

20-15398(L)
20-15399(CON), 20-16045(CON), 20-35044(CON)

**IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

CITY AND COUNTY OF SAN FRANCISCO, COUNTY OF SANTA CLARA,
LOS ANGELES LGBT CENTER, WHITMAN-WALKER CLINIC, INC. d/b/a
WHITMAN-WALKER HEALTH, BRADBURY-SULLIVAN LGBT
COMMUNITY CENTER ON HALSTEAD, HARTFORD GYN CENTER,
MAZZONI CENTER, MEDICAL STUDENTS FOR CHOICE, AGLP: THE
ASSOCIATION OF LGBTQ+ PHYCHIATRISTS, AMERICAN ASSOCIATION
OF PHYSICIANS FOR HUMAN RIGHTS d/b/a GLMA: HEALTH
PROFESSIONALS ADVANCING LGBTQ EQUALITY, COLLEEN
MCNICHOLAS, ROBERT BOLAN, WARD CARPENTER, SARAH HENN,
RANDY PUMPHREY, STATE OF CALIFORNIA, STATE OF WASHINGTON,

Plaintiffs-Appellees,

(Caption continued on inside cover)

On Appeal from the United States District Courts
for the Northern District of California
and the District of Washington

**AMICI CURIAE BRIEF BY SCHOLARS OF THE LGBT POPULATION
IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE**

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CITY AND COUNTY OF SAN FRANCISCO,

Plaintiff-Appellee,

v.

ALEX M. AZAR, II, Secretary of the U.S. Department of Health and Human
Services; et al.,

Defendants-Appellants,

COUNTY OF SANTA CLARA; et al.,

Plaintiffs-Appellees,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M.
AZAR, II, in his official capacity as Secretary of Health and Human Services,

Defendants-Appellants,

STATE OF CALIFORNIA,

Plaintiff-Appellee,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of
Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICES,

Defendants-Appellants,

STATE OF WASHINGTON,

Plaintiff-Appellee,

v.

ALEX M. AZAR, II; U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICES,

Defendants-Appellants.

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INTEREST OF AMICI CURIAE¹

Amici curiae (identified in the Appendix to this brief) 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 have a substantial interest in the subject of this litigation and submit this brief to help to clarify the effects of Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2018) (codified at 45 C.F.R. pt. 88) (the “Rule”), on LGBT people. 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*, 576 U.S. 644, 667 (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

¹ [This brief is filed with the consent of all parties, as permitted by Federal Rule of Appellate Procedure 29(a)(2) and Local Rule 29.3. No party’s counsel has authored this amicus brief, in whole or in part, and no party or party’s counsel has contributed money that was intended to fund the preparation or submission of the brief. No person—other than amici curiae, its members, or its counsel—contributed money that was intended to fund preparing or submitting this brief.]

F. Supp. 2d 757, 763-64 (E.D. Mich. 2014) *rev'd by Obergefell v. Hodges*, 576 U.S. 644 (2015); *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010).

SUMMARY OF ARGUMENT

Congress drafted the Church Amendments, 42 U.S.C. § 300a-7, and the other statutes that the Rule purports to implement (the “provider-conscience statutes”) to protect religious liberty. Yet, recognizing the importance of healthcare and the consequences of its denial, Congress drafted the provider-conscience statutes to apply only to circumscribed services offered by specified groups of health providers who receive identified streams of federal funds.

The Rule, by contrast, is designed to expand the circumstances in which healthcare workers may deny necessary medical care. Elevating religious objections to care over all other interests, the Department of Health and Human Services (“HHS”) declined to include in the Rule even minimal protections for patients, such as an exception for emergency situations or an express statement in the Rule that people cannot be turned away based on their demographic characteristics. As the district courts below held, the Rule exceeds the authority granted to HHS by the provider-conscience statutes, is arbitrary and capricious, violates the Constitution, conflicts with numerous other laws, and otherwise contravenes the Administrative Procedure Act (“APA”), 5 U.S.C. § 706(2).

