat[ing] a satisfactory explanation for its action including a rational connection between the fact found and the choice made."[65] In addition, an agency can only change an existing policy if it provides a "reasoned explanation" for disregarding or overriding the basis for the prior policy.[66]

1. The Proposed Rule is arbitrary and capricious

In promulgating this Proposed Rule, HHS acted in an arbitrary and capricious manner in violation of the APA, and as a result the rule should be withdrawn in its entirety. The Proposed Rule is arbitrary and capricious on a number of grounds.

HHS fails to provide "adequate reasons" or a "satisfactory explanation" for this rulemaking based on the underlying facts and data. As stated in the Proposed Rule itself, between 2008 and November 2016, the Office of Civil Rights received ten complaints alleging violations of federal religious refusal laws; OCR received an additional 34 such complaints between November 2016 and January 2018. By comparison, during a similar time period from fall 2016 to fall 2017, OCR received *over 30,000 complaints* alleging either civil rights or HIPAA violations. These numbers demonstrate that rulemaking to enhance enforcement authority over religious refusal laws is not warranted.

HHS also fails to adequately assess the costs imposed by this Proposed Rule, both by underestimating quantifiable costs, and by neglecting to address the costs that would result from delayed or denied care. Under Executive Order 12866, when engaging in rulemaking, "each agency shall assess both the costs and the benefits of the intended regulation and, recognizing that some costs and benefits are difficult to quantify, propose or adopt a regulation only upon a reasoned determination that the benefits of the intended regulation justify the costs."[67] Under Executive Order 13563, an agency must "tailor its regulations to impose the least burden on society" and choose "approaches that maximize net benefits (including

[64] 5 U.S.C. § 706(2)(A), (B), (C).
[65] *Encino Motorcars, LLC v. Navarro*, 136 S.Ct. 2117, 2125 (June 20, 2016) (citing *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 103 (1983)).
[66] *Id*. at 2125-26.
[67] Executive Order 12866 on Regulatory Planning and Review (September 30, 1993).

potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[68]

HHS has failed to take the appropriate steps to ensure that the Proposed Rule is consistent with applicable law and does not conflict with the policies or actions of other agencies. Under Executive Order 12866, in order to ensure that agencies does not promulgate regulations that are "inconsistent, incompatible, or duplicative with its other regulations of those of other Federal agencies," each agency must include any significant regulatory actions in the Unified Regulatory Agenda.[69] HHS failed to include any reference to this significant regulation in its regulatory plans, and therefore failed to put impacted entities, including other federal agencies, on notice of possible rulemaking in this area. In addition, prior to publication in the Federal Register, the Proposed Rule must be submitted to the Office of Information and Regulatory Affairs (OIRA), within the Office of Management and Budget (OMB), to provide "meaningful guidance and oversight so that each agency's regulatory actions are consistent with applicable law, the President's priorities, and the principles set forth in this Executive order [12866] and do not conflict with the policies or actions of another agency."[70] According to OIRA's website, HHS submitted the Proposed Rule to OIRA for review on January 12, 2018, one week prior to the Proposed Rule being published in the Federal Register. Standard review time for OIRA is often between 45 and 90 days; one week was plainly insufficient time for OIRA to review the rule, including evaluating the paperwork burdens associated with implementing it. In addition, it is extremely unlikely that within that one week timeframe, OIRA could or would have conducted the interagency review necessary to ensure that this Proposed Rule does not conflict with other federal statutes or regulations.

The timing of the Proposed Rule also illustrates a lack of sufficient consideration. The Proposed Rule was published just two months after the close of a public comment period for a Request for Information closely related to this Rule.[71] The 12,000-plus public comments were not all posted until mid-December, one month before this Proposed Rule was released. Nearly all of the comments submitted at that time related to the subjects covered by the Proposed Rule—namely, the refusal of care by federally funded health care institutions or their employees on the basis of personal beliefs. This short period of time calls into question the comprehensiveness of the review of the Request for Information and whether the Proposed Rule was developed in an arbitrary and capricious manner.

The Proposed Rule also conflicts with several key federal statutes, as well as the U.S. Constitution. It makes no mention of Title VII,[72] the leading federal law barring employment discrimination, or current Equal Employment Opportunity Commission (EEOC) guidance on Title VII.[73] With respect to religion, Title VII requires reasonable accommodation of

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[68] Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Sec. 1 (b).
[69] Executive Order 12866, at Sec. 4(b),(c).
[70] *Id*. at Sec. 6(b).
[71] "Removing Barriers for Religious and Faith-Based Organizations To Participate in HHS Programs and Receive Public Funding," 82 Fed. Reg. 49300 (Oct. 25, 2017).
[72] 42 U.S.C. § 2000e-2 (1964).
[73] *Title VII of the Civil Rights Act of 1964*, U.S. EQUAL EMP'T. OPPORTUNITY COMM'N (2018), https://www.eeoc.gov/laws/statutes/titlevii.cfm.

employees' or applicants' sincerely held religious beliefs, observances, and practices when requested, unless the accommodation would impose an "undue hardship" on an employer.[74] For decades, Title VII has established the legal framework for religious accommodations in the workplace. When a health care worker requests an accommodation, Title VII ensures that employers can consider the effect an accommodation would have on patients, coworkers, public safety, and other legal obligations. The Proposed Rule, however, sets out an entirely different and conflicting standard, leaving health care employers in the impossible position of being subject to and trying to satisfy both. Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel filed comments that raised similar concerns and stated clearly that Title VII should remain the relevant legal standard.[75]

Furthermore, the language in the Proposed Rule could put health care entities in the untenable position of being forced to hire people who intend to refuse to perform essential elements of the job for which they are being hired. For example, there is no guidance about whether it is impermissible "discrimination" for a Title X-funded health center not to hire a counselor or clinician whose essential job functions would include counseling women with positive pregnancy tests because the applicant refuses to provide non-directive options counseling. It is not only nonsensical for a health care entity to be forced to hire someone it knows will refuse to fulfill essential job functions, but it would also foster confusion by imposing duties on employers far beyond Title VII and current EEOC guidance.

The Proposed Rule also conflicts with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires hospitals that have a Medicare provider agreement and an emergency room or department to provide to anyone requesting treatment an appropriate medical screening to determine whether an emergency medical condition exists, and to stabilize the condition or if medically warranted to transfer the person to another facility.[76] Under EMTALA every hospital is required to comply – even those that are religiously affiliated.[77] Because the Proposed Rule does not mention EMTALA or contain an explicit exception for emergencies, some institutions may believe they are not required to comply with EMTALA's requirements. This could result in patients in emergency circumstances – such as those experiencing an ectopic pregnancy or miscarriage - not receiving necessary care. The Proposed Rule fails to explain how entities will be able to comply with the new regulatory requirements in a manner consistent with the statutory requirements of EMTALA, making the Proposed Rule unworkable.

Finally, the Establishment Clause of the First Amendment requires the government to adequately account for just these sorts of consequences when considering whether to grant

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[74] *See id.*

[75] Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), *available at* https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html.

[76] *See* 42 U.S.C. s 1295dd(a)-(c)

[77] *See, e.g.*, *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220, 228 (3rd Cir. 2000); In In re Baby K, 16 F.3d 590, 597 (4th Cir. 1994); *Nonsen v. Medical Staffing Network, Inc.* 2006 WL 1529664 (W.D. Wis.); *Grant v. Fairview Hosp.*, 2004 WL 326694, 93 Fair Empl. Prac. Cas. (BNA) 685 (D. Minn. 2006); *Brownfield v. Daniel Freeman Marina Hosp.*, 208 Cal. App. 3d 405 (Ca. Ct. App. 1989); *Barris v. County of Los Angeles*, 972 P.2d 966, 972 (Cal. 1999).

religious exemptions to existing legal requirements and, in fact, bars granting an exemption when it would detrimentally affect any third party.[78] It requires an agency to "take adequate account of the burdens" that an exemption "may impose on nonbeneficiaries" and must ensure that any exemption is "measured so that it does not override other significant interests."[79] The proposed exemptions clearly impose burdens on and harm others and thus, violate the clear mandate of the Establishment Clause.

In promulgating a regulation that is inconsistent with federal statutes and regulations, as well as the Constitution, HHS engaged in arbitrary and capricious rulemaking, and its conduct was further compounded by a failure by OIRA to engage in appropriate oversight and review. For these reasons, the Proposed Rule should be withdrawn.

2. The Proposed Rule is not in accordance with law and exceeds statutory authority

The Proposed Rule is also not in accordance with law because much of its language exceeds the plain parameters and intent of the underlying statutes it purports to enforce. It defines common phrases and words used throughout existing refusals of care laws and civil rights laws in ways that stretch their intended meaning beyond recognition. Therefore, the Proposed Rule violates the APA and should be withdrawn.

For example, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization.[80] The statute does not contain a definition for the phrase "assist in the performance." Instead the Proposed Rule creates a definition, but one that is not in accordance with the Church Amendments themselves. The proposed definition includes participation "in any activity with an *articulable connection* to a procedure, health service or health service program, or research activity" and greatly expands the types of services that can be refused to include merely "making arrangements for the procedure" no matter how tangential.[81] This means individuals not "assisting in the performance" of a procedure within the ordinary meaning of the term, such as the hospital room scheduler, the technician charged with cleaning surgical instruments, and other hospital employees, could now assert a new right to refuse. As Senator Church stated from the floor of the Senate during debate on the Church Amendments: "The amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal

[78] U.S. Const. amend. I; *Cutter v. Wilkinson*. 554 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 18 n.8 (1989); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[79] *Cutter*, 544 U.S. at 720, 722; see also *Thornton*, 472 U.S. at 709-10.
[80] 42 USC 300a-7.
[81] 83 Fed. Reg. 3892.

to perform what would otherwise be a legal operation."[82] This overly broad definition opens the door for religious and moral refusals from precisely the type of individuals that the amendment's sponsor himself sought to exclude. This arbitrary and capricious broadening of the amendment's scope goes far beyond what was envisioned when the Church Amendments were enacted.

If workers in very tangential positions, such as schedulers, are able to refuse to do their jobs based on personal beliefs, the ability of any health system or entity to plan, to properly staff, and to deliver quality care will be undermined. Employers and medical staff may be stymied in their ability to establish protocols, policies and procedures under these vague and broad definitions. The Proposed Rule creates the potential for a wide range of workers to interfere with and interrupt the delivery of health care in accordance with applicable standards of care.

The definition of "referral" similarly goes beyond any understanding of the term, allowing refusals to provide any information based on which an individual could get the care they need.[83] Any information distributed by any method, including online or print, regarding any service, procedure, or activity could be refused by an individual or entity if the information given would lead to a service, activity, or procedure to which the provider objects.

Under the Coats and Weldon Amendments, "health care entity" is defined to encompass a limited and specific range of individuals and entities involved in the delivery of health care.[84] The Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term.[85] Such an attempt to expand the meaning of a statutory term Congress already took the time to define not only fosters confusion, but contravenes congressional intent. By expressly defining the term "health care entity" Congress implicitly rejected the inclusion of the other terms HHS now attempts to insert.[86]

The Proposed Rule defines workforce to include "volunteers, trainees or other members or agents of a covered entity, broadly defined when the conduct of the person is under the control of such entity."[87] Under this definition, virtually any member of the health care workforce could ostensibly refuse to serve a patient in any way.

