UNITED STATES U.S. DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	Case Nos. 1:19-cv-4676-PAE 1:19-cv-5433-PAE 1:19-cv-5435-PAE

AMICI CURIAE BRIEF BY SCHOLARS OF THE LGBT POPULATION

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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 Church Amendments, 42 U.S.C. § 300a-7 (2018), and the other statutes that the Rule purports to implement (the "provider-conscience statutes") to protect religious liberty, which is a core principle of our democracy. At the same time, recognizing the importance of health care and the consequences of its denial, Congress drafted the Church Amendments, among other provider-conscience statutes, to apply only to a circumscribed set of services offered by a specified group of health providers who receive identified streams of federal funds. 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 or an express statement in the Rule that people cannot be turned away based on their demographic characteristics. 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 Plaintiffs' Cross-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 such care can be refused on religious grounds, and the agency declined to rule out that application. As a result, HHS was obligated to address the wealth of evidence in the administrative record that LGBT people face pervasive stigma and discrimination in health care and elsewhere; that such stigma and discrimination drive a variety of health disparities between LGBT people and non-LGBT people, such as higher prevalence of suicide ideation and attempts among LGBT people; and that such stigma and discrimination are commonly motivated by religious beliefs – which indicate that the Rule will harm LGBT people. HHS's improper decision to ignore or discount this evidence, while relying on speculative benefits, is alone sufficient to invalidate the Rule.

ARGUMENT

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

Amici do not believe that the provider-conscience statutes are properly applied to deny care to people based on their sexual orientation, gender identity, or other demographic characteristics. For example, these statutes do not authorize providers who provide services to non-LGBT people to deny cardiovascular or orthopedic care to an individual based on the provider's disapproval of that individual's LGBT identity. However, the preamble to the Rule is equivocal, at best, on this point. For example, HHS dismissed concerns that the Rule would disparately impact women, LGBT people, and religious minorities, stating only "[t]he terms defined in this rule do not apply to women, LGBT persons, or religious minorities in any way that differs from how Congress applied the terms in the statutes it adopted." 84 Fed. Reg. at 23,197. HHS also rejected commenter requests that the Rule expressly state that it does not authorize denials of care based on sexual orientation and gender identity. *See, e.g.*, *id.* at 23,215. In response to commenters who argued that the protections related to sterilization in the Church Amendments do not apply to treatment for gender dysphoria, HHS stated only that it would consider this issue on a case-by-case basis. *Id.* at 23,205. HHS has, at a minimum, left the door wide open to apply the Rule's terms to a broad spectrum of care provided to LGBT people.

Regardless of HHS's own view as to application of the provider-conscience statutes to denials of care based on sexual orientation or gender identity, moreover, the breadth and vagueness of the Rule invite providers and LGBT people to believe that the Rule does authorize such denials of care. As a result, HHS was 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 rejection and discrimination create what is referred to in public health research as "minority stress," which two decades of research has shown leads to adverse health outcomes for LGBT people and is a major cause of health disparities between LGBT and non-LGBT Americans; and (C) anti-LGBT discrimination in health care and beyond is often religiously motivated.[1] This uncontroverted evidence indicates that the Rule, to the extent it applies or is viewed as applying to LGBT people qua LGBT people, will exacerbate discrimination, ill health, and health disparities facing this population.

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

LGBT-identified people comprise approximately 4.5% of the U.S. adult population; younger people are more likely than older people to identify as LGBT, including 8.2% of millennials (born 1980-1999). Frank Newport, *In U.S., Estimate of LGBT Population Rises to 4.5%* (May 22, 2018), https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx.[2]

[1] 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 Williams Institute (72082) ("Williams Institute Comment"); American Medical Association (70564) ("AMA Comment"); County of Santa Clara (54930) ("Santa Clara Comment"); Empire Justice Center (71892) ("EJC Comment"); Human Rights Watch (71217) ("HRW Comment"); Human Rights Campaign (70848) ("HRC Comment"), Lambda Legal (72186) ("Lambda Comment"); National Center for Lesbian Rights (69074) ("NCLR Comment"), and National Center for Transgender Equality (71274) ("NCTE Comment"), among others.