Amici file in support of Plaintiffs-Appellees and urge this court to uphold the district courts' opinions in their entirety. The court in *Washington v Azar*, 426 F. Supp. 3d 704, 721 (E.D. Wash. 2019), in particular, invalidated the Rule on the ground that amici urge here: the failure of the United States Department of Health and Human Services ("HHS") to address with any intellectual rigor the harms that the Rule stands to impose on LGBT people. As the *Washington* court explained, the Rule is arbitrary and capricious because, among other things, "HHS disregarded the comments and evidence showing the Rule would severely and disproportionately harm certain vulnerable populations, including women; lesbian, gay[,] bisexual, and transgender people (LGBT individuals); individuals with disabilities; and people living in rural areas." *Id.*

As the *Washington* court did, this Court should conclude that the Rule is invalid because HHS failed to actually weigh the evidence that the Rule would increase denials of care based on sexual orientation or gender identity, rendering its actions arbitrary and capricious. See *Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (agency action is arbitrary and capricious if the agency "offered an explanation for its decision that runs counter to the evidence before the agency"). The Rule is broadly worded in ways that would enable HHS to assert—and healthcare providers and LGBT people to believe—that such care can be refused on religious grounds, and HHS declined to rule out that

application. Given that reality, HHS had to address the evidence in the administrative record that LGBT people face pervasive stigma and discrimination in healthcare and elsewhere; that such stigma and discrimination drive health disparities affecting LGBT people, such as higher prevalence of suicide ideation and attempts; and that such stigma and discrimination are commonly motivated by religious beliefs. This evidence shows that the Rule will harm LGBT people because they are more likely to be denied care under the Rule; in addition to imposing the costs of finding alternative care (where such care may not even be available for persons in managed care settings or rural areas), these denials will have a proven impact on the mental and physical health of LGBT people. HHS's decision to ignore or discount this evidence, while relying on speculative benefits, is alone enough to invalidate the Rule as arbitrary and capricious.

ARGUMENT

First principles of administrative law require agency decisionmakers to weigh the costs and benefits of agency action. *State Farm*, 463 U.S. at 43. Here, HHS failed to meaningfully weigh the harms that the Rule would impose on LGBT people against the benefits that it believed the Rule would provide. First, because the Rule is plausibly read to allow healthcare providers to deny coverage to LGBT people, HHS had to decide whether such denials would be costly. Second, the administrative record contained a wealth of evidence showing that refusals to treat LGBT people

(and fear of such refusals) already causes costly harms to LGBT people. The Rule will only exacerbate those harms because, as HHS admitted, it will cause even more providers to deny treatment on religious grounds. Third, HHS did not meaningfully weigh the harms to LGBT people from an increase in treatment refusals, despite vast record evidence of those harms. It also inflated the benefits of the Rule by guessing that even LGBT people who lose out on treatment under the Rule would be so pleased that strangers were invoking their religious beliefs in denying them care that they would not mind the harsh reality that they were being denied necessary treatment. That unexplained discounting of costs and inflation of benefits is a textbook example of arbitrary decisionmaking and requires vacating the Rule.

I. BECAUSE THE RULE IS PLAUSIBLY READ TO ALLOW HEALTHCARE PROVIDERS TO DENY COVERAGE TO LGBT PEOPLE, HHS HAD TO DECIDE WHETHER SUCH DENIALS WOULD BE COSTLY.

HHS left the door wide open for the Rule's terms to apply to a broad spectrum of care provided to LGBT people. Commenters made their concerns on this point clear to HHS, which dismissed them. For instance, HHS 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.*, 84 Fed. Reg. at 23215. HHS also dismissed concerns that the Rule would disparately affect women, LGBT people, and religious minorities, responding with the vague assertion that "[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.” *Id.* at 23197. Yet HHS acknowledged that healthcare providers had asserted the right to withhold treatment to LGBT people (such as treatment for gender dysphoria) and did not outright deny commenters’ views that the Rule could indeed be read this way. *Id.* at 23205.

The breadth and vagueness of the Rule invite providers and LGBT people to believe that the Rule *does* authorize such denials—marking a divergence from HHS’s finding nearly a decade earlier that a similar rule would endanger access to care by the LGBT population. 76 Fed. Reg. 9969 (Feb. 23, 2011). This change of stance made it all the more necessary for HHS to consider the evidence of harm to LGBT people that could result from the Rule. *See* Exec. Order No. 12,866 §§ 6-7, 58 Fed. Reg. 51741 (Oct. 4, 1993) (requiring the issuing agency of a new rule to provide an “assessment of the potential costs and benefits of the regulatory action”); Exec. Order No. 13,563 § 1(c) (Jan. 18, 2011) (directing the issuing agency, when possible, to “consider (and discuss qualitatively) values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts”); 76 Fed. Reg. 3821. In doing so, HHS was not only prohibited from relying on explanations that are “implausible” or “counter to the evidence before the agency,” *State Farm*, 463 U.S. at 43, but was affirmatively required to present “good reasons” for reversing its 2011 finding. *FCC v. Fox Television Stations, Inc.*, 556

U.S. 502, 515-16 (2009); see *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125-26 (2016) (agency departing from prior policy must give “reasoned explanation . . . for disregarding facts and circumstances that underlay or were engendered by the prior policy”) (citation and quotation marks omitted). HHS failed to meet these requirements here; because it did not do so, the Rule is invalid.