The Weldon Amendment is expanded under the Proposed Rule by defining "discrimination" against a health care entity broadly to include a number of activities, including denying a grant

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[82] S9597, https://www.gpo.gov/fdsys/pkg/GPO-CRECB-1973-pt8/pdf/GPO-CRECB-1973-pt8.pdf (emphasis added). Senator Church went on to reiterate that "[t]his amendment makes it clear that Congress does not intend to compel the courts to construe the law as coercing religious affiliated hospitals, doctors, or nurses to perform surgical procedures against which they may have religious or moral objection." S9601 (emphasis added).
[83] 83 Fed. Reg. 3895.
[84] The Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009); Public Health Service Act, 42 U.S.C. § 238n (2018).
[85] 83 Fed. Reg. 3893.
[86] The doctrine of expressio unius est exclusio alterius (the expression of one thing implies the exclusion of others) as applied to statutory interpretation creates a presumption that when a statute designates certain persons, things, or manners of operation, all omissions should be understood as exclusions.
[87] 83 Fed. Reg. 3894.

or employment as well as an unspecified catch-all phrase "any activity reasonably regarded as discrimination."[88] Such a vague and inappropriate definition provides no functional guidance to entities on how to comply with the applicable requirements, thereby fostering confusion and undermining non-discrimination laws. Because of the potential harm to individuals if religious refusals were allowed, courts have long rejected arguments that religiously affiliated organizations can opt out of anti-discrimination requirements.[89] Instead, courts have held that the government has a compelling interest in ending discrimination and that anti-discrimination statutes are the least restrictive means of doing so. Indeed, the majority opinion in *Burwell v. Hobby Lobby Stores, Inc.* makes it clear that the decision should not be used as a "shield" to escape legal sanction for discrimination in hiring on the basis of race, because such prohibitions further a "compelling interest in providing an equal opportunity to participate in the workforce without regard to race," and are narrowly tailored to meet that "critical goal."[90] In seeking to craft a regulatory scheme mirroring "other civil rights laws," HHS is in fact hampering enforcement of the very civil rights laws it claims to be emulating.

Moreover, the Proposed Rule states that the exemptions that Weldon provides is not limited to refusals of abortion care on the basis of religious or moral beliefs – the denial may be for any reason at all.[91] The preamble uses language such as "those who choose not to provide" or "would rather not" as justification for a refusal. This unbounded license to deny care is made more dangerous by the fact that the Proposed Rule contains no mechanism to ensure that patients receive the care they need if their provider refuses to furnish a service. The onus will be on the patient to question whether her hospital, medical doctor, or health care professional has religious, moral, or other beliefs that would lead them to deny services, or if services were denied, the basis for refusal. The Proposed Rule does not have any provisions that stipulate that patients must be given notice that they may be refused certain health care services on the basis of religious or moral beliefs.

The Proposed Rule also purports to equip OCR with a range of enforcement tools that it in fact lacks the authority to employ, including referring matters to the Department of Justice "for additional enforcement,"[92] something not contemplated within any of the statutes referenced in the Proposed Rule. These measures, combined with the impermissibly broad definitions and other inappropriately expansive interpretations of the underlying statutes, would have a chilling effect on the provision of a range of medically necessary health care services.

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[88] 83 Fed. Reg. 3892.

[89] *See, e.g., Bob Jones Univ. v. United States*, 461 U.S. 574 (1983) (holding that the government's interest in eliminating racial discrimination in education outweighed any burdens on religious beliefs imposed by Treasury Department regulations); *Newman v. Piggie Park Enters., Inc.*, 390 U.S. 400 (1968) (holding that a restaurant owner could not refuse to comply with the Civil Rights Act of 1964 and not serve African-American customers based on his religious beliefs); *Dole v. Shenandoah Baptist Church*, 899 F.2d 1389, 1392 (4th Cir. 1990) (holding a religious school could not compensate women less than men based on the belief that "the Bible clearly teaches that the husband is the head of the house, head of the wife, head of the family"); *Hamilton v. Southland Christian Sch., Inc.*, 680 F.3d 1316 (11th Cir. 2012) (reversing summary judgment for religious school that claimed a religious right to fire teacher for becoming pregnant outside of marriage).

[90] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, slip op. at 46 (2014).

[91] 83 Fed. Reg. 3890-91.

[92] 83 Fed. Reg. 3898.

Conclusion

The Proposed Rule departs from the core mission of HHS, would undermine patient care, and is contrary to law. We therefore urge that it be withdrawn.

If you have any questions regarding these comments, please contact Julianna S. Gonen, PhD, JD, NCLR Policy Director, at jgonen@nclrights.org or 202-734-3547.

National Center for Lesbian Rights

NCTE Cmt.

National Center for TRANSGENDER EQUALITY

March 27, 2018

Office for Civil Rights, U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: NPRM on Religious Exemptions for Health Care Entities (RIN 0945-ZA03)

To Whom It May Concern:

The National Center for Transgender Equality (NCTE) submits the following comments to express our strong opposition to expanding exemptions for health care entities based on religious or moral objections.

Founded in 2003, NCTE is one of the nation's leading social justice organizations working for life-saving change for the over 1.5 million transgender Americans and their families. Over our years of advocacy, we have time and again seen the harmful impact that discrimination in health care settings has on transgender people and their loved ones, including discrimination based on religious or moral disapproval of who transgender people are and how they live their lives. Our experience has shown us that discrimination against transgender people in health care—whether it is being turned away from a doctor's office or emergency room, being denied access to basic care, or being mistreated and degraded simply because of one's transgender status—is widespread and creates significant barriers to care. The sweeping and excessive expansions to religious and moral exemptions sought by this rule go far beyond established law and threaten to severely exacerbate the barriers to care that transgender people and other vulnerable patient populations face.

We deeply respect and value freedom of religion, which is already protected by our Constitution, numerous federal statutes, and existing Department regulations. But refusing or obstructing access to medical care is a perversion of that cherished principle. In health care, patients must come first. By opening the door to health care refusals that go far beyond those permitted under federal law, this rule is harmful, unnecessary, and unsupported by federal law, and it would undermine the critical purposes of the Department's programs and the civil rights laws it is responsible for enforcing.

Simply put, the proposed rule is contrary to law and would harm patients. We urge the Department to reject this harmful and unnecessary rule.

I. Expanding religion-based exemptions can exacerbate the barriers to service access that transgender people and other vulnerable populations face.

For many Americans, including transgender Americans, discrimination in health care settings remains a grave and widespread problem and contributes to a wide range of health disparities. The proposed rule

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would exacerbate this urgent problem by encouraging actions that deny or obstruct access to timely medical care.

A. Transgender people face widespread discrimination in health care settings.

An estimated 0.6% of the U.S. adult population is transgender, representing 1.4 million adults over the age of 18, as well as hundreds of thousands of young Americans.[1] The medical and scientific community overwhelmingly recognizes that a person's innate experience of gender is an inherent aspect of the human experience for all people, including transgender people.[2] For example, the American Psychological Association states that having "deeply felt, inherent" gender identity that is different from the gender one was thought to be at birth is part of "healthy and normative" range of variation in human development found across cultures and across history.[3] The Department has previously recognized that "variations in gender identity and expression are part of the normal spectrum of human diversity."[4]

Many, though not all, transgender people experience a medical condition known as gender dysphoria. Gender dysphoria is a serious medical condition that is codified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5), which defines it as clinically significant distress or impairment related to an incongruence between one's experienced gender and the gender one was thought to be at birth.[5] Like anyone, transgender people need preventive care to stay healthy and acute care when they become sick or injured. Some may also need medical care to treat gender dysphoria. Under the treatment protocol widely accepted by the medical community, medically necessary treatment for gender dysphoria may require steps to help an individual transition from living as one gender to another.[6] This treatment, sometimes referred to as "transition-related care," may include

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[1] Andrew R. Flores et al., *How Many Adults Identify as Transgender in the United States?* (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf. *See also* Jody L. Herman et al. *Age of Individuals who Identify as Transgender in the United States* (2017), https://williamsinstitute.law.ucla.edu/wp-content/uploads/TransAgeReport.pdf (estimating that 0.7% of people in the United States between the ages of 13 and 17, or 150,000 adolescents, are transgender).

[2] *See, e.g.*, Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 AMERICAN PSYCHOLOGIST 832, 834-35 (2015), https://www.apa.org/practice/guidelines/transgender.pdf; Brief of American Academy of Pediatrics, American Psychiatric Association, American College of Physicians, and 17 Additional Medical and Mental Health Organizations in Support of Respondent, *G. G. v. Gloucester County Sch. Bd.,* No. 16-274 8–9 (Sup. Ct. *filed* March 2, 2017) (affirming that "[e]veryone—whether they are transgender or cisgender—develops awareness of their gender identity along a 'pathway'" with typical stages and that transgender identity is a normal variation of this development); Human Rights Campaign, Am. Acad. of Pediatrics, & Am. College of Osteopathic Pediatricians, *Supporting & Caring for Transgender Children* (2016), https://assets2.hrc.org/files/documents/SupportingCaringforTransChildren.pdf; World Prof. Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 16 (7th ed. 2011), https://www.wpath.org/publications/soc.

[3] Am. Psychological Ass'n, Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, *e*, 70(9):832, 834-35 (2015).

[4] Substance Abuse & Mental Health Servs., *Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth* 1 (2015), https://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf.

[5] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 452 (5th ed. 2013).

[6] *See generally* World Prof. Ass'n for Transgender Health, *supra* note 2; Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM 3869 (2017). *See also* Am. Medical Ass'n, *AMA Policies on GLBT Issues, Patient-Centered Policy H-185.950, Removing Financial Barriers to Care for Transgender Patients* (2008), http://www.imatyfa.org/assets/ama122.pdf (recognizing WPATH *Standards* as "internationally accepted"); Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012),

counseling, hormone therapy, and/or a variety of possible surgical treatments, depending on the individualized needs of each patient.[7] It is the overwhelming consensus among major medical organizations—including the American Medical Association,[8] the American College of Physicians,[9] the American Psychological Association,[10] the American Psychiatric Association,[11] the American Academy of Family Physicians,[12] the Endocrine Society,[13] the American College of Obstetricians and Gynecologists,[14] and the World Professional Association for Transgender Health[15]—that transition-related treatments are medically necessary, effective, and safe when clinically indicated to alleviate gender dysphoria. For example, the American Psychiatric Association "[a]dvocates for removal of barriers to care…for gender transition treatment," emphasizing that "[s]ignificant and long-standing medical and psychiatric literature exists that demonstrates clear benefits of medical and surgical interventions to gender variant individuals seeking transition" and "[a]ccess to medical care (both medical and surgical) positively impacts the mental health of transgender and gender variant individuals."[16] Numerous studies and meta-analyses have demonstrated the significant benefits of transition-related care in the treatment of gender dysphoria.[17] Indeed, transition-related treatments are the only treatments that have been demonstrated to be effective in treating gender dysphoria.[18]

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http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06d_APA_ps2012_Transgen_Disc.pdf (citing WPATH *Standards*); Am. Psychological Ass'n, *Policy on Transgender, Gender Identity & Gender Expression Non-Discrimination* (2008), http://www.apa.org/about/policy/transgender.aspx (same).