[2] Earlier data are in the administrative record. *See* Williams Institute Comment at 8 n.26.

LGBT people have faced a long, painful history of public and private discrimination in the United States. In *Obergefell*, the Supreme Court observed that gay men and lesbians have been "prohibited from most government employment, barred from military service, excluded under immigration laws, targeted by police, and burdened in their rights to associate." 135 S. Ct. at 2596. The Seventh Circuit has explained that "homosexuals are among the most stigmatized, misunderstood, and discriminated-against minorities in the history of the world[.]" *Baskin*, 766 F.3d at 658; *see also 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*, 570 U.S. 744 (2013); *Brocksmith 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 anti-LGBT violence, stigma, and discrimination remain widespread.

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

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

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

Surveys of LGBT people reveal widespread discrimination in health care. Among other findings from a recent nationally-representative survey, 8% of LGB people and 29% of

transgender people who had visited a health care provider *in the preceding year* reported that a provider refused them care because of their sexual orientation or gender identity. Mirza & Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care (hereinafter "Mirza & Rooney"; cited in Lambda Comment at 11, 13). According to another large survey, almost 56% of LGB respondents and 70% of transgender respondents reported experiencing at least one of several forms of discrimination in care. Lambda Legal, *When Health Care Isn't Caring* 5 (2010) (hereinafter "Lambda Survey"; cited in Lambda Comment at 10-12); *see also* James, et al., *The Report of the 2015 U.S. Transgender Survey* 97 (2016) (hereinafter "USTS"; cited in NCTE Comment at 4).

The stigma and discrimination that LGBT people experience are not limited to health care. A variety of research finds that LGBT people face persistent and pervasive prejudice at work and school, in housing and by businesses, and from their families of origins. *See* Brief of Amici Curiae Ilan H. Meyer, PhD, and Other Social Scientists and Legal Scholars Who Study the LGB Population in Support of Respondents 11-12, *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719 (2018) (filed Oct. 30, 2017) (hereinafter "Meyer Brief"; 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.

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

Denials of health care can have harmful repercussions for LGBT people's health, well-being, and dignity. An individual who, or family that, is denied care must, at a minimum, experience the inconvenience and expense of seeking alternative providers. This can be

especially difficult for those who live in communities where no such alternatives are available or readily available. *See, e.g.*, Mirza & Rooney (nearly a fifth of LGBT individuals reported it would be "very difficult" or "not possible" to find the same type of service at a different hospital, health center, or clinic; higher percentages of LGBT people living outside of a metropolitan area reported such difficulty or impossibility); Frazer, M. S. & Howe, E.E. (2016) LGBT Health and Human Services Needs in New York State: A Report from the 2015 LGBT Health and Human Services Needs Assessment. The Lesbian, Gay, Bisexual & Transgender Community Center: New York, NY, at 16-18 & fig. 19 (2016) (refusals of care and long distances are obstacles for LGBT people across New York, but especially for those living Upstate) (cited in EJC Comment at 2). Where delay in obtaining care has consequences for physical or mental health, those damaging repercussions are exacerbated and 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 Institute Comment at 9; Meyer Brief at 15.

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. As the Institute of Medicine has explained, "[f]ear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care." IOM at 63. In the nationally-representative survey cited above, "8 percent of all LGBTQ people – and 14 percent of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year – avoided or postponed needed medical care because of disrespect or discrimination from health care staff." Mirza & Rooney; *see also*

Lambda Survey at 12-13. This chilling effect results in disparities in LGBT people's utilization of health care, such as lesbians being less likely than straight women to get preventive services for cancer, and transgender individuals facing barriers to accessing HIV prevention and care. *See* Office of Disease Prevention & Health Promotion, *Lesbian, Gay, Bisexual, & Transgender Health*, https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health (last visited Sept. 3, 2019) (hereinafter "ODPHP"; cited in Williams Institute Comment at 10); IOM at 222-25.