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

Evidence before HHS established that (a) LGBT people experience high levels of rejection and discrimination in healthcare; (b) both the experience and expectation of rejection and discrimination create what is referred to in public health research as “minority stress,” which decades of research shows leads to adverse health outcomes and health disparities for LGBT people; and (c) anti-LGBT discrimination in healthcare and beyond is often religiously motivated. This evidence indicates that the Rule, to the extent it applies or is viewed as applying to LGBT people qua LGBT people,² will exacerbate discrimination, ill health, and health disparities facing this population.³

² In this brief, we focus on harms that result from broad-based denials of care to LGBT people. But even were the rule to be construed to apply only to permit denials of gender-affirming care, HHS was obligated—and failed—to consider the costs imposed by those denials.

³ Unless otherwise indicated, the sources discussed in this brief are part of the administrative record, submitted to HHS in response to the proposed rule, by the

A. LGBT People Face Pervasive Discrimination in Healthcare and Other Settings.

LGBT people—who make up roughly 4.5% of the U.S. adult population⁴—have faced a long, painful history of public and private discrimination in the United States. They are “among the most stigmatized, misunderstood, and discriminated-against minorities in the history of the world,” *Baskin*, 766 F.3d at 658, having been “prohibited from most government employment, barred from military service, excluded under immigration laws, targeted by police, and burdened in their rights to associate,” *Obergefell*, 576 U.S. at 660-61; *see also, e.g., Brocksmit v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014) (“The hostility and discrimination that transgender individuals face in our society today is well-documented.”). 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 LGBT people continue to face persistent and pervasive

Williams Institute (AR72082) (“Williams Institute Comment”); American Medical Association (70564) (“AMA Comment”); County of Santa Clara (AR54930) (“Santa Clara Comment”); Empire Justice Center (AR71892) (“EJC Comment”); Human Rights Watch (AR71217) (“HRW Comment”); Human Rights Campaign (AR70848) (“HRC Comment”), Lambda Legal (AR72186) (“Lambda Comment”); National Center for Lesbian Rights (AR69074) (“NCLR Comment”), and National Center for Transgender Equality (AR71274) (“NCTE Comment”), among others.

⁴ Frank Newport, *In U.S., Estimate of LGBT Population Rises to 4.5%* (May 22, 2018). (The Table of Authorities in this brief includes URLs for all sources available on the internet.) Earlier data are in the administrative record. *See Williams Institute Comment* at 8 n.26.

violence, stigma, and discrimination at work and school, in housing and by businesses, from their families of origins, and in healthcare. See Brief of Amici Curiae Ilan H. Meyer, PhD, and Other Social Scientists and Legal Scholars Who Study the LGB Population (“Meyer Brief”), No. 16-111, 11-12, *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm’n*, 138 S. Ct. 1719 (2018), *cited in and appended to* Williams Institute Comment. Even among high schoolers—perhaps the population most likely to have adopted more-accepting norms—LGBT youth continue to be disproportionately targeted for harassment. *Id.* at 11 n.9, 31-32.

The discrimination that LGBT people face in all walks of life pervades their healthcare experience too. According to the Institute of Medicine (now the Health and Medicine Division of the National Academies), which operates under a congressional charter and provides independent, objective analysis of scientific research, “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,” including the “outright denial of care” on some occasions. Institute of Medicine (“IOM”), *The Health of Lesbian, Gay, Bisexual, & Transgender People*, at 62 (2011), *cited in* Williams Institute Comment at 8.

Survey results included in the administrative record revealed widespread discrimination against LGBT people in healthcare. In a recent nationally

representative survey, 8% of LGB people and 29% of transgender people who had visited a healthcare provider *in the preceding year* reported that a provider refused them care outright because of their sexual orientation or gender identity. Mirza & Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), *cited in* Lambda Comment at 11, 13 (hereinafter “Mirza & Rooney”). In another nationally representative survey of LGBTQ⁵ people, 16% of all respondents said they had experienced some form of discrimination while going to a doctor or health clinic, and 22% of transgender respondents said they have avoided doctors or healthcare for fear of discrimination. NPR, Robert Wood Johnson Foundation & Harvard T.H. Chan School of Public Health, *Discrimination in America: Experiences and Views of LGBTQ Americans*, 2, 10 (2017). According to another large survey, almost 56% of LGB respondents and 70% of transgender respondents reported experiencing at least one of several forms of discrimination in care. Lambda Legal, *When Health Care Isn’t Caring* (“Lambda Survey”) 5 (2010), *cited in* Lambda Comment at 10-12; *see also* James et al., *The Report of the 2015 U.S. Transgender Survey* (“USTS”) 97 (2016), *cited in* NCTE Comment at 4. In addition, a recent qualitative study documented numerous instances of mistreatment and discrimination against LGBTQ people in healthcare settings. Human Rights

⁵ “Q” stands for questioning.