[7] *See* World Prof. Ass'n for Transgender Health, *supra* note 2 at 16.

[8] Am. Medical Ass'n, *supra* note 6.

[9] Am. College of Physicians, *Lesbian, Gay, Bisexual and Transgender Health Disparities: A Policy Position Paper from the American College of Physicians*, 163 ANNALS OF INTERNAL MEDICINE 135, 140 (2015).

[10] Am. Psychological Ass'n, *supra* note 6.

[11] Am. Psychiatric Ass'n, *supra* note 6.

[12] Am. Acad. of Family Physicians, *Resolution No. 1004: Transgender Care* (2012), https://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf.

[13] Hembree et al., *supra* note 6.

[14] Am. College of Obstetricians & Gynecologists, *Committee Opinion No. 512: Health Care for Transgender Individuals*, 118 OBSTETRICS & GYNECOLOGY 1454 (2011), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Care-for-Transgender-Individuals.

[15] World Prof. Ass'n for Transgender Health, *supra* note 2.

[16] Am. Psychiatric Ass'n, *supra* note 6.

[17] *See, e.g.*, Ashli A. Owen-Smith, et al., *Association Between Gender Confirmation Treatments and Perceived Gender Congruence, Body Image Satisfaction, and Mental Health in a Cohort of Transgender Individuals*. J SEXUAL MEDICINE (Jan. 17 2018); Gemma L. Witcomb et al., *Levels of Depression in Transgender People and its Predictors: Results of a Large Matched Control Study with Transgender People Accessing Clinical Services*, J. AFFECTIVE DISORDERS (Feb. 2018) Cecilia Dhejne et al., *Mental Health and Gender Dysphoria: A Review of the Literature*, 28 INT'L REV. PSYCHIATRY 44 (2016); William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES OF SEXUAL BEHAVIOR 759 (2012); Marco Colizzi, Rosalia Costa, & Orlando Todarello, *Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from a Longitudinal Study*, 39 PSYCHONEUROENDOCRINOLOGY 65 (2014); Audrey Gorin-Lazard et al., *Hormonal Therapy is Associated with Better Self-Esteem, Mood, and Quality of Life in Transsexuals*, 201 J. NERVOUS & MENTAL DISORDERS 996 (2013); M. Hussan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY 214 (2010); Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 ARCHIVES OF SEXUAL BEHAVIOR 679 (2005); Giuloio Garaffa, Nim A. Christopher, & David J. Ralph, *Total Phallic Reconstruction in Female-to-Male Transsexuals*, 57 EUROPEAN UROLOGY 715 (2010); Caroline Klein & Boris B. Gorzalka, *Sexual Functioning in Transsexuals Following Hormone Therapy and Genital Surgery: A Review*, 6 J. SEXUAL MEDICINE 2922 (2009).

[18] *See, e.g.,* Substance Abuse & Mental Health Servs., *supra* note 3.

Despite the medical consensus regarding the necessity of transition-related care, many transgender people have struggled to get access to medically necessary care—including care recommended to treat gender dysphoria, as well as medical care for unrelated conditions. Numerous studies have documented the widespread and pervasive discrimination experienced by transgender people and their families in the health care system. For example, the 2015 U.S. Transgender Survey, a national study of nearly 28,000 transgender adults in the United States, found that:

- Just in the year prior to taking the survey, one-third (33%) of respondents who saw *any health care provider* during that year were turned away because of being transgender, denied treatment, physically or sexually assaulted in a health care setting, or faced another form of mistreatment or discrimination due to being transgender.[19]
- In the year prior to taking the survey, nearly one-quarter (22%) of respondents who visited a *drug or alcohol treatment program* where staff thought or knew they were transgender were denied equal treatment or service, verbally harassed, or physically assaulted there due to being transgender.[20]
- In the year prior to taking the survey, 14% of respondents who visited a *nursing home or extended care facility* where staff thought or knew they were transgender were denied equal treatment or service, verbally harassed, or physically assaulted there due to being transgender.[21]
- In the year prior to taking the survey, one-quarter (25%) of respondents *experienced a problem with their health insurance* related to being transgender. This included being denied coverage for treatments for gender dysphoria as well as being denied coverage for a range of unrelated conditions simply because they are transgender.[22]
- In the year prior to taking the survey, 23% of respondents *avoided seeking medical care* when they needed it because of fear of being mistreated, and 33% avoided seeking necessary health care because they could not afford it.[23]

The 2015 U.S. Transgender Survey also revealed patterns of marked health disparities affecting respondents. Respondents were approximately five times more likely than the general population to have been diagnosed with HIV, with elevated rates among people of color and in particular among Black transgender women, who were over 60 times more likely to be living with HIV than the general population.[24] Standard questions based on the K-6 Kessler Psychological Distress Scale revealed that transgender respondents were approximately eight times more likely than the general population to have experienced serious psychological distress in the month prior to taking the survey.[25] Further, respondents were nearly twelve times more likely to have attempted suicide in the previous year than the general population.[26] Rates of suicide attempts and psychological distress were particularly high among respondents who had faced barriers to accessing medical care and anti-transgender discrimination in health care and other settings.

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[19] Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 96–97 (2016), www.ustranssurvey.org/report.
[20] *Id.* at 216.
[21] *Id.* at 219.
[22] *Id.* at 95.
[23] *Id.* at 98.
[24] *Id.* at 122.
[25] *Id.* at 105.
[26] *Id.* at 112.

Similarly, a nationally representative 2017 study found that transgender respondents faced high rates of discrimination in health care settings.[27] Out of those who had visited a doctor or health care provider in the previous year:

- Nearly one-third (29%) reported that a health care provider refused to see them because of their actual or perceived gender identity.
- One in eight (12%) said that a health care provider refused to provide them with care related to gender dysphoria.
- More than one in five (21%) said that a health care provider used harsh or abusive language when treating them.
- Nearly one-third (29%) experienced unwanted physical contact or sexual assault by a health care provider.

For many transgender people, especially those living outside of metropolitan areas, simply finding a different provider is not a viable option. Many transgender respondents to the 2017 study reported that it would be very difficult or impossible for them to find alternative providers to get the care they need if they were turned away by a health care provider. For example, nearly one-third (31%) of transgender respondents said it would be "very difficult" or "not possible" to find the same type of service at a different hospital and 30% said it would be "very difficult" or "not possible" to find the same type of service at a different community health center or clinic.[28]

Health disparities facing transgender people have been recognized in a major 2011 report of the National Academy of Medicine (then the Institute of Medicine),[29] and by the Department's Healthy People 2020 initiative.[30] These disparities do not reflect inherent pathology; as the American Psychiatric Association has stated, "[b]eing transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression."[31] Discrimination and barriers to care exacerbate the marked health disparities affecting transgender individuals,[32] including by increasing transgender people's risk factors for poor physical and mental

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[27] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2016), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care.

[28] *Id*.

[29] Inst. of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.

[30] Dep't of Health & Human Servs., *Healthy People 2020: LGBT Health Topic Area* (2015), http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health ("LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights.")

[31] Am. Psychiatric Ass'n, *supra* note 6.

[32] See, e.g., Ilan H. Meyer et al., *Demographic Characteristics and Health Status of Transgender Adults in Select US Regions: Behavioral Risk Factor Surveillance System, 2014*, 107 AM. J. PUB. HEALTH 582 (2017); Joint Comm'n, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide* (2011), http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf.

health[33] and driving high rates of HIV.[34] Numerous studies have found that when transgender people are supported in their environment, including by accessing the health care they need without discrimination, the health disparities they experience decrease substantially.[35]

As leading medical organizations such as American Medical Association[36] and the American Psychological Association[37] have emphasized, robust laws protecting patients from discrimination are essential in addressing these disparities and reducing the barriers to care facing millions of Americans, including transgender Americans, while expanding religious exemptions can dangerously exacerbate those barriers to care. In response to the Department's recent Request for Information regarding "Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding," numerous medical organizations expressed concerns with expanding religious exemptions in health care, including the American Psychiatric Association,[38] the American Psychological Association,[39] the American Medical Association,[40] the American Academy of Pediatrics,[41] and the American Academy of Nursing.[42]

B. Other vulnerable populations, including women, lesbian, gay, and bisexual people, communities of color, people with disabilities, and people with limited English proficiency, struggle to access adequate care.

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[33] Ctrs. for Disease Control & Prevention, *Lesbian, Gay, Bisexual, and Transgender Health* (2014), http://www.cdc.gov/lgbthealth/about.htm.

[34] Ctrs. for Disease Control & Prevention, *HIV and Transgender Communities* (2016), https://www.cdc.gov/hiv/pdf/policies/cdc-hiv-transgender-brief.pdf.

[35] *See, e.g.,* Lily Durwood, Katie A. McLaughlin, & Kristina R. Olson, *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, 56 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 116 (2017); Kristina R. Olson et al., *Mental Health of Transgender Children Who Are Supported in Their Identities*, 137 PEDIATRICS (2016); Annelou L. C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS (2014).

[36] Am. Medical Ass'n, *Letter to Director Roger Severino* (Sept. 1, 2017), https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2017-09-01_Letter-to-Severino-re-Section-1557-Identity-Protection.pdf.

[37] Am. Psychological Ass'n, Comment Letter on Request for Information on Patient Protection and Affordable Care Act: Reducing Regulatory Burdens and Improving Health Care Choices to Empower Patients (July 12, 2017), https://www.regulations.gov/document?D=CMS-2017-0078-2528.

[38] Am. Psychiatric Ass'n, Comment Letter on Request for Information on Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding (Nov. 22, 2017), https://www.regulations.gov/document?D=HHS-OS-2017-0002-10700.

[39] Am. Psychological Ass'n, Comment Letter on Request for Information on Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding (Nov. 21, 2017), https://www.regulations.gov/document?D=HHS-OS-2017-0002-8429.

[40] Am. Medical Ass'n, Comment Letter on Request for Information on Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding (Nov. 17, 2017), https://www.regulations.gov/document?D=HHS-OS-2017-0002-7327https://www.regulations.gov/document?D=HHS-OS-2017-0002-7327.

[41] Am. Acad. of Pediatrics, Comment Letter on Request for Information on Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding (Nov. 21, 2017), https://www.regulations.gov/document?D=HHS-OS-2017-0002-12098.

[42] Am. Academy of Nursing, Comment Letter on Request for Information on Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding (Nov. 24, 2017), https://www.regulations.gov/document?D=HHS-OS-2017-0002-11760.

Similarly, a wide range of vulnerable communities face routine discrimination and barriers to care. While the Department's primary focus should be on eliminating these barriers to care, its proposed rule does the opposite and threatens to exacerbate them.

