IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, et al., Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	No. 1:20-CV-05583-AKH

[PROPOSED] *AMICUS CURIAE* BRIEF OF COUNTY OF SANTA CLARA, CITY OF CHICAGO, AND 45 LOCAL GOVERNMENTS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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City of Columbus, Ohio

Cook County, Illinois

City of Dayton, Ohio

City of Duluth, Minnesota

City of Hayward, California

Howard County, Maryland

City of Holyoke, Massachusetts

City of Houston, Texas

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City of Los Angeles, California

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City of Seattle, Washington

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City of Somerville, Massachusetts

City of Saint Paul, Minnesota

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City of Tacoma, Washington

City of Tempe, Arizona

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INTEREST OF *AMICI CURIAE*[1] AND INTRODUCTION

Amici are 47 counties, cities, and towns located throughout the United States, including throughout most of the Plaintiff States. *Amici* range from massive metropolises such as New York City, to rural farm communities such as Monterey County. Notwithstanding our differences, *amici* are united in our opposition to the U.S. Department of Health and Human Services' (HHS) Affordable Care Act (ACA) Section 1557 nondiscrimination 2020 Rule ("2020 Rule").[2] The 2020 Rule unlawfully withdraws federal nondiscrimination protections from many of our most at-risk residents in intimate and important healthcare contexts, gutting HHS' prior 2016 Rule.[3] It inflicts tremendous harm on *amici*, our communities, and our residents—most of all our LGBTQ residents, limited English proficiency (LEP) speakers, and people seeking pregnancy-related care.

By its terms, the 2020 Rule *invites* discrimination in healthcare against patients who face disproportionate barriers to health and impedes their ability to challenge such discrimination. Its numerous provisions operate in discrete and mutually reinforcing ways to harm health and disconnect entire communities from necessary healthcare. In its "arguable centerpiece,"[4] the 2020 Rule erases federal prohibitions on healthcare discrimination based on sex stereotyping and

[1] No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici* or their counsel made a monetary contribution to this brief's preparation or submission. Counsel for all parties consented to the filing of this brief.

[2] Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (codified at 42 C.F.R. pts. 438, 440, & 460 and 45 C.F.R. pts. 86, 92, 147, 155, & 156).

[3] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (formerly codified at 45 C.F.R. pt. 92) ("2016 Rule").

[4] *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Hum. Servs.*, --- F.Supp.3d ----, 2020 WL 5232076, at *33 (D.D.C. Sept. 2, 2020).

gender identity,[5] all but enabling discrimination against LGBTQ people. It replicates this change in ten unrelated regulations, permitting, among other things, discrimination based on gender identity and sexual stereotyping by Medicaid managed care organizations (MCOs),[6] which serve most people who are reliant on Medicaid for their health insurance.[7] The 2020 Rule also excises federal prohibitions on healthcare discrimination based on pregnancy-related conditions.[8] It eliminates nondiscrimination obligations for many health insurers and most federal programs[9]—including the primary, preventative, and public health services administered by HHS components such as the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA)—that serve hundreds of millions of Americans.[10] It imports Title IX's sweeping abortion exemption, authorizing denials of care for abortions, miscarriages, and ectopic pregnancies, even when they are life-saving.[11] It authorizes religiously affiliated providers, health systems, and insurers to deny care and coverage to patients, endangering patients in

[5] 85 Fed. Reg. at 37,161-62.

[6] *Id.* at 37,243, 37,247-48 (42 C.F.R. §§ 147.104, 155.120, 155.220, 156.200, 156.1230, 438.3, 438.206, 440.262, 460.98, 460.112).

[7] Kaiser Family Found., *Total Medicaid MCO Enrollment* (2018), *archived at* https://perma.cc/GM8Y-VWXX (69% of Medicaid beneficiaries rely on Medicaid MCOs, and few have the means to finance their healthcare on their own).

[8] 85 Fed. Reg. at 37,161-62.

[9] *Id.* at 37,162, 37,244-45 (45 C.F.R. § 92.3).