Watch (“HRW”), *“All We Want Is Equality”: Religious Exemptions and Discrimination Against LGBT People in the United States* 20-26 (2018), cited in HRW Comment at 3.

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

Denials of healthcare have harmful repercussions for LGBT people’s health, wellbeing, and dignity. A person who is denied care must, at a minimum, experience the inconvenience and expense of seeking alternative providers. This can be especially difficult for those who live in communities where alternatives are not readily available. *See, e.g.,* Mirza & Rooney, *supra* (nearly a fifth of LGBT individuals reported it would be “very difficult” or “not possible” to find the same type of healthcare service at a different hospital, health center, or clinic; higher percentages of LGBT people living outside of a metropolitan area reported such difficulty or impossibility).⁶ Where delay in obtaining care has consequences for physical or mental health, those repercussions are exacerbated and could result in needless suffering, disability, or death. Discrimination related to sexual orientation or gender identity can also be psychologically damaging to the victim, because it

⁶ *See also* Frazer & Howe, *LGBT Health and Human Services Needs in New York State: A Report from the 2015 LGBT Health and Human Services Needs Assessment* 16-18 & fig. 19 (2016) (refusals of care and long travel distances to healthcare providers are obstacles for LGBT people across New York, but especially for those living Upstate), cited in EJC Comment at 2.

conveys a strong symbolic message of disapprobation of something core to that person's identity. Williams Institute Comment at 9; Meyer Brief 15.

Beyond these immediate impacts, healthcare refusals can also cause LGBT people—including not only those who experience discrimination firsthand but also those who learn about discrimination against others in the community—to defer or outright avoid needed care in order to minimize the risk of discriminatory encounters. As the IOM has explained, “[f]ear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care.” IOM, *supra*, at 63. In the nationally representative survey cited above, “8 percent of all LGBTQ people—and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff.” Mirza & Rooney, *supra*; see also Lambda Survey at 12-13. This chilling effect results in disparities in LGBT people's use of healthcare. Lesbians, for example, are less likely than straight women to get preventive services for cancer, and transgender individuals face barriers to accessing HIV prevention and care. See Office of Disease Prevention & Health Promotion (“ODPHP”), *Lesbian, Gay, Bisexual, & Transgender Health*, cited in Williams Institute Comment at 10; IOM, *supra*, at 222-25.

Not only do healthcare refusals risk worsening LGBT people's access to and utilization of healthcare, but they also 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, *supra*; IOM, *supra*, at 4-5; Williams Institute Comment at 7-10; Meyer Brief 20-24. 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, *supra*; *see also* IOM, *supra*, 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 ODPHP, an office within HHS itself, “[r]esearch suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights” and that “[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination.” ODPHP, *supra*; *see* CDC, *Stigma & Discrimination* (last visited Sept. 3, 2019; cited in Williams Institute Comment at 9). Likewise, “[c]ontemporary health disparities based on sexual orientation and gender identity are rooted in and reflect the historical stigmatization

of LGBT people.” IOM, *supra*, at 32. And although that “historical stigmatization” might be thought to affect older LGBT people more acutely, LGBT youth experience it as well. As IOM has observed, “the disparities in both mental and physical health . . . are seen between LGBT and heterosexual and non-gender-variant youth,” owing to “experiences of stigma and discrimination during the development of” the LGBT youths’ “sexual orientation and gender identity and throughout the life course.” *Id.* at 142.

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, *id.* at 20—describes how LGBT people experience chronic stress stemming from their stigmatization. While stressors, such as loss of a job or housing, are ubiquitous in society and experienced by LGBT and non-LGBT people alike, LGBT people are additionally exposed to 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 creates an elevated risk for diseases caused by stress, including many mental and physical disorders. See Meyer Brief 12-24; Williams Institute Comment at 7-10.