For example, despite the substantial progress made after the enactment of the Affordable Care Act, health care discrimination against women remains rampart.[43] Many health plans continue to exclude treatments that are primarily required by women, such as coverage of pregnancy-related conditions.[44] In many parts of the country, access to reproductive health services is sparse, and some hospitals refuse to treat patients experiencing miscarriages, ectopic pregnancies, and other conditions affecting reproductive health, even when the condition is emergent or the patient has nowhere else to go.[45] Even among providers who do offer reproductive health services, many refuse to provide them to women who are unmarried or who do not conform to sex stereotypes, or subject women to harassment and mistreatment.[46] Women are also more likely than men to receive substandard care for conditions such as heart disease or chronic pain,[47] which further limits women's options when seeking a provider who will meet their needs.

Gender disparities in health care disproportionately affect women of color. Women of color are particularly likely to experience discrimination and harassment in health care.[48] Research has found that women of color face significant barriers to reproductive care: for example many respondents were neglected by medical staff, received inadequate or misleading information about the range of treatment options they had for labor and delivery, or were stigmatized and shamed by medical providers based on racial stereotypes.[49] In many states, women of color are more likely than white women to receive their care at Catholic hospitals, whose ethical directives regarding reproductive care often prevent patients from receiving treatment consistent with medical standards of care.[50] Inadequate access to reproductive care is one of the main drivers in persistent racial disparities in maternal mortality—with Black women being three to four times more likely to die in childbirth than white women[51]—as well as higher rates of

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[43] *See, e.g.,* Nat'l Women's Law Ctr., *Turning to Fairness* (2012), https://nwlc.org/wp-content/uploads/2015/08/nwlc_2012_turningtofairness_report.pdf.

[44] *See, e.g.,* Nat'l Women's Law Ctr., *NWLC Section 1557 Complaint: Sex Discrimination Complaints Against Five Institutions*, http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions (Section 1557 complaints filed against five institutions that exclude pregnancy coverage).

[45] *See, e.g.,* Nat'l Women's Law Ctr., *Health Care Refusals Harm Patients: The Threat to Reproductive Health Care* (2014), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/refusals_harm_patients_repro_factsheet_5-30-14.pdf.

[46] *Id.*

[47] *See, e.g.*, Judith H. Lichtman et al., *Symptom Recognition and Healthcare Experiences of Young Women with Acute Myocardial Infarction*, 10 J. AM. HEART ASS'N 1 (2015); Jennifer A. Kent, Vinisha Patel, & Natalie A. Varela, *Gender Disparities in Health Care*, 79 MOUNT SINAI J. MED. 555 (2012); Diane E. Hoffmann & Anita J. Tarzian, *The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain*, 29 J. LAW, MED. & ETHICS, 13 (2001); Inst. of Med., *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* 75–77 (2011).

[48] Nat'l Public Radio, Robert Wood Johnson Foundation, & Harvard T. H. Chan School of Public Health, *Discrimination in America: Experiences and Views of American Women* (2017), https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2017/12/NPR-RWJF-HSPH-Discrimination-Women-Final-Report.pdf.

[49] Ctr. for Reproductive Rights, Nat'l Latina Inst. for Reproductive Health, & SisterSong Women of Color Reproductive Justice Collective, *Reproductive Injustice: Racial and Gender Discrimination in U.S. Health Care* 20-22 (2014), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf.

[50] Kira Shepherd & Katherine Franke, *Bearing Faith: The Limits of Catholic Health Care for Women of Color* (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.

[51] Ctr. for Reproductive Rights et al., *supra* note 49.

cervical cancer and HIV among women of color.[52] People of color of all genders often face prohibitive barriers to care: for example, people of color are significantly more likely to be uninsured,[53] and people of color in rural America are also more likely to live in an area with a shortage of health professionals, leaving many with no alternatives if they are refused care.

People with disabilities also continue to face discriminatory barriers to care, including physical barriers in health care settings, mistreatment by health care providers, and the unavailability or inaccessibility of health care providers who are competent in meeting their health care needs. These barriers are often especially heighted for people with disabilities who live or spend much of their time in provider-controlled settings, including Medicaid-funded Home and Community-Based Services, where they receive supports and services for daily living, including assistance with dressing, grooming, bathing, transportation to social and health-related appointments, and participating in recreational activities. These services can be intensely intimate and implicate a person's right to pursue and maintain romantic relationships, build a family, and make basic decisions about one's life. In such settings, expansive religious exemptions that encourage aides to interfere with someone's health care can be extremely harmful for the health of a person with a disability and their ability to exercise their right to basic self-determination.

Lesbian, gay, and bisexual people (LGB) experience frequent discrimination when accessing health-related services. For example, a recent study found that 8% of LGB respondents reported that a doctor or other health care provider refused to see them because of their sexual orientation, and 7% experienced unwanted physical contact by a health care provider.[54] Many LGB people, especially those in rural areas, report that finding an alternative provider if they are refused treatment or harassed would be very difficult or even impossible.[55] Additionally, many LGB people struggle to access reproductive and sexual health services, including fertility services and HIV prevention treatments such as pre-exposure prophylaxis (PrEP). Inadequate access to care contributes to significant health disparities affecting the LGB

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[52] *See, e.g.,* Ctrs. for Disease Control & Prevention, *Cervical Cancer Rates by Rates and Ethnicity* (Jun. 19, 2017), https://www.cdc.gov/cancer/cervical/statistics/race.htm; *HIV Among Women* (March 9, 2018), https://www.cdc.gov/hiv/group/gender/women/index.html (noting that at the end of 2015, 59% of women living with diagnosed HIV were Black, 19% were Latina, and 17% were white, and that Black women were more likely to contract HIV through sexual contact than white women).

[53] Kaiser Family Found., *Uninsured Rates for the Nonelderly by Race/Ethnicity* (2016), https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[54] Mirza & Rooney, see *supra* note 27. *See also* Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV* (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf; Ning Hsieh & Matt Ruther, *Despite Increased Insurance Coverage, Nonwhite Sexual Minorities Still Experience Disparities in Access to Care,* 36 HEALTH AFFAIRS 1786 (Oct. 2017), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0455?journalCode=hlthaff; Human Rights Watch, *All We Want is Equality: Religious Exemptions and Discrimination against LGBT People in the United States* (2018), https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people.

[55] Mirza & Rooney, see *supra* note 27 (finding that 18% of LGBT people overall and 41% of LGBT people living outside of metropolitan areas report that it would be "very difficult" or "impossible" to find equivalent treatment at another hospital if they were to be turned away).

population,[56] including higher prevalence of disabilities and chronic conditions,[57] certain cancers,[58] cardiovascular disease,[59] and depression, anxiety, and other mental health conditions.[60] Barriers to accessing care also contribute to high rates of HIV infection among gay and bisexual men, who account for 56% of all people living with HIV in the United States and 70% of new HIV infections.[61]

C. Transgender people and other vulnerable communities already face barriers to care based on the personal beliefs of health care workers or administrators.

The personal beliefs of health care providers, administrators, and others in the health care industry have too often been used to deny individuals access to health care and other critical services—a problem that can be significantly worsened by expanding existing exemptions. For example, religious or moral disapproval has been invoked to refuse to provide infertility and reproductive care,[62] treat patients with HIV,[63] treat a newborn because of her parents' same-sex relationship,[64] and provide emergency services and other care for people who are suffering miscarriages.[65] Religious objections have also been invoked to deny transgender people access to medical care—both care related and unrelated to gender transition—or subject transgender people to degrading or abusive treatment in medical settings. Consider the following examples:

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[56] *See generally* Dep't of Health & Human Servs., *supra* note 30.

[57] David J. Lick, Laura E. Durso, & Kerri L. Johnson, *Minority Stress and Physical Health Among Sexual Minorities*, 8 PERSPECTIVES ON PSYCHOLOGICAL SCIENCE 521 (2013), http://williamsinstitute.law.ucla.edu/research/health-and-hiv-aids/minority-stress-and-physical-health-among-sexual-minorities.

[58] *Id.*; Jennifer Kates et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.* (2016), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US.

[59] *Id.*

[60] *Id.;* Human Rights Campaign et al., *Health Disparities Among Bisexual People* (2015), http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HRC-BiHealthBrief.pdf.

[61] Ctrs. for Disease Control & Prevention, *CDC Fact Sheet: HIV Among Gay and Bisexual Men* (2017), https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.

[62] Casey Ross, *Catholic Hospitals are Multiplying, Boosting Their Impact on Reproductive Health*, SCIENTIFIC AMERICAN (Sept. 14, 2017), https://www.scientificamerican.com/article/catholic-hospitals-are-multiplying-boosting-their-impact-on-reproductive-health-care; Nat'l Women's Law Ctr., *supra* note 45; *see also North Coast Women's Care Medical Grp., Inc. v. San Diego County Superior Court*, 189 P.3d 959, 959 (Cal. 2008).

[63] *See, e.g.,* Complaint, *Simoes v. Trinitas Reg'l Med. Ctr.*, No. UNNL-1868-12 (N.J. Super. Ct. *filed* May 23, 2012); Nat'l Women's Law Ctr., supra note 45.

[64] Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents and There's Nothing Illegal About It*, WASH. POST (Feb. 19, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/02/19/pediatrician-refuses-to-treat-baby-with-lesbian-parents-and-theres-nothing-illegal-about-it; *see also* Amicus Brief of Lambda Legal Defense and Education Fund et al., *Masterpiece Cakeshop et al. v. Colo. Civil Rights Comm'n et al.,* No. 16-111, 17–19 (Sup. Ct. *filed* Oct. 30, 2017).

[65] Am. Civil Liberties Union, *Health Care Denied: Patients and Physicians Speak out About Catholic Hospitals and the Threat to Women's Health and Lives* (2016), https://www.aclu.org/report/report-health-care-denied?redirect=report/health-care-denied; Nat'l. Women's Law Ctr., *Denied Care When Losing a Pregnancy: Pharmacies Refuse to Fill Needed Prescriptions* (Apr. 16, 2015), http://www.nwlc.org/our-blog/denied-care-when-losing-pregnancy-pharmacies-refuse-fill-needed-prescriptions; Nat'l Women's Law Ctr., *Below the Radar: Health Care Providers' Religious Refusals Can Endanger Pregnant Women's Lives and Health* (2011), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2015/08/nwlcbelowtheradar2011.pdf; Samantha Lachman, *Lawsuits Target Catholic Hospitals for Refusing to Provide Emergency Miscarriage Management*, HUFFINGTON POST (June 10, 2016), https://www.huffingtonpost.com/entry/catholic-hospitals-miscarriage-management_us_5759bf67e4b0e39a28aceea6.