[10] *See* Ctrs. for Medicare & Medicaid Servs., CMS Fast Facts, *CMS Program Data – Populations* (2020), *archived at* https://perma.cc/5GFN-ZGD6 (Medicare, Medicaid, and the Children's Health Insurance Program alone serve over 146 million people).

[11] The 2020 Rule imports Title IX's so-called abortion neutrality exception, which states that Title IX shall not "be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion." 20 U.S.C. § 1688; *see* 85 Fed. Reg. at 37,245 (45 C.F.R. § 92.6).

uncovered emergencies or without other options for care, and potentially implicating access to critical healthcare services such as birth control, certain fertility treatments, and care for HIV and hepatitis.[12] It undoes language access requirements that support meaningful healthcare for LEP patients—relaxing the standards governing the provision of language assistance services and dispensing with the notices that inform LEP patients of the no-cost translation and interpretation resources available to them.[13] And the 2020 Rule enables health insurers to categorically deny coverage for gender-affirming healthcare, even when it is medically necessary, and even when identical services are covered for other patients.[14]

Individually and collectively, the 2020 Rule's provisions impair access to healthcare for *amici*'s residents—contrary to the purpose, structure, and plain language of Section 1557 of the ACA[15] and the ACA itself. Through its insurance expansions and its patient protections, such as Section 1557, the ACA successfully expanded health insurance coverage and benefits to millions more Americans who can now access the primary and preventative healthcare that achieves better outcomes sooner, in more appropriate settings, and at lesser governmental and overall expense. The 2020 Rule threatens these core gains. It erases many of the 2016 Rule's concrete codifications of Section 1557's promise of nondiscrimination. In its place, the 2020 Rule invites discrimination against people in need of life-affirming and lifesaving healthcare—despite the robust record documenting the lasting harms from discrimination for individuals and communities, and despite the utter absence of factual or legal basis for the change. Its

[12] 85 Fed. Reg. at 37,245 (45 C.F.R. § 92.6(b)).

[13] *Id.* at 37,162, 37,245-46 (45 C.F.R. § 92.101).

[14] The 2020 Rule eliminates the 2016 Rule's express prohibition on such categorical coverage denials. *See* 81 Fed. Reg. at 31,471-72 (former 45 C.F.R. § 92.207(3)-(4)).

[15] 42 U.S.C. § 18116 ("Section 1557").

repudiation of nondiscrimination protections stigmatizes and harms, leading to delayed and forgone healthcare, significant programmatic and administrative costs, and direct harms to our residents, communities, and local governments. The 2020 Rule as a whole erodes *amici*'s ability to foster inclusive communities in which everyone has the right to respect and the opportunity to lead a healthy, independent life.[16] By utterly ignoring these harms, HHS violates the basic requirements of administrative rulemaking. *See Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1915 (2020). The 2020 Rule should be vacated in its entirety.

ARGUMENT

I. The ACA Enables Local Governments to Provide Better Healthcare

As local governments, *amici* are responsible, often by legal mandates and always by practical realities, for protecting the health and safety of our communities. We assist children and the elderly, operate law enforcement agencies and jail facilities, provide emergency medical transportation and safety-net healthcare services, and, as we have witnessed recently all across the nation during the COVID-19 pandemic, perform critical public health work. *Amici* administer the "smaller governments closer to the governed" that "touch on citizens' daily lives." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 536 (2012) (*NFIB*). *Amici* are often the only entities with the ability to perform these vital public functions that are necessary for our residents to enjoy healthy, productive lives.

[16] As of this writing, the majority of the 2020 Rule is currently in effect; only its definition of "on the basis of sex" and its incorporation of Title IX's religious exemption have been enjoined. *See Walker v. Azar*, --- F. Supp. 3d ----, 2020 WL 4749859, at *1, 10 (E.D.N.Y. Aug. 17, 2020); *Whitman-Walker Clinic.*, 2020 WL 5232076, at *45.

Amici are obligated to provide many healthcare services to our residents regardless of their ability to pay.[17] We do not, and cannot, condition emergency transportation in our ambulances, examination and treatment in our public health clinics and emergency departments, emergent care in our safety-net hospitals, or use of our suicide hotlines or mobile crisis services on ability to pay the bill. *See NFIB*, 567 U.S. at 593 (opinion of Ginsburg, J.). Thus, when our residents are less healthy or more reliant on emergency or safety-net services, *amici* incur greater direct costs.