When an LGBT person is turned away from healthcare because of sexual orientation or gender identity, that is a “prejudice event,” a type of minority stress, that has both tangible (*i.e.*, the implications of needing to find a new provider) and symbolic (*i.e.*, the personal rejection and reverberation of social disapprobation) effects. And being denied—or threatened with denial of—healthcare increases expectations of future rejection and discrimination among LGBT people. 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 a stigmatizing social environment. For example, when an LGBT person seeks healthcare in a world where rejection and discrimination in healthcare settings are common, that person will likely experience stress in deciding whether to even seek the needed service; whether to come out to the provider; whether to bring a spouse who may “out” the patient; and, generally, how and from whom to disguise their LGBT identity. LGBT people thus vigilantly strive to protect themselves from mistreatment in healthcare settings. To avoid discrimination, many LGBT people will delay or altogether skip obtaining care. *See Meyer Brief 12-24; Williams Institute Comment at 7-10.*

C. Anti-LGBT Discrimination Is Often Religiously Motivated.

While many people and institutions of faith welcome and affirm LGBT people—and many LGBT people are themselves people of faith—the record

contains many examples of anti-LGBT discrimination undertaken in the name of religion. According to HHS, “[m]ultiple comments provided lists of various incidents in which providers declined to participate in a service or procedure to which they had a religious or moral objection.” 84 Fed. Reg. at 23252; *see also, e.g.*, Lambda Comment at 14-17; NCLR Comment at 9-11; HRW, *supra*, at 20-26.

Among those incidents are multiple outright denials of care. For instance, 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 Comment at 5. In 2000, a doctor refused on religious grounds to perform donor insemination for lesbians. *See N. Coast Women’s Care Med. Grp., Inc. v. Superior Court (Benitez)*, 189 P.3d 959, 963-64 (Cal. 2008), *cited in* Lambda Comment at 14). Similarly, an Alabama clinic refused a lesbian couple fertility services because of the doctor’s “religious belief that he only treats straight married couples.” HRW at 20-21. And in 2015, 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-affirming care. *See Complaint, Conforti v. St. Joseph’s Healthcare Sys.*, No. 2:17-cv-0050 (D.N.J., Jan. 5, 2017), *cited in* Lambda Comment at 16.

In addition to outright denials of care, anti-LGBT proselytizing and harassment is common in healthcare settings. “One of the most common stories about hostility and harassment” among over 13,000 public comments and stories that Human Rights Campaign collected from individuals in this rulemaking “included unwanted proselytizing by hospital or clinic staff.” HRC Comment at 2. A different commenter relayed the story of a transgender person who reported their transgender status because it is “a relevant piece of medical information,” only to have the doctor immediately respond, “I believe the transgender lifestyle is wrong and sinful.” NCTE Comment at 10. According to another: “Since coming out, I have avoided seeing my primary physician because when she asked me my sexual history, I responded that I slept with women and that I was a lesbian. Her response was, ‘Do you know that’s against the Bible, against God?’” Lambda Comment at 15. That commenter also referenced a case involving a nurse consultant who “visited the home of a same-sex couple, one of whom was in the end stages of AIDS,” and proselytized against “the ‘homosexual lifestyle.’” *Knight v. Conn. Dep’t of Pub. Health*, 275 F.3d 156, 161 (2d Cir. 2001), cited in Lambda Comment at 15.

The administrative record here also includes incidents where healthcare providers sought to practice or urged conversion therapy on LGBT people.⁷ One commenter relayed the story of a gay man whose doctor told him “that it was not medicine [he] needed but to leave [his] ‘dirty lifestyle.’” Lambda Comment at 15. The doctor told the man of “other patients” whom he had put “in touch with ministers who could help gay men repent and heal from sin, and he even suggested that [the man] simply needed to ‘date the right woman’ to get over [his] depression”—and “even went so far as to suggest that his daughter might be a good fit for [him].” *Id.* The same commenter described another case in which a religious-counseling student intended to practice conversion therapy on her LGBT clients, in violation of the applicable professional code of ethics. *Keeton v. Anderson-Wiley*, 664 F.3d 865, 868-69 (11th Cir. 2011), *cited in* Lambda Comment at 14.

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

The Rule is expressly designed to expand the circumstances in which healthcare providers can deny care. According to HHS, “as a result of this rule, more individuals, having been apprised of those rights, will assert them.” 84 Fed. Reg. at 23250. In other words, even more providers than already do will refuse to treat

⁷ Experiences of conversion therapy have been linked to negative health outcomes for LGBT people. Christy Mallory, et al., *Conversion Therapy & LGBT Youth*, at 1 (June 2019).

patients—including LGBT patients—on the basis of religious objections. The Rule thus serves to increase the risk and expectation that LGBT people will be denied healthcare, leading to increased incidents of discrimination and increased patient stress related to seeking healthcare. Conversely, HHS concluded that the 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 23246. But HHS cannot have it both ways. If it is expanding the protections available for those who would deny medical care, it is necessarily decreasing the availability of care for those who seek the denied services. *See Washington*, 426 F. Supp. 3d at 721; *San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1012 (N.D. Cal 2019). In turn, the Rule risks reducing the health and wellbeing of LGBT people and exacerbating health disparities between LGBT and non-LGBT populations.