> 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." … The rest of the time between the examination and him writing the prescription, he asked questions about how transgender women find sexual intimacy. As he had yet to hand over the prescription, I felt compelled by the power dynamic to provide answers to questions I would normally tell an asker are none of his or her business…. [I]t was very creepy having this conversation with this person, and I felt I had the filthy end of the stick and was being subordinated by this doctor because he felt he could. – Karen S.[66]
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> My Dignity Health insurance covered my hormones (because my doctor did not specifically note it as trans-related), and scheduled my top surgery before suddenly cancelling their coverage. Someone at their company had "connected the dots" and realized I was seeking transition-related services, which they denied due to their company's Catholic values. I was forced to pay for the surgery out of pocket, destroying my family's finance and putting me in considerable debt.[67]
>
> I was told by [mental health] professionals that I can only be "fixed" by "accepting Jesus" and denying who I really am when I sought assistance with beginning transition.[68]

In addition, the personal beliefs of hospital administrators and other health care workers have been used to interfere with doctors' exercise of their medical judgment. Some hospitals have invoked their religious affiliation to not only refuse to provide emergency care related to miscarriages, transition-related medical care, and other needs, but also to prevent doctors from providing those treatments at the hospital, in spite of those doctors' best medical judgment.[69] For example, in 2016 a New Jersey hospital approved and scheduled Jionni Conforti's hysterectomy, then abruptly cancelled the procedure at the last minute and refused to allow his surgeon to perform it when an administrator discovered the patient was transgender despite his doctor's determination that the procedure was medically necessary.[70] These practices are especially concerning in light of the rapidly growing number of religiously affiliated hospitals. For example, the number of Catholic hospitals—which represent the largest denomination in the health care field—has increased by 22% since 2001, and Catholic hospitals now own one in six hospital beds across the country.[71] Catholic hospitals must follow religious directives that often restrict the provision of certain treatments, including for emergency contraception, sterilization, abortion, fertility services, and ectopic

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[66] Amicus Brief of Transgender Legal Defense and Education Fund et al., *Masterpiece Cakeshop et al. v. Colo. Civil Rights Comm'n et al.*, No. 16-111, 11 (Oct. 30, 2017).

[67] This quotation has been excerpted from a story shared by a 2015 U.S. Transgender Survey respondent after completing of the survey.

[68] This quotation has been excerpted from a story shared by a 2015 U.S. Transgender Survey respondent after their completion of the survey.

[69] For example, complaints have been filed against Catholic hospitals for refusing to allow doctors to provide care to transgender patients that the doctors are regularly allowed to provide for non-transgender people. *See, e.g.*, Complaint, *Hastings v. Seton Med. Ctr.*, No. CGC-07-470336 (Cal. Sf. Super. Ct. Dec. 19, 2007) (case settled). *See also Health Care Denied*, *supra* note 65.

[70] *Conforti v. St. Joseph's Healthcare System*, No. 2:17-cv-00050-JLL-JAD (D.N.J. filed Jan. 5, 2017).

[71] Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals: 2016 Update of the Miscarriage of Medicine Report* (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf?token=54%2Fj8Gp90FWPtm7ExSkDGRuC77o%3D.

pregnancies.[72] Providers at such hospitals often find that they are unable to provide the standard of care for treatments such as miscarriage managements,[73] and one study of physicians working at religiously affiliated hospitals found that nearly one in five (19%) experienced a conflict between the religious directives of their hospital and their ability to practice in accordance with medical standards and their clinical judgment.[74]

Religious beliefs have also been invoked to justify refusals to provide critical human services for lesbian, gay, bisexual, and transgender (LGBT) individuals and families, as well as unmarried parents. The potential for harmful discrimination justified by religious beliefs is further illustrated by countless cases of religion being cited as a basis for denial of service or humiliating treatment toward LGBT people in restaurants, hotels, retail stores, and by individual government employees.[75]

For many patients, such refusals do not merely represent an inconvenience: in many cases, they can result in necessary or even emergent care being delayed or denied outright, putting their health and in some instances their lives at risk. These refusals are particularly dangerous in situations where individuals have limited options, such as in emergencies, when needing specialized services, in many rural areas,[76] or in areas where religiously affiliated hospitals are the primary or sole hospital serving a community.[77]

Expanding exemptions beyond established law as the proposed rule attempts to do—and encouraging service providers receiving federal funds to discriminate against intended program beneficiaries—would aggravate these harms even further. Permitting a broader range of service providers that receive taxpayer money to use a religious or moral litmus test to determine which services they provide and who receives care would result in many patients in need being denied access to medical care and other essential

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[72] *See* U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (2009), http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf; Lois Uttley et al., *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care* (2013), http://static1.1.sqspcdn.com/static/f/816571/24079922/1387381601667/Growth-of-Catholic-Hospitals-2013.pdf?token=O2KPmDeCHsArsY1wqp0wEBigKC4%3D.

[73] Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J. PUB. HEALTH (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458.

[74] Debra B. Stulberg et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, 25 J. GENERAL INTERNAL MED. 725–30 (2010), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881970.

[75] *See*, *e.g.*, Amicus Brief of Lambda Legal Defense and Education Fund et al., *Masterpiece Cakeshop,* No. 16-111 (documenting instances of discrimination against LGBT people, including discrimination based on religious objections, in a variety of settings); Amicus Brief of National LGBTQ Task Force, et al., *Masterpiece Cakeshop,* No. 16-111; Amicus Brief of Transgender Legal Defense and Education Fund et al., *Masterpiece Cakeshop*, No. 16-111 (same); Amicus Brief of Transgender Law Center et al., *Masterpiece Cakeshop,* No. 16-111, 12–13 (Sup. Ct. filed Oct. 30, 2017) (same).

[76] People living in rural areas often struggle to access care due to a variety of factors, including physician shortages, financial and geographic barriers to transportation, and a lack of available specialists who can meet their needs. *See, e.g.,* Martin MacDowell et al., *A National View of Rural Health Workforce Issues in the USA*, 10 RURAL REMOTE HEALTH 1531 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760483; Carol Adaire Jones et al., *Health Status and Health Care Access of Farm and Rural Populations,* U.S. DEP'T OF AGRIC. ECON. RESEARCH SERV. (2009), https://www.ers.usda.gov/publications/pub-details/?pubid=44427; Thomas A. Arcury et al., *The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region*, 40 HEALTH SERVS. RESEARCH 135 (2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130; Corinne Peek-Asa et al., *Rural Disparity in Domestic Violence Prevalence and Access to Resources,* 20 J. OF WOMEN'S HEALTH 1743 (Nov. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3216064.

[77] *See e.g., Health Care Denied*, *supra* note 65; Uttley et al., *supra* note 72.

services—jeopardizing the welfare of many intended HHS program recipients and compromising the Department's ability to meet its legal obligations and fulfil its mission.

II. Expanding exemptions undermines the Department's mandate to protect the health and well-being of all Americans.

Reducing discrimination and other barriers to accessing health care services, as well as reducing the accompanying health disparities, is core to the Department's mission and its obligations under laws authorizing its programs. Weakening protections and limiting program access by expanding religion-based exemptions fundamentally runs contrary to this mission.

The Department's core mission is to "enhance and protect the health and well-being of all Americans…by providing for effective health and human services."[78] The foremost purpose of the Department is to provide for services and supports for individuals and communities who need them—a purpose that is statutorily prescribed by Congress in the statutes authorizing many of the Department's programs.[79] Ensuring that beneficiaries of Department programs and other patients have fair and equal access to services and reducing barriers to those services is an inseparable and necessary component of this responsibility. The Department's ability to ensure equal, nondiscriminatory access to services would be significantly weakened by the proposed rule. In order to meet its legal obligations and its statutory mission, HHS must prioritize the needs and rights of patients over those of organizations seeking federal funds. Creating new or expanded exemptions for recipients of federal funds at the cost of patients' access to health services prevents the Department from meeting its responsibilities to HHS program beneficiaries and patients around the country.

Protecting religious freedom is an important value, and many health care providers with deeply held religious or moral beliefs have played important roles in addressing our nation's health care needs. Yet the driving force of this value is the core constitutional principle of separation of church and state—a principle that is fundamentally undermined by the expansion of religious exemptions in health care. Health care providers, entities, and grantees should be allowed—and *are* allowed under current practices and policies—to maintain their distinct religious identities when providing health care services, so long as they comply with generally applicable requirements, including nondiscrimination laws, that exist to protect patients. Protecting the right to practice religion does not require the sweeping expansion of religion-based exemptions that this proposed rule attempts to implement, which would amount to government-funded discrimination and subvert HHS' mission and compelling interest in promoting public health and wellbeing.

III. The exemptions proposed in the rule go far beyond what the applicable statutes permit and exceed the Department's authority.

[78] Dep't. of Health & Human Servs., *About HHS* (2017), https://www.hhs.gov/about/index.html.

[79] *See*, *e.g.*, 34 U.S. Code § 11201 (establishing Runaway and Homeless Youth programs because "youth who have become homeless or who leave and remain away from home without parental permission…are urgently in need of temporary shelter and services").

The Department has the authority and responsibility to enforce laws as they are written, including laws creating and delimiting religious and moral exemptions. This rule, however, proposes exemptions that are far broader than permitted under the statutes that the Department cites. By redefining key terms, eliminating important limitations and requirements included in the law, and applying statutes outside of their intended scope, the proposed rule attempts to significantly expand existing exemptions. The Department does not have the statutory authority to expand or create new religious exemptions to its statutorily prescribed programs beyond the exemptions permitted by statutes. Reading additional exceptions into a statute where Congress already contemplated and enumerated specific ones, contrary to fundamental principles of statutory construction, is in excess of the statutory authority provided in the laws the Department seeks to enforce.[80]

A. The Department's regulation proposes an impermissible and harmful reinterpretation of the Church Amendments.

The Department's rule proposes a reinterpretation of the Church Amendments that broadens their impact far beyond what the statute permits, potentially allowing a range of refusals that would severely compromise patients' access to medically necessary care.

Redefinition of "assist in the performance"

One of the most concerning transformations proposed by this regulation is the reinterpretation of what it means to "assist in the performance" of a procedure. In the 2008 rule, the Department defined the term as the participation in "any activity with a reasonable connection" to a procedure to which an individual objects.[81] This definition itself is so broad that it could be applied to services and forms of "assistance" even beyond those contemplated by Congress when the law was enacted. The current rule, however, attempts to expand the application of the Church Amendments even further than the 2008 rule did by defining the statutory term to mean "any activity with an *articulable* connection" to a procedure to which an individual objects.[82]

Although the preamble claims that this definition "mirrors the definition used for the term in the 2008 Rule,"[83] the definition is in fact an attempt to radically expand potential refusals. By allowing health care workers to refuse to engage in activities with a merely "articulable" connection to the service to which a provider or entity has an objection, the proposed rule opens the door to refusals to perform activities whose asserted nexus to the procedure being objected to is greatly attenuated and patently unreasonable, as long as it can be put into words.[84] Individuals wishing to obstruct access to care could seek to invoke

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[80] *See, e.g., U.S. v. Smith*, 499 U.S. 160 (1991).
[81] 45 C.F.R. § 88 (2008).
[82] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 83 Fed. Reg. 3880, 3923 (proposed Jan. 26, 2018) (to be codified at 45 C.F.R. pt. 88) [hereinafter Proposed Rule].
[83] *Id*. at 3892.
[84] *Compare, e.g., Erzinger v. Regents of Univ. of Cal.*, 137 Cal. App. 3d 389, 394 (Ct. App. 1982), *cert. denied* 462 U.S. 1133 (1983) ("The proscription [of the Church Amendments] applies only when the applicant must participate in acts

the rule to refuse to perform functions whose connection to a sterilization or abortion is extremely remote—such as bringing a meal to a patient after a procedure, handling scheduling tasks that may include booking follow-up appointments for sterilization or abortion procedures, or preparing a patient room. The proposed definition may also be invoked by health care workers or entities who refuse to treat unrelated conditions simply because a patient has had an abortion or sterilization procedure or may have one in the future. For example, it may be invoked by a cardiologist, oncologist, or even an emergency room doctor—as well as nurses, other medical staff, and administrative staff—to refuse to treat a patient for an unrelated condition because they object to asking about or taking into account an abortion or sterilization procedure that a patient has had in the past or intends to have in the future.