Amici bear massive, but avoidable, direct costs from the less effective, less timely, and more expensive care people seek when they delay or forgo healthcare. It costs thousands more to treat an uninsured person who contracts HIV/AIDS than it does to provide a high risk person with preventative one-pill-a-day pre-exposure prophylaxis (PrEP) medication.[18] Without primary and preventative care, prescription drugs, and early diagnosis and treatment, our residents become sicker and more costly to treat, and also more likely to access healthcare through avoidably costly means, such as by ambulance calls or emergency department visits.[19]

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[17] *See, e.g.*, Nat'l Ass'n of Cty's, *Counties' Role in Health Care Delivery and Financing* 3, 5-15 (2007), *archived at* https://perma.cc/Z6SX5JD5; Eileen Salinsky, Nat'l Health Policy Forum, *Governmental Public Health: An Overview of State and Local Public Health Agencies* 9-10 (Aug. 18, 2010), *archived at* https://perma.cc/E48M-ADZH.

[18] Avert, *Pre-exposure Prophylaxis for HIV Prevention* (Feb. 25, 2020), *archived at* https://perma.cc/8AGU-ALQF ("PrEP drug costs are lower than HIV treatment costs, both per-dose and for the duration of use. Moreover, PrEP is prescribed to be taken consistently, but only when someone is at heightened risk of HIV, whereas, should someone acquire HIV, they will need to be on antiretroviral treatment (ART) for their entire life in order to stay healthy.").

[19] "Because those without insurance generally lack access to preventative care, they do not receive treatment for conditions—like hypertension and diabetes—that can be successfully and affordably treated if diagnosed early on. When sickness finally drives the uninsured to seek care, once treatable conditions have escalated into grave health problems, requiring more costly and extensive intervention." *NFIB*, 567 U.S. at 594 (internal citations omitted) (opinion of Ginsburg, J.); *see also* The Nat'l Academies' Inst. of Med., *Care Without Coverage: Too Little, Too Late* (2002), *archived at* https://perma.cc/T542-Q8YP;

In the absence of capable, culturally competent care, our residents are more likely to develop chronic diseases—the persistent, prevalent, but preventable conditions such as hypertension, diabetes, certain heart diseases, and obesity, all of which are among the most common and costly of America's health problems, and that increase the risk of severe illness from COVID-19.[20] Without early behavioral healthcare, mental health and substance use costs also swell, potentially forcing *amici* to divert finite funds from other critical functions and further tax the public.

By prohibiting discrimination in health insurance and health programs and enhancing access to care, the ACA allowed many *amici* to deliver the ongoing primary and preventative healthcare services that produce better health outcomes for our residents sooner, in more appropriate settings, and at lesser expense.[21] With the support of the ACA's health insurance expansions and its array of patient-protective provisions,[22] federal, state, and local governments

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Benjamin T. Squire et al., *At-Risk Populations and the Critically Ill Rely Disproportionately on Ambulance Transport to Emergency Departments*, 56 Annals Emergency Med. 341, 346 (2010**)**.

[20] Ctrs. for Disease Control & Prevention, *Coronavirus Disease 2019: People Who Are at Higher Risk* (Apr. 15, 2020), *archived at* https://perma.cc/UR8W-LNYU.

[21] With the support of the ACA, many of *amici*'s health systems piloted dramatic system improvements that significantly improve quality of care and quality of life at lesser expense. For example, due to the ACA, the County of Santa Clara was able to pilot a chronic conditions care management program that decreased participants' emergency department visits by more than fourfold. Cal. Ass'n of Pub. Hosps. & Health Sys., *Impact of Medi-Cal Expansion: Santa Clara Valley Health & Hospital System* at 1 (2017), *archived at* https://perma.cc/XN93-EKAP. Major gains like this were made possible because the ACA created lasting health and financial benefits for states and local governments and their communities. *See* Jessica Schubel & Matt Broaddus, Ctr. on Budget and Policy Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect* (May 23, 2018), *archived at* https://perma.cc/YPL6-MN2Q.