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

HHS arbitrarily and capriciously concluded that the Rule will improve access to healthcare and quality care while securing societal good. 84 Fed. Reg. at 23246. 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). First, HHS failed to reasonably assess the costs of the Rule in terms of harms to patients (LGBT or otherwise). HHS’s analysis falls far short even of the least burdensome approach to addressing unquantifiable costs set forth in the

agency’s Guidelines for Regulatory Impact Analysis. U.S. Department of Health and Human Services, *Guidelines for Regulatory Impact Analysis* (“*Guidelines*”) 51 (2016). Although the *Guidelines* are not binding, HHS’s failure to account for these costs demonstrates that the Rule is arbitrary and capricious and violates the APA.

Second, HHS unreasonably relied on speculative benefits of the Rule. In carrying out its flawed assessment, HHS applied inconsistent evidentiary standards that allowed the agency to dismiss foreseeable harms while relying on speculative benefits. HHS’s “‘internally inconsistent’ treatment of the anecdotal evidence—relying upon it when it supports the rule but dismissing it when it does not—renders the rulemaking process arbitrary and capricious” in violation of the APA. *Washington*, 426 F. Supp. 3d at 721; *see Bus. Roundtable v. SEC*, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011) (agency cannot “inconsistently and opportunistically” frame the rule’s effects); *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.

“Agencies have long treated cost as a centrally relevant factor when deciding whether to regulate. . . . [and] any disadvantage could be termed a cost.” *Michigan v. EPA*, 576 U.S. 743, 752-53 (2015). 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,” including harm to the patient’s health “if an alternative is not readily found, depending on the condition” and “search costs for finding an alternative.” 84 Fed. Reg. at 23251. HHS also “recognize[d] that, in some circumstances, some patients do experience emotional distress as a consequence of providers’ exercise of religious beliefs or moral convictions.” *Id.* HHS concluded that “[t]hese three potential harms” would also apply to “denials of care based on, for example, inability to pay the requested amount.” *Id.* In doing so, HHS improperly conflated harm from denials based on general inability to access care with harm from denials of care based on LGBT status.

This conclusion is flatly contrary to the minority stress research provided to HHS. While a denial of care based on an inability to pay would be a general stressor that LGBT and non-LGBT people alike might experience, a denial of care related to a person’s status as a sexual or gender minority is a prejudice that imposes unique tangible and symbolic harms on the LGBT victim, and has more severe health implications than a denial not related to prejudice. HHS therefore ignored that denial of care to LGBT people, based solely on their demographic status, comes with a unique additional harm beyond the harm of denial itself. And by conflating the reasons for denial, HHS factored a cost out of the equation.

Though HHS seemed to partially acknowledge this reality by conceding two additional harms to patients—harm caused by a provider refusing to provide even a

referral and the possibility that “others in the community to which the patient belongs may be less willing to seek medical care”—that would not occur for someone who is unable to pay, *id.*, it deemed irrelevant commenters’ voluminous evidence related to patients being turned away from care. HHS ignored this evidence because “comment[ers] . . . [did not] establish[] a causal relationship between this rule and how it would affect health care access, and [did not] provid[e] any data the Department believes enables a reliable quantification of the effect of the rule on access to providers and to care.” 84 Fed. Reg. at 23250. And while HHS acknowledged that the LGBT population (among other demographic groups) “face[s] health care disparities of various forms,” 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 23251-23252.

In so responding, HHS improperly shifted the burden to commenters instead of evaluating the evidence presented. The agency, not commenters, must “use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible.” Exec. Order No. 13,563 § 1(c); 76 Fed. Reg. at 3821. Agencies should also consider not just “direct cost . . . in complying with the regulation,” but also “any adverse effects” the Rule might have on “health and safety.” Exec. Order No. 12,866 § 6(a)(3)(C)(ii). As the district court in *Washington*

correctly stated, this failure to adequately account for costs renders the Rule arbitrary and capricious. *Washington*, 426 F. Supp. 3d at 721; *see also New York v. U.S. Dept. of Health and Human Servs.*, 414 F. Supp. 3d 475, 548-56 (S.D.N.Y. 2019).

HHS cannot justify its failure here by claiming that the evidence does not explicitly show a causal relationship between the Rule and harm to LGBT people and other vulnerable populations. In an ideal world, commenters might have been able to “isolat[e] the impact of the exercises of religious belief or moral conviction attributable to this final 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 23251. But the lack of such data does not relieve HHS 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 healthcare and health disparities that LGBT people face. If sufficient evidence was not available, HHS should have conducted “additional research prior to rulemaking,” 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). HHS did not even purport to weigh the costs of error against the benefits of speed.