Implied redefinition of "sterilization"

The expanded exemptions proposed in the rule might even be construed to permit refusals related to medical treatments that are needed to treat a disease or disorder that may have a merely *incidental* effect of impacting fertility, including certain types of treatments for gender dysphoria. Although the Church Amendments were never intended to reach such medical treatments, the breadth and vagueness of several provisions in the proposed rule may be interpreted to support such an application. For example, twice in the proposed rule, the Department cites *Minton v. Dignity Health*, a case involving denial of care for gender dysphoria, as a purported example of a violation of existing religious exemptions.[85] In this case, a hospital abruptly canceled a hysterectomy for a patient, Evan Minton, after discovering he was transgender and that the procedure was recommended to treat gender dysphoria. The procedure was cancelled in spite of Mr. Minton's doctor's objections and previous determination that the treatment was medically necessary.[86] The same hospital routinely permitted Mr. Minton's physician and other physicians to perform hysterectomies—and in fact, his doctor performed another hysterectomy at the hospital for a non-transgender patient on the very same day that Mr. Minton's hysterectomy was scheduled[87]—but it refused to allow Mr. Minton's procedure to be performed because hospital administrators asserted a religious objection to the use of the procedure to treat gender dysphoria. While Mr. Minton was fortunate to be able to reschedule his procedure—with the same surgeon—at another hospital, many patients who are so abruptly refused care are not so lucky and may face medical complications from delayed treatment.

Applying the Church Amendments in this context—as the Department's citation to the *Minton* case implies—would exceed and contradict the plain meaning of the statute. Like treatments for many other conditions, certain treatments for gender dysphoria, such as hormone treatments and certain surgeries, can have an incidental effect of temporarily or permanently reducing fertility and in some cases eliminating fertility entirely. The primary purpose of such procedures, however, is not to sterilize, but to treat an unrelated medical condition. Similarly, a range of other conditions have treatments that can lead to sterilization. For example, forms of chemotherapy and certain other cancer treatments can and in some cases will necessary lead to permanent sterilization, and many medications, including a variety of antibiotic and seizure control medications, can also have an incidental effect of reducing or eliminating fertility. If religious or moral exemptions related to sterilization were construed to encompass treatments

related to the actual performance of abortions or sterilizations. Indirect or remote connections with abortions or sterilizations are not within the terms of the statute.").

[85] Proposed Rule, 83 Fed. Reg. at 3888–89.

[86] Complaint at 6–7, *Minton v. Dignity Health*, No. 17-558259 (Calif. Super. Ct. *filed* Apr. 19, 2017).

[87] *Id.* at 2.

that have an incidental effect of affecting fertility, this reinterpretation could lead to refusals that substantially exceed the plain language of the statute and open the door for patients to be denied a dangerously wide range of medically necessary treatments.

Application to other services other than abortion or sterilization

We are also concerned that the proposed rule's sweeping and ambiguous language, in conjunction with the preamble, may lead to an expansive misinterpretation of sections (c)(2) and (d) of the Church Amendments that may encourage refusals of *any* health care service for a religious or moral reason, even those with no connection to sterilization or abortion at all—far exceeding the longstanding application of this statute.[88] This ambiguity may lead covered entities to believe that they can refuse to provide or refer for any service—such as vaccines, psychiatric medication, infertility treatments, and HIV-related care—that is inconsistent with their personal beliefs, jeopardizing the health of numerous Americans. It may also lead covered entities to believe that they can refuse to provide services based on objections about who the patient is: it can encourage, for example, a provider who has a moral or religious objections to providing services for LGBT people, women, people with disabilities, or people of color to refuse to treat them at all, regardless of the treatment they require.

B. The proposed rule impermissibly expands the Coats-Snowe and Weldon Amendments.

Redefinition of "referral"

We are deeply troubled by the Department's proposal to reverse its long-standing interpretation of the application of the Weldon Amendment. We are particularly concerned about the Department's attempt to radically redefine what it means to provide a referral for a patient. There is no legal basis to support the proposed transformation of the term from its plain meaning as it is used in medicine—that is, transferring the care of a patient to a particular health care provider[89]—to "the provision of *any* information…pertaining to a health care service" so long as the health care entity believes that the health care service is a "possible outcome" of providing that information.[90] This breathtakingly broad definition attempts to exempt providers not only from transferring care to another health provider, but from supplying information that has even an exceedingly remote connection to a procedure they object to, so long as they simply believe that it is *not impossible* that doing so may lead the patient to receive the objected-to treatment—even if they do not believe that it is likely or plausible. For example, it may embolden a health care provider to refuse to inform a woman about a pregnancy complication she is experiencing, even if it can be treated, based on their belief that it is *possible* though unlikely she will opt to terminate the pregnancy. While the Department claims that statutory language—such as references to "referring for" an abortion or "making arrangements to provide referrals"—suggests that Congress

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[88] *See, e.g., Elbaum v. Grace Plaza of Great Neck*, 148 A.D.2d 244, 255–56 (N.Y. App. Div. 1989) (finding that a nursing home's reliance on the Church Amendments to justify refusal to remove feeding tube was "misplaced" because the statute only pertains to sterilization and abortion procedures).

[89] *See, e.g.,* American Acad. of Family Physicians, *Consultations, Referrals, and Transfers of Care* (2017), https://www.aafp.org/about/policies/all/consultations-transfers.html ("A referral is a request from one physician to another to assume responsibility for the management of one or more of a patient's specific problems…. This represents a temporary or partial transfer of care to another physician for a particular condition.")

[90] Proposed Rule, 83 Fed. Reg. at 3924.

intended for this term to be interpreted broadly,[91] the definition that it proposes extends so far beyond the plain meaning of the term that it amounts to a radical revision of the statutory language that undermines rather than effectuates Congress' intent.

Redefinition of "health care entity"

The Department's broad redefinition of the term "health care entity" also ignores Congress' clear intent to limit the entities affected by these statutes. For example, the Coats-Snowe Amendment defines "health care entity" as an "individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions."[92] In contrast, the Department has proposed a far-reaching definition of this term, applicable to all statutes, that combines definitions from multiple statutes.[93] This attempt to supplant the varying statutory definitions of this term with a catch-all list creates confusion about the health care entities that must comply with each statute. It also disregards the congressional intent to cabin the application of each statute, evidenced by the fact that Congress took the time to create separate definitions for each statute rather than to create a universally applicable definition of the term, and by its deliberate decision to include some types of health care entities in each definition while excluding others.

C. The proposed rule impermissibly expands exemptions for Medicare and Medicaid organizations.

The essential care that Medicaid and Medicare programs provide to many Americans are already riddled with expansive exemptions for grantees and other participants, leaving many beneficiaries with no avenue to receive the care they need.[94] It is deeply concerning, therefore, that the proposed rule attempts to expand several exemptions applicable to these programs beyond the statutory language, including the counseling and referral provisions of 42 U.S.C. 1396u-2(b)(3)(B) and 42 U.S.C. 1395w-22(j)(3)(B) and the provisions of the Consolidated Appropriations Act of 2017 related to Medicare Advantage. Expanding religious exemptions in the manner proposed both exceeds the Department's authority and undermines its statutorily prescribed mission to serve beneficiaries and facilitate their access to needed medical care.

Redefinition of "referral"

First, we are troubled by the impact that the expansive redefinition of "referral" could have on patient care for Medicaid and Medicare Advantage recipients. In the context of the counseling and referral

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[91] *Id*. at 3895.

[92] 42 U.S.C. § 238n(c)(2). *See also* Weldon Amendment, Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat 3034 (2009).

[93] Proposed Rule, 83 Fed. Reg. at 3924.

[94] *See, e.g.,* Amy Littlefield, *How a Catholic Insurer Built a Birth Control Obstacle Course in New York*, REWIRE NEWS (Jan. 26, 2017), https://rewire.news/article/2017/01/26/catholic-insurer-built-birth-control-obstacle-course-new-york (describing the refusal of New York's largest Medicaid plan to cover a range of services based on religious objections). *See also* Catholic Health Association of the United States, *Catholic Health Care in the United States* (2018), https://www.chausa.org/docs/default-source/default-document-library/cha_2018_miniprofile7aa087f4dff26ff58685ff00005b1bf3.pdf?sfvrsn=2 (noting that Catholic hospitals, which are required to comply with ethics guidelines that limit access to reproductive and other care, reported one million Medicaid discharges in 2017).

provisions, the proposed rule may be interpreted as allowing Medicaid managed care organizations and Medicare Advantage organizations not only to refuse to cover a counseling or referral service that they object to, but also to refuse to cover or provide for any provider-patient communication that they believe can *possibly* lead to a service to which they object, no matter how remote the connection. Similarly, this novel definition of "referral" suggests that the Consolidated Appropriations Act of 2017 exempts not only Medicare Advantage organizations who refuse to refer for abortions in the natural reading of the term—that is, to transfer care of the patient to another provider—but also those who refuse to provide or cover the provision of any information that they believe can possibly lead to a patient obtaining an abortion. This attempt to rewrite the statutory language is unsupported by statutory language or congressional intent and threatens the health and safety of the program beneficiaries whom these programs are required to serve.

Attempt to transform a statutory construction provision into a freestanding exemption

Further, the proposed rule misinterprets the counseling and referral provisions of 42 U.S.C. § 1396u-2(b)(3)(B) and 42 U.S.C. § 1395w-22(j)(3)(B) by turning a statutory construction provision into a freestanding religious exemption. The Department's proposed exemption relies on narrow provisions that are intended only to qualify the statutes' prohibition on interference with doctor-patient communications. The provisions that the Department cites are pulled from a section whose primary purpose is to prohibit covered entities from interfering with a health care provider's ability to advise an enrollee about their health status or available treatments, regardless of whether those treatments are covered.[95] These provisions clarify a limitation to that prohibition: namely, that a covered entity's refusal to cover a procedure or service does not constitute interference with doctor-patient communication under this section. These provisions are not intended to create a general religious exemption for Medicaid MCOs and Medicare Advantage organizations, but rather they are statutory construction clauses that explain specifically how the prohibition on interference with communication is meant to be construed. Congress' limited intent when enacting these statutes is underscored not only by the plain language of this subsection, which clearly qualifies only a specific requirement of the statute, but also by the choice to explicitly label 42 U.S.C. § 1396u-2(b)(3)(B) as "Construction." The proposed rule, however, disregards the congressional intent evidenced in the statutory language and isolates this section from its context, misrepresenting its limited scope and instead presenting it as a standalone religious exemption that allows Medicaid managed care organizations and Medicare Advantage organizations to refuse to cover any counseling or referral service that they disapprove of.