[22] *See, e.g.*, 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a) (preventing health insurance denials because of people's pre-existing conditions); 300gg, 300gg-4(b) (barring higher premium charges based on health status); 300gg-11 (prohibiting lifetime or annual limits on the value of essential health benefits); 300gg-12 (banning rescission, a previously common practice where insurance companies rescinded coverage when the insured suffered a catastrophic illness); 300gg-19 (guaranteeing beneficiaries the right to appeal adverse coverage decisions); 18022(c) (imposing annual out-of-pocket maximums for covered benefits).

have saved billions in reduced uncompensated care costs in the decade since the ACA was enacted,[23] in part due to the 2016 Rule itself.[24]

The 2020 Rule threatens these gains. It is intended and expected to reduce individuals' access to needed insurance benefits, promote refusals of needed services, enable discriminatory and substandard care, and, ultimately, disconnect entire communities from the primary and preventative healthcare services that lead to better health outcomes at lesser expense. "It is implausible that Congress meant the Act to operate in this manner." *King v. Burwell*, 135 S. Ct. 2480, 2493 (2015).

II. Discrimination Against *Amici*'s Residents Imperils Public Health and Welfare

Laws embodying a "commitment to eliminating discrimination … serve[] compelling state interests of the highest order." *Roberts v. U.S. Jaycees*, 468 U.S. 609, 624 (1984). Nondiscrimination laws like Section 1557, which embody this commitment, make it clear that everyone deserves competent and respectful healthcare. Despite this clear commitment in the ACA, and despite the dispositive and recent command of the Supreme Court in *Bostock v. Clayton County Georgia*, 140 S. Ct. 1731 (2020), the 2020 Rule nevertheless enshrines exclusion into the regulations that codify Section 1557's facially neutral federal nondiscrimination provisions. The 2020 Rule *itself* stigmatizes and harms.

The 2020 Rule invites healthcare providers to reject, humiliate, demean, and discriminate against people in need of life-affirming and lifesaving healthcare. As the administrative record

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[23] *See, e.g.*, Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion Under the ACA: Updated Findings from a Literature Review* 8-11 (Mar. 28, 2018), *archived at* https://perma.cc/GU93-U9DE.

[24] *See* Notice of Proposed Rulemaking Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,171, 54,181-92, 54,208-09 (Sept. 8, 2015) ("2015 NPRM") ("the Section 1557 regulation will likewise contribute to a decrease in payments by the … government for uncompensated care").

and research amply show, such discrimination is already rampant: In a 2010 survey, 70% of transgender respondents and nearly 56% of lesbian, gay, or bisexual respondents reported "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."[25] In a study of LGBTQ adults' life experiences, "13% reported having objects thrown at them, 23% reported being threatened with violence, . . . almost half were targets of verbal abuse," and "21% reported violence or a property crime."[26] Far too often, discrimination and stigma are a stark reality for our LGBTQ residents, our LEP speakers, and people seeking pregnancy-related care.[27]

The discrimination that the 2020 Rule enacts and invites harms health in ways that endure beyond a specific encounter or episode. The lasting negative effects of discrimination on health are well-researched, abundant, and severe: discrimination "has a significant negative effect on both mental and physical health, . . . produces significantly heightened stress responses, and is related to participation in unhealthy and nonparticipation in healthy behaviors."[28] Discrimination is linked by substantial evidence to a range of negative mental health outcomes, including

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[25] Lambda Legal, *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV* (2010), *archived at* https://perma.cc/UF9F-444M.

[26] Valarie K. Blake, *Remedying Stigma-Driven Health Disparities in Sexual Minorities*, 17 Housing J. Health L. & Pol'y 181, 201-02 (2017), *archived at* https://perma.cc/Q3Q4-J554 (citing Gregory M. Herek, *Confronting Sexual Stigma and Prejudice: Theory and Practice*, 63 J. Soc. Issues 905, 908-09 (2007)).