Nor may HHS simply disregard costs that are uncertain or difficult to quantify. *See, e.g., Ctr. for Biological Diversity*, 538 F.3d at 1192, 1200 (agency acted arbitrarily and capriciously when it excluded from a cost-benefit analysis benefits that the agency deemed “too uncertain to support their explicit valuation”). While the Rule may result in “a range of values” for the costs to patients, that value “is certainly not zero” and must be “accounted for.” *Id.* at 1200.⁸ Yet HHS failed to follow even the least burdensome approach recommended for “nonquantifiable effects” in its *Guidelines*—an approach that entails categorizing effects in a table and then roughly indicating the direction and magnitude of the impact of each effect. *Guidelines* at 50. Instead, HHS simply stated that the unquantified costs were “[c]ompliance procedures (recordkeeping and compliance reporting) and seeking of alternative providers of certain objected-to medical services or procedures.” 84 Fed. Reg. at 23227.

By “offer[ing] an explanation for its decision that runs counter to the evidence before [it]”—evidence of significant costs to LGBT people—HHS violated first principles of agency decisionmaking. *State Farm*, 463 U.S. at 43; *see, e.g., Competitive Enter. Inst. v. Nat’l Highway Traffic Safety Admin.*, 956 F.2d 321, 326-

⁸ Even when presented with reliable data on certain metrics related to providers’ moral objections to abortion, because the data provided a range instead of “a single measure,” HHS dismissed it wholesale without considering the impact of any values within the range. 84 Fed. Reg. at 23252, n.346.

27 (D.C. Cir. 1992) (agency failed to consider impact on safety); *Corrosion Proof Fittings v. EPA*, 947 F.2d 1201, 1225 (5th Cir. 1991) (same); *Gresham v. Azar*, 363 F. Supp. 3d 165, 177-78 (D.D.C. 2019) (“Despite acknowledging at several points that commenters had predicted coverage loss, the agency did not engage with that possibility.”), *aff’d* 950 F.3d 93 (D.C. Cir. 2020).

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, more individuals, having been apprised of those rights, will assert them.” 84 Fed. Reg. at 23250. If HHS is correct that the Rule will increase denials of care, it cannot plausibly assert that the Rule creates no barriers to care. HHS’s arbitrariness is more pronounced still, given the agency’s recognition in 2011 that the exercise of provider-conscience rights “could limit access to reproductive health services and information, including contraception, and could impact a wide range of medical services, including care for sexual assault victims, provision of HIV/AIDS treatment, and emergency services.” 76 Fed. Reg. at 9968, 9974. HHS has failed provide any “reasoned explanation” for disregarding these findings underlying the 2011 rule. *Fox*, 556 U.S. at 515-16; *see* S.A. 96-97; *Washington*, 426 F. Supp. 3d at 721.

HHS’s dismissive approach is apparent in its analogy between harms to patients that would result from denials of healthcare and the costs borne by building

and apartment owners of “ensur[ing] that facilities are accessible to persons with disabilities” to comply with nondiscrimination mandates. 84 Fed. Reg. at 23251. Unlike patients seeking care, landlords are not innocent third parties; it is their facilities and practices that, even if unwittingly, create barriers for people with disabilities. And much more is at stake for patients here than mere inconvenience and expense. Being denied healthcare can be devastating. Being denied 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 healthcare denials contributes to health disparities for the LGBT population. *See supra* at 18-19. HHS’s analogy is not merely inapt; it reveals an entire lack of concern for patients denied care, contrary to HHS’s mission “to enhance and protect the health and well-being of all Americans.” HHS, *Introduction: About HHS* (last visited July 27, 2020).

B. HHS Improperly Inflated the Benefits of the Rule.

In stark contrast to its treatment of the vast evidence of the Rule’s foreseeable harms to patients, 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.” 84 Fed. Reg. at 23246. This conclusion defies logic. *See, e.g., GameFly, Inc. v. Postal Regulatory Comm’n*, 704 F.3d 145, 148 (D.C. Cir. 2013)

(“[I]f the result reached is illogical on its own terms, the [agency’s] order is arbitrary and capricious.” (citation and quotation marks omitted)); *cf. California v. Azar*, 950 F.3d 1067, 1101 (9th Cir. 2020) (finding that HHS’s cost benefit analysis was not arbitrary and capricious because HHS “reasonably concluded” that the harms cited by commenters “would not develop” based on available evidence).⁹ If more medical providers can deny care, it cannot follow that access to care will increase or that quality of care will improve. *Washington*, 426 F. Supp. 3d at 721 (finding it “elementary” that allowing more individuals to deny care will result in reduced access to care, “especially for those individuals in vulnerable populations who will be the target of the religious or moral objections,” including LGBT people). HHS’s contention that overall care will increase because providers who otherwise would