Omission of critical, patient-protective statutory language

[95] 42 U.S.C. 1396u-2(b)(3)(A) ("Subject to subparagraphs (B) and (C), under a contract under section 1396b(m) of this title a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional…from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract…."); 42 U.S.C. 1395w-22(j)(3)(A) ("Subject to subparagraphs (B) and (C), a Medicare Choice organization (in relation to an individual enrolled under a Medicare Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional…from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan….").

Additionally, the proposed rule omits requirements, enumerated in both 42 U.S.C. § 1396u-2(b)(3)(B) and 42 U.S.C. § 1395w-22(j)(3)(B), that organizations that decline to cover certain treatments notify enrollees of their policy. The statutory construction clauses do not exempt an organization merely on the basis that it has a religious or moral objection to covering a service: it also requires, as a condition of the exemption, that the organization "make available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service."[96] The Department's omission of this requirement from its proposed rule will create confusion regarding organizations' legal obligations to disclose their policies to potential and current enrollees and may lead to or encourage noncompliance with the law. Without sufficient enforcement of notification requirements, potential enrollees may be unable to make an informed choice about their health care, and current enrollees may find themselves unable to access care that they would reasonably expect to be covered.

Similarly, the proposed rule misrepresents the exemption provided to entities participating in Medicare Advantage in the Consolidated Appropriations Act of 2017, omitting requirements in the law that ensure that enrollees and the Department itself are notified of objections to covering abortions. The proposed rule asserts that an exemption exists when an "entity will not provide, pay for, provide coverage of, or provide referrals for abortions."[97] In contrast, the statute itself provides an exemption when "the entity *informs the Secretary* that it will not provide, pay for, provide coverage of, or provide referrals for abortions."[98] By excising this important language, the Department may create ambiguity about covered entities' obligations to notify the Department of its objections to covering abortions—a requirement that is necessary to allow the Department to meet its statutory obligation to "make appropriate prospective adjustments to the capitation payment" to entities declining to cover abortions.[99] The statute, furthermore, explicitly states that "a Medicare Advantage organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services"[100]—a notification requirement that the proposed rule omits, potentially creating confusion regarding a Medicare Advantage organization's responsibilities to inform enrollees about the scope of their coverage.

IV. The proposed exemptions run counter to numerous federal and state laws and raise serious constitutional questions.

A. *Conflict with the Establishment Clause of the Constitution*

Expanding religious exemptions in the manner proposed may run afoul of constitutional restrictions on the scope of religious exemptions. The Supreme Court has noted that there are limits to permissible accommodations based on religious beliefs, and that "at some point, accommodation may devolve into an unlawful fostering of religion."[101] To comply with the Constitution, "an accommodation must be

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[96] 42 U.S.C. 1396u-2(b)(3)(B)(ii); 42 U.S.C. 1395w-22(j)(3)(B)(ii).
[97] Proposed Rule, 83 Fed. Reg. at 3926.
[98] Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. II, sec. 209 (emphasis added).
[99] *Id*.
[100] *Id*.
[101] *Corp. of the Presiding Bishop v. Amos*, 483 U.S. 327, 334-35 (1986) (internal quotation marks omitted).

measured so that it does not override other significant interests"[102] or "impose unjustified burdens on other[s],"[103] and any "detrimental effect on any third party" must be seriously considered.[104] The exemptions proposed in the rule—which would allow many providers and entities to take taxpayer dollars and then refuse to provide a range of needed medical services—would *by definition* impose significant burdens on many intended HHS program recipients. The rule, however, includes no discussion or consideration of the impact its proposed exemptions may have on patients and other third parties, and in fact undermines important statutory limitations on those exemptions that are intended to prevent or mitigate the harms patients may face, thereby raising serious constitutional concerns.

B. *Conflict with federal statutes*

Additionally, many of the exemptions proposed in the rule may conflict with a range of patient protections included in other federal laws. While these protections are subject to the religious exemptions provided under federal law, they are not subject to exemptions whose scope exceeds federal law, including the expanded exemptions proposed in this rule. Adopting an interpretation of religious exemption laws that conflicts with the requirements of other federal laws would compromise the Department's ability to enforce existing law as required. Further, doing so will cause confusion for covered entities about how to navigate seemingly inconsistent obligations under different laws, and subject them to increased liability.

Emergency Medical Treatment and Active Labor Act (EMTALA)

For example, if the proposed rule is implemented, it can subject hospitals to standards that conflict with their obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals that have a Medicare provider agreement and an emergency department to provide medical screening and stabilizing treatments to patients in emergency conditions (including labor).[105] The proposed rule contemplates no exceptions to the broad, automatic exemptions it promotes, such as exceptions for emergencies or life-threatening conditions. A hospital could therefore reasonably interpret the proposed rule as requiring it to exempt essential personnel from providing, for example, comprehensive care for a patient experiencing emergent pregnancy-related complications, even when doing so means that the hospital is unable to provide the patient with stabilizing care, in violation of its obligations under EMTALA. The Department provides no guidance about how a hospital can comply with the expanded refusal rights suggested by this proposed rule in cases where doing so would result in an EMTALA violation—potentially putting the hospital in the impossible position of having to somehow satisfy two conflicting requirements. Indeed, the preamble underscores the potential conflict between EMTALA and the Department's approach when it criticizes an American College of Obstetrics and Gynecologists statement reaffirming that physicians must provide emergency care when a safe transfer

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[102] *Cutter v. Wilkinson*, 544 U.S. 709, 722 (2005); *see also Estate of Thornton v. Caldor, Inc.* 472 U.S. 703, 709-10 (1985) ("unyielding weighting" of religious interests of those taking exemption "over all other interests" violates Constitution).
[103] *Cutter*, 544 U.S. at 726; *see also Texas Monthly, Inc. v. Bullock*, 480 U.S. 1, 18 n.8 (1989) (religious accommodations may not impose "substantial burdens on nonbeneficiaries").
[104] *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014) (citing *Cutter*, 544 U.S. at 720). Indeed, every member of the Court, whether in the majority or in dissent, reaffirmed that religious accommodations cannot unduly burden third parties. *See id.* at 2786–87 (Kennedy, J., concurring); *id.* at 2790, 2790 n.8 (Ginsburg, J., joined by Breyer, Kagan, and Sotomayor, JJ., dissenting). *See also Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[105] 42 U.S.C. § 1395dd.

is not possible, regardless of their personal beliefs. The preamble suggests that this position—a simple recitation of a widely accepted legal and professional obligation for physicians—is "evidence of discrimination toward, and attempted coercion of, those who object to certain health care procedures based on religious or moral convictions" and its implementation "could constitute a violation of Federal health care conscience laws."[106]

Affordable Care Act

The proposed rule is also inconsistent with several provisions of the Affordable Care Act, including Section 1554 and Section 1557. Section 1554 prohibits the Department from promulgating any regulation that "creates any unreasonable barriers to…appropriate medical care" or "impedes timely access to health care services"; that "restricts the ability of health care providers to provide full disclosure of all relevant information to patients" or interferes with their ability to communicate about "a full range of treatment options"; that "violates the principles of informed consent and the ethical standards of health care professionals"; or that "limits the availability of health care treatment for the full duration of a patient's medical needs."[107] This proposed rule violates each and every one of these requirements. Additionally, by pursuing broad exemptions that would likely result in discrimination against patients, the proposed rule conflicts with Section 1557 of the Affordable Care Act, which prohibits discrimination in health care on the basis of race, national origin, disability, age, and sex,[108] and runs counter to clear congressional intent evidenced in this section and throughout the ACA to protect the rights of patients and reduce barriers to accessing health care.

Title VII of the Civil Rights Act of 1964

Further, the proposed rule's approach, which appears to allow for no limitations even when those exemptions unjustifiably harm patients or employers, conflict with the well-established standard under other federal laws, such as Title VII of the Civil Rights Act, creating confusion and increased liability for hospitals and other health care employers. As the Supreme Court has long held, Title VII requires that employers reasonably accommodate employees' religious exercise unless doing so would impose undue hardship on the employer, ensuring that the employer can consider the effect that an accommodation would have on clients, patients, co-workers, and its own operations, as well as factors such as public safety, patient health, and other legal obligations.[109] A standard that appears to allow for none of these considerations, and instead appears to require broad and automatic exemptions regardless of the consequences, would create confusion for employers and undermine the federal government's

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[106] Proposed Rule, 83 Fed. Reg. at 3887–3888 (criticizing an American College of Obstetrics and Gynecologists ethics committee that reaffirms a physicians' duty to provide emergency care when transfer is not feasible and suggesting that it is "evidence of discrimination toward, and attempted coercion of, those who object to certain health care procedures based on religious or moral convictions" and "could constitute a violation of Federal health care conscience laws").

[107] 42 U.S.C. § 18114.

[108] 42 U.S.C. § 18116.

[109] *See, e.g., Ansonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 70 (1986) ("In enacting [Title VII], Congress was understandably motivated by a desire to assure the individual additional opportunity to observe religious practices, but it did not impose a duty on the employer to accommodate at all costs"). *See also, e.g., Wilson v. U.S. West Communications*, 58 F.3d 1337 (8th Cir. 1995) (affirming that Title VII requires reasonable accommodation employee only when the accommodation does not create an undue hardship on the employer); *Noesen v. Med. Staffing Network, Inc.*, 2006 WL 152996, at *4 (W.D. Wis. June 1, 2006), *aff'd* 232 F. App'x 581 (7th Cir. 2007); *Grant v. Fairview Hosp. & Healthcare Servs.,* 2004 WL 326694 at *4 (D. Minn. Feb. 18, 2004).

ability to properly enforce federal laws.[110] Such a standard could require health care employers to hire individuals who refuse to do essential components of their job. For example, it could require small hospitals to staff their emergency rooms with employees who are unwilling to provide emergency treatment to pregnant or transgender patients even when doing so makes it impossible for the hospital to provide life-saving care to patients or comply with other legal obligations such as under EMTALA. Similarly, this standard could require a clinic that is funded under Title X—and that is therefore statutory required to provide non-directive pregnancy options counseling[111]—to employ medical or administrative staff who refuse to discuss or even simply schedule appointments for pregnancy counseling, even when doing so prevents the clinic from serving its patients or complying with other laws.

C. *Conflict with state and local laws*

Finally, the proposed rule threatens to interfere with the enforcement of hundreds of state and local laws—including laws that protect patients from malpractice and discrimination, laws requiring providers to disclose important information to patients, and laws that prohibit unfair insurance practices and set other minimum standards for private insurance or Medicaid programs. The Department's claims that "this rulemaking does not impose substantial direct effects on States or political subdivision of States" and "does not implicate" federalism concerns under Executive Order 13,132[112] are, as a factual matter, false: as the Department itself recognizes in the preamble, the principles and requirements espoused in its proposed rule conflict with many state and local laws,[113] and the Department challenges several state laws and policies throughout its preamble.[114] While the Department argues that it is merely enforcing existing law and thus minimally impacts state and local governments, its proposed rule in fact represents a significant and unwarranted expansion of existing federal laws—an expansion that is fundamentally at odds with the prevailing interpretation on which many state and local governments have relied when enacting laws to protect their residents.