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

Substantial research identifies anti-LGBT stigma and discrimination as the drivers of health disparities between LGBT and non-LGBT populations. According to HHS itself, "[r]esearch suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights" and that "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination." ODPHP; *see also* Centers for Disease Control & Prevention, *Stigma & Discrimination*, https://www.cdc.gov/msmhealth/stigma-and-discrimination.htm (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 at 32. With respect to youth, "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." *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, IOM 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 uniquely 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 confers an elevated risk for diseases caused by stress, including many mental and physical disorders. *See* Meyer Brief at 12-24; Williams Institute Comment at 7-10.

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

stress because it leads to vigilance by LGBT people seeking to defend themselves against potential discrimination. Unlike tangible prejudice events, expectations of rejection and discrimination are stressful even in the absence of a specific event because they are based on what the LGBT person has learned from repeated exposure to a stigmatizing social environment. 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* Meyer Brief at 12-24; Williams Institute Comment at 7-10.

C. Anti-LGBT Discrimination is Often Religiously Motivated

While many people and institutions of faith are welcoming and affirming of LGBT people – and many LGBT people are themselves people of faith – the record contains many examples of anti-LGBT discrimination done in the name of religion. According to HHS, "[m]ultiple comments provided lists of various incidents in which providers declined to participate in a service or procedure to which they had a religious or moral objection." 84 Fed. Reg. at 23,252; *see also, e.g.*, Lambda Comment at 14-17; NCLR Comment at 9-11; Human Rights Watch, *"All We Want Is Equality": Religious Exemptions & Discrimination Against LGBT People in the United States* 20-26 (2018) (providing numerous examples) (hereinafter "HWR"; cited in HRW Comment 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 Comment at 5). In *N. Coast Women's Care Med. Grp., Inc. v. Super. Ct. (Benitez)*, 189 P.3d 959, 963-64 (Cal. 2008) (cited in Lambda Comment at 14), doctors refused on religious grounds to perform donor insemination for lesbians. Similarly, an Alabama clinic refused a lesbian couple fertility services because of the doctor's "religious belief that he only treats straight married couples." HRW at 20-21. In *Conforti v. St. Joseph's Healthcare Sys.*, No. 2:17-cv-0050 (D.N.J., Jan. 5, 2017), a transgender man was denied a medically necessary hysterectomy that his treating physician was ready to perform, because the religiously-affiliated hospital where the physician had admitting privileges did not permit gender-transition care. Lambda Comment at 16.

In addition to outright denials of care, anti-LGBT proselytizing and harassment is common in health care settings. According to the Human Rights Campaign, among over 13,000 public comments and stories it collected from individuals in this rulemaking, "[o]ne of the most common stories of hostility and harassment . . . included unwanted proselytizing by hospital or clinic staff." HRC Comment 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 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. Similarly, in *Knight v. Conn. Dep't of Pub. Health*, 275 F.3d 156, 161 (2d Cir. 2001) (cited in Lambda Comment at 15), a nurse consultant "visited the home of a same-

sex couple, one of whom was in the end stages of AIDS[,]" and proselytized against "the 'homosexual lifestyle.'"

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

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

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

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.

[3] According to recent estimates outside of the administrative record, approximately 698,000 LGBT adults have received conversion therapy, and tens of thousands of youth will receive conversion therapy from licensed health care professionals or from religious or spiritual advisors before they reach the age of 18. Christy Mallory, et al., *Conversion Therapy & LGBT Youth,* at 1 (June 2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-LGBT-Youth-Update-June-2019.pdf.

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

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

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

Under Executive Orders 12,866 and 13,563, HHS was required to fully analyze the costs and benefits of the Rule. 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 inconsistent evidentiary standards that allowed the agency to dismiss foreseeable harms while relying on speculative benefits. Because HHS "inconsistently and opportunistically framed" the Rule's effects, among other flaws, the

Rule violates the APA. *Bus. Roundtable v. SEC*, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011); *see also Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1198 (9th Cir. 2008) (agency "cannot put a thumb on the scale by undervaluing the benefits and overvaluing the costs . . . .").