⁹ This case differs significantly from *California*, which involved a different rule. First, plaintiffs in that case were not asserting that the challenged rule redefined terms in the statute it purported to interpret; here, HHS has incorrectly interpreted the language of the provider-conscience laws. *San Francisco*, 411 F. Supp. 3d at 1024-25. Second, unlike in *California*, HHS here failed to adequately consider the reliance interests engendered by its prior rules. *See New York*, 414 F. Supp. 3d at 553. (“HHS’s failure to seriously and conscientiously consider recipients’ reliance interests, too, made the Rule arbitrary and capricious”); *see also DHS v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1915 (2020) (agency’s action was arbitrary and capricious, in part because it failed “to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing concerns”). Finally, HHS in this case is not entitled to the deference the *California* Court gave, because it failed to satisfy the predicate for giving such deference that its inferences not contradict the evidence before it. *See State Farm*, 463 U.S. at 43.

have withdrawn from their professions will now stay in the medical field, if true, still does not address the availability of the particular services to which providers purport to have religious objections.

Worse still, HHS came to this conclusion even though it stated that 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,” 84 Fed. Reg. at 23252; even though there were “no empirical data on how previous legislative or regulatory actions to protect conscience rights have affected access to care or health outcomes,” *id.* at 23251; 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.

The data disparity points up the flaws in HHS’s reasoning. For example, in concluding that the Rule will have a positive impact on the recruitment and retention of healthcare professionals, HHS cited only two sources: a 2009 convenience-sample survey of members of the Christian Medical Association and a letter from the American Association of Pro-Life Obstetricians and Gynecologists. *See* 84 Fed. Reg. at 23246-47. There was no evidence in these two documents of any provider leaving the medical field, or failing to enter the medical field, due to the prior interpretation of the provider-conscience statutes. It was therefore arbitrary and capricious for HHS to elevate these two sources over the wealth of data provided on

the harms the Rule would impose on vulnerable patients, as well as over comments from the American Medical Association, among other professional associations, that the Rule “would undermine patients’ access to medical care and information.” AMA Comment at 1; *see, e.g., Gen. Chem. Corp. v. United States*, 817 F.2d 844, 857 (D.C. Cir. 1987) (conclusion arbitrary and capricious where supporting analysis was “internally inconsistent”).

Even when HHS conceded that an asserted benefit could not be quantified, it still assigned that benefit a significant value—unlike its treatment of foreseeable harms to patients. HHS concluded that the Rule would benefit patient care, despite admitting that it knew of no “data that provides a basis of quantifying” those benefits. *See, e.g.,* 84 Fed. Reg. at 23249-50. Unable “to monetize the benefits of respect for [healthcare providers’] conscience,” HHS was left to assert, in conclusory fashion, that those benefits “are clearly significant.” *Id.* at 23250.

HHS’s unsupported assertions did not end there. It surmised, without citing a shred of evidence, that some patients, “out of respect for the beliefs of providers, may want a service but not take any offense, nor deem it any burden on themselves, for the provider to not provide that service to them.” *Id.* at 23251. It went further still in supposing that “[s]ome patients may even value the health care provider’s willingness to obey his or her conscience, because the patient feels that provider can be trusted to act with integrity in other matters as well.” *Id.* Such guesswork cannot

substitute for the reasoned decisionmaking the APA requires. *See, e.g., Latronica v. Local 1430 Int’l Bhd. of Elec. Workers Pension Fund*, 820 F. App’x 12, at *14 (2d Cir. 2020) (unpublished) (determination “based on speculation” is “arbitrary and capricious”); *Sorenson Commc’ns, Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014) (agency action based on “sheer speculation” is arbitrary and capricious).

In short, the scant data on which HHS relied to estimate the benefits of the Rule cannot be squared with HHS’s treatment of the vast and diverse evidence of the harms caused by the Rule. *See Washington*, 426 F. Supp. 3d at 721. HHS’s dismissal of commenters’ copious evidence and reliance instead on speculative benefits reflect differing evidentiary standards that alone demonstrate that the Rule is arbitrary and capricious.

CONCLUSION

For the foregoing reasons, we urge the court to affirm the district courts’ decisions and vacate the Rule in its entirety.

Date: Oct 20, 2020

Respectfully Submitted,

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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APPENDIX

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