V. The proposed rule erodes core tenets of the medical system.

The propose rule undermines longstanding ethical and legal principles of informed consent. Informed consent—a fundamental principle of patient-centered care—relies on the disclosure of medically accurate information by providers in order to allow patients to make competent and voluntary decisions about their medical treatment.[115] Health care providers must provide information that is accurate and sufficient to allow a patient to provide informed consent to a course of treatment or lack of treatment, and a health care provider's refusal to provide adequate information can constitute a violation of both medical

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[110] Indeed, when similar regulations were proposed in 2008, EEOC Commissioners and Legal Counsel raised concerns about potential conflict with established Title VII standards and emphasized that Title VII should remain the legal standard for determining religious accommodations. Letter from EEOC Commissioners and General Counsel (Sept. 24, 2008), https://www.eeoc.gov/eeoc/foia/letters/2008/titlevii_religious_hhsprovider_reg.html

[111] *See, e.g.*, Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, 131 Stat. 135 (2017).

[112] Proposed Rule, 83 Fed. Reg. at 3919.

[113] *Id*. at 3888.

[114] *See, e.g., id.* at 3886.

[115] *See, e.g.,* Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* (4th ed. 1994).

standards of care[116] and legal standards.[117] The proposed rule, however, encourages providers to flout their obligations to provide patients with necessary medical information. By encouraging health care providers and entities to refuse to provide key information and disregarding statutory requirements that patients be given notice that they may not receive complete and accurate information, the proposed rule degrades trust and open communication between doctors and patients and prevents patients from being able to make an informed decision about their health care.

For example, by proposing to expand the definition of "referral" to the provision of *any* information by a health care worker who believes that it could *possibly* lead a patient to obtain a treatment to which they object, the Department encourages health care providers to withhold critical information about available treatments, their risks and benefits, or even the patient's diagnosis. As discussed above, the proposed rule even omits statutory requirements that health care entities inform patients of their objections to certain treatments or policies of refusing to provide or cover them. By omitting these notification requirements from its proposed rule, the Department creates confusion about what information health care providers must give to patients about their or their employees' religious or moral objections and encourages entities to ignore these obligations. Especially in light of studies indicating that most patients are unaware that religiously affiliated health care institutions might refuse to provide treatments based on religious objections, [118] the Department's apparent reluctance to fully enforce disclosure requirements jeopardizes patients' ability to make informed decisions about their health care.

VI. The Department's failure to follow required rulemaking procedures and base its rule on available evidence suggests an arbitrary and capricious process.

The Department failed to follow normal rulemaking procedures in issuing the proposed rule in several respects and to consider important evidence regarding the rule's impact. Together with the fact that the rule exceeds the Department's statutory authority, runs counter to existing laws, and undermines the constitutional and other legal rights of patients, this rushed and inadequate rulemaking procedure strongly suggests a violation of the Administrative Procedure Act.[119]

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[116] *See, e.g., The AMA Code of Medical Ethics' Opinions on Informing Patients: Opinion 9.09 – Informed Consent*, 14 AM. MED. J. ETHICS 555-56 (2012), http://journalofethics.ama-assn.org/2012/07/coet1-1207.html ("The physician's obligation is to present the medical facts accurately to the patient…. The physician has an ethical obligation to help the patient make choices from among therapeutic alternatives consistent with good practice."); Am. Nurses Ass'n, *Code of Ethics for Nurses with Interpretive Statements* (2001), https://www.truthaboutnursing.org/research/codes/code_of_ethics_for_nurses_US.html ("Patients have the moral and legal right to determine what will be done with their own person; to be given accurate, complete and understandable information in a manner that facilitates an informed judgment; to be assisted with weighing the benefits, burdens, and available options in their treatments…."); Am. Pharmacists Ass'n, *Code of Ethics for Pharmacists* (1994).

[117] *See., e.g., Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240 (Ct. App. 1989).

[118] Ensuring that disclosure requirements are rigorously enforced is particularly important in light of research indicating that most patients are unaware that some religiously affiliated health care entities may refuse to provide treatments based on their religious beliefs. *See, e.g.,* Nadia Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J. LAW & MED. 85 (2016), http://journals.sagepub.com/doi/pdf/10.1177/0098858816644717.

[119] The Administrative Procedure Act instructs a reviewing court to hold agency actions as unlawful when they are found to be "(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right; (D) without observance of procedure required by law; (E) unsupported by substantial evidence…; or (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court." 5 U.S.C. § 706.

A. Failure to include the rule in the Department's Unified Regulatory Agenda

First, under longstanding Executive Orders governing the rulemaking process, proposed rules must first appear in the agency's Regulatory Agenda.[120] Executive Order 13,771, signed by President Trump, reaffirms that "no regulation shall be issued by an agency if it was not included on the most recent version or update of the published Unified Regulatory Agenda…unless the issuance of such regulation was approved in advance in writing by the Director" of the Office of Management and Budget.[121] We are aware of no circumstance that would justify the Director approving an exception to this normal process in this instance. We are concerned that the failure of the Department to comply with these requirements reflects a hasty development of the rule that lacked sufficient review of its impact and factual and legal basis.

B. Failure to conduct a meaningful federalism analysis

The Department also failed to comply with the requirements of Executive Order 13,132, which requires agencies to conduct a thorough review of any federalism implications of its regulations, including by identifying effects the regulation would have on existing state and local laws and on the ability of states to exercise power in realms traditionally reserved for them, as well as identifying and in some cases providing funding for costs that would be incurred by state and local governments.[122] The Department's cursory review of federalism implications meets none of those basic requirements. Its conclusion that the regulation has *no* federalism implications is directly contradicted the Department's own statements that its regulation could upend numerous existing state and local laws and policies, require changes to state programs such as Medicaid, and limit the manner in which many states can regulate health care in the future.[123] Regardless of the merits of the Department's interpretation of existing federal law, it is required to make a fact-based federalism assessment that recognizes these impacts of the regulation on state and local laws.

C. Failure to assess the costs of denied or delayed health care

Additionally, the Department failed to comply with Executive Order 13,563, which permits agencies to propose a rule only after conducting an accurate assessment of costs and benefits, and after reaching a reasoned determination that the benefits outweigh the costs and that the regulations are tailored "to impose the least burden on society."[124] While the Department considered the substantial financial costs that its new notification requirements may have on certain health care entities, it failed to even attempt to assess the most significant cost its rule would have if adopted: the cost incurred by patients whose access to care may be denied, delayed, or limited, including substantial financial and health-related costs to patients, to health care entities, and to government-funded health programs. Neglecting to take this cost into consideration or even acknowledge it—despite the Department's past recognition of the pervasiveness of barriers to health care faced by many patients[125]—is suggestive of an arbitrary and

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[120] *E.g.,* Exec. Order No. 13,771, 82 Fed. Reg. 9339, 9340 (Jan. 30, 2017); Exec. Order No. 12,866, 58 Fed. Reg. 190 (Oct. 4, 1993).
[121] *Id*.
[122] Exec. Order No. 13,132, 64 Fed. Reg. 43,255 (Aug. 4, 1999).
[123] *See, e.g,* Proposed Rule, 83 Fed. Reg. at 3886–3888.
[124] Exec. Order No. 13,563, 76 Fed. Reg. 3821 (Jan. 21, 2011).
[125] *See, e.g.,* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (2016).

capricious process that entirely failed to consider a crucially important aspect of the issued addressed in the rule.

D. Failure to adequately consider comments from the Department's closely related RFI

We are further concerned that the timing of the publication of the proposed rule reflects an insufficient consideration of public comments to the Department's recent Request for Information on a closely related topic, "Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding." The Department completed its comment period on the Request for Information in November 24, only two months before the publication of this rule, and received over 12,000 comments—the vast majority of which were not posted publicly until mid-December.[126] Many, if not most, of these public comments focused on the precise topic of this proposed rule: religious exemptions for health care workers and institutions. Yet despite the clear and close connection between the RFI and the proposed rule, the brief period of time between them suggests that it is unlikely that the proposed rule reflects a serious, reasoned analysis of the many comments the Department received on the RFI.

This hasty rule development stands in sharp contrast with the typical process for HHS and other agency rules, which commonly spans over several months or years instead of only a few weeks. An illustrative example is the Department's rulemaking process implementing Section 1557 of the Affordable Care Act, which began with a Request for Information in 2013, a proposed rule in 2015, and a final rule in 2016 issued after thorough consideration of more than 25,000 public comments.[127] Given that this proposed rule invokes dozens of distinct statutes, affects numerous areas of both health care service provision and coverage, and imposes sweeping and burdensome new notice and certification requirements—all without any change in the governing statutory or case law—it deserves at least as much deliberation.

VII. Expanding religion-based exemptions is unnecessary.

In addition to raising legal and constitutional questions, an expansion of religion-based exemptions is unnecessary as a matter of policy. Federal statutes and existing regulations, including the existing OCR conscience rule, already provide a broad range of special exemptions for health care providers or entities with religious or moral objections to many services, and these exemptions provide more than adequate protections, as evidenced by the large number of faith-based organizations that have received and continue to receive federal grants and other federal funding.

Among the laws and regulations that protect health care entities, in addition to the statutes cited by the proposed rule, is the Religious Freedom Restoration Act (RFRA). RFRA protects any grantee from any government action (including a denial or limitation of a grant or contract) that substantially burdens their exercise of religion, unless the government can meet the high burden of demonstrating that the action is narrowly tailored to serve a compelling interest. The protections in RFRA are more than sufficient to ensure that faith-based organizations and providers with religious or moral objections to certain procedures can receive case-by-case accommodations, as appropriate, to have a fair opportunity to

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[126] Dan Diamond, *HHS Defends Withholding Comments Critical of Abortion, Transgender Policy*. POLITICO (Dec. 18, 2017), https://www.politico.com/story/2017/12/18/hhs-faith-based-rule-withholding-comments-236759.

[127] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,376.

receive federal funds. Existing Department regulations explicitly acknowledge that their requirements are subject to limitations under RFRA and other federal laws.[128]

Conclusion

We strongly urge the Department to refrain from expanding health care refusal rights as proposed in this rule. Doing so would undermine vulnerable populations' access to essential health services and compromise the Department's ability to meet its responsibilities to legal beneficiaries and its legal obligations. Protecting religious freedom is important, and a range of existing laws and regulations already provide more than adequate protections for individuals and entities with religious or moral objections to providing specific services. It is therefore unwise and unnecessary for the Department to put patients at risk by allowing them to be mistreated or denied care using the federal dollars that are intended to help them. Moreover, the proposed rule is contrary to law in numerous respects. We strongly urge the Department to abandon this unnecessary, untenable, and harmful proposed rule and instead maintain the existing 2011 rule on the topic, while preserving OCR's primary focus on enforcing the civil rights and privacy rights of patients.

Thank you for your consideration.

[128] *See, e.g.,* 45 C.F.R. pt. 92 §92.2(b)(2).

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, vs. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	Case No. 2:19-cv-00183-SAB [PROPOSED] ORDER GRANTING MOTION FOR LEAVE TO FILE *AMICI CURIAE* BRIEF BY SCHOLARS OF THE LGBT POPULATION IN SUPPORT OF PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

On September 20, 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.

IT IS SO ORDERED this _____ day of _____, 2019.

_____
HON. STANLEY A. BASTIAN
UNITED STATES DISTRICT JUDGE

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