A. HHS Improperly Disregarded Evidence of Foreseeable Harm to Patients

"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*, 135 S. Ct. 2699, 2707 (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 23,251. 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 be applicable for denials of care based on, for example, inability to pay the requested amount." *Id.* But this conclusion is flatly contrary to the minority stress research provided to HHS. Whereas 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 event that imposes unique tangible and symbolic harms on the LGBT victim, and has more severe health implication than a similar event not related to prejudice (as discussed above). HHS seems to acknowledge this, in part, when it concedes two additional harms to patients – the 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.*

Though HHS purported to recognize these various harms, it deemed irrelevant commenters' voluminous evidence related to patients from being turned away from care. Specifically, HHS brushed this evidence aside because "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 23,250. Similarly, while HHS acknowledged that the LGBT population (among other demographic groups) "face[s] health care disparities of various forms[,]" *id.* at 23,251, it deemed that evidence irrelevant because commenters did not "explain the extent to which such disparities are the product of the lawful exercise of religious beliefs or moral convictions." *Id.* at 23,252.

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

More importantly, HHS's requirement that commenters prove a *causal* relationship between the Rule and harm to LGBT people is an impossible standard because the Rule was not finalized at the time commenters made their submissions 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).

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 that LGBT people face. *See supra* Part II. Indeed, HHS cannot simply disregard costs that are uncertain or difficult to quantify. *See, e.g.*, *Ctr. for Biological Diversity*, 538 F.3d at 1190, 1198 (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 . . . ."). Ultimately, while there may be "a range of values" for the costs to patients of the Rule, that value "is certainly not zero" and must be "accounted for." *Id.* at 1200.[4] In violation of the APA, HHS turned a blind eye to the voluminous evidence documenting the significant adverse impact the regulation would have on patient health. *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[.]"); *Competitive Enter. Inst. v. Nat'l Highway Traffic Safety Admin*., 956 F.2d 321, 326-27 (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*,

[4] 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 23,252, n.346.

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.").

That HHS discounted all of the evidence about potential harms to patients is even more remarkable and 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 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 the agency recognized in a 2011 rule 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. 9968, 9974 (Feb. 23, 2011). HHS has failed provide a "reasoned explanation" for disregarding these findings underlying the 2011 rule. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009).

Ultimately, HHS's position seems to be that it does not matter that patients will be harmed by the Rule. HHS analogized harms to patients that would result from denials of health 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 Fair Housing Act and the Americans with Disabilities Act. 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 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 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." 84 Fed. Reg. at 23,246. 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[,]" *id.* at 23,252; even though there was "no empirical data on how previous legislative or regulatory actions to protect conscience rights have affected access to care or health outcomes[,]" *id*. at 23,251; and even though HHS held such a lack of data against commenters concerned about the Rule's impact on patients, *see supra* Part III.A.

For example, in concluding that the Rule will have a positive impact on the recruitment and retention of health care professionals, HHS cited only two sources – a 2009 convenience-sample survey of members of the Christian Medical Association, and a letter from the American Association of Pro-Life Obstetricians and Gynecologists. *See* 84 Fed. Reg. at 23,246-47. But it was arbitrary and capricious for HHS to elevate these sources over the wealth of data provided on the harms the Rule stands to impose on vulnerable patients, as well as over comments from the American Medical Association, among other professional associations, that the Rule "would

undermine patients' access to medical care and information[.]" AMA 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. *See, e.g.*, 84 Fed. Reg. at 23,249-50 (assigning benefits related to patient care where HHS was not "aware of data that provides a basis of quantifying these effects"); *id.* at 23,250 ("It is difficult to monetize the benefits of respect for conscience to the individual and society as a whole, but they are clearly significant."). HHS also made completely unsupported assertions that should not be credited, such as:

> Some persons, 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. Some 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. at 23,251.

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

IV. CONCLUSION

For the foregoing reasons, we urge the court to grant Plaintiffs' Cross-motion for Summary Judgment, to hold that the Rule violates the APA, and to deny Defendants' Motion for Summary Judgment.

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Respectfully submitted,

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