[27] *See, e.g.*, Comment of City of New York, HHS-OCR-2019-0007-150529 at 20-24 (Aug. 13, 2019) (detailing many of these stigmas and their harms).

[28] Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 Psych. Bull. 513, 513 (2009).

depression, psychological distress, anxiety, and diminished well-being.[29] Physically, discrimination causes "exaggerated cardiovascular responses to stress," as exhibited by changes in blood pressure and cortisol levels and other negative physical effects, all of which "may erode an individual's protective resources and increase vulnerability to physical illness" and "lead to wear and tear on the body."[30] It thus increases the risk of certain diseases, such as depression, obesity, schizophrenia, heart disease, metabolic syndrome, rheumatoid arthritis, fibromyalgia, and allergic conditions.[31] Discrimination also "leave[s] individuals with less energy or resources for making healthy behavior choices," which leads to "health behaviors that have clear links to disease outcomes," as well as "nonparticipation in behaviors that promote good health," such as seeking preventative healthcare.[32] Indeed, people who experience frequent discrimination are three to nine times less likely to seek healthcare.[33] When patients who face or fear facing discrimination from their healthcare providers do seek medical care, the care they receive is less effective. They are less likely to disclose important clinical information,[34] less likely to comply

[29] *Id.* (citing Yin Paradies, *A Systematic Review of Empirical Research on Self-reported Racism and Health*, 35 Int'l J. Epidemiology 888–901 (2006); David R. Williams et al., *Racial/Ethnic Discrimination and Health: Findings From Community Studies*, 93 Am. J. Pub. Health 200–08 (2003)).

[30] *Id.* at 513-14.

[31] *Id.* at 544.

[32] *Id.* at 514 (describing how discrimination leads individuals to make decisions that lead to negative health outcomes, such as smoking, alcohol and substance abuse, and unprotected sex, and to avoid protective behaviors, such as cancer screenings and diabetes self-management).

[33] Sarah Wamala et al., *Perceived Discrimination, Socioeconomic Disadvantage and Refraining from Seeking Medical Treatment in Sweden*, 61 J. Epidemiology Cmty. Health 409, 409 (2006), *archived at* https://perma.cc/9R2P-VPK6.

[34] Valarie K. Blake, *Remedying Stigm-Driven Health Disparities in Sexual Minorities*, 17 Hous. J. Health L. & Pol'y 181, 211 (2017).

with their providers' recommendations, and more likely to report receiving poor quality care.[35] Concealing one's LGBTQ status from a healthcare provider, in particular, is associated with worse mental health outcomes, greater risk of cancer, greater risk of infectious disease, and more rapid onset and progression of HIV symptoms.[36]

HHS is well-aware of the profound and prolonged harms of discrimination, including for LGBTQ people in particular. The 2016 Rule devotes dozens of pages to the subject.[37] Today, HHS recognizes nondiscrimination as a key metric for disease prevention and public health promotion.[38] It offers guidance to providers on "how to provide affirming services for transgender patients,"[39] and acknowledges that "transgender people, especially transgender women of color, may delay seeking medical care because of fear or actual experience of negative treatment by health care staff." A decade ago, HHS had already found that "LGBT individuals

[35] Maureen R. Benjamins & Steven Whitman, *Relationships Between Discrimination in Health Care and Health Care Outcomes Among Four Race/Ethnic Groups*, 37 J. Behav. Med. 403 (2014).

[36] Valarie K. Blake, *Remedying Stigma-Driven Health Disparities in Sexual Minorities*, 17 Hous. J. Health L. & Pol'y 181, 211 (2017) (citing Larissa A. McGarrity & David M. Huebner, *Is Being Out About Sexual Orientation Uniformly Healthy?: The Moderating Role of Socioeconomic Status in a Prospective Study of Gay and Bisexual Men*, 47 Annals Behav. Med. 28, 28–29 (2014)).

[37] *See, e.g.*, 81 Fed. Reg. at 31,387-90, 31,429-37, 31,459-62; *see also* 80 Fed. Reg. 54,171, 54,181-92, 54,208-09.

[38] Dep't of Health & Hum. Servs., Office of Disease Prevention & Health Promotion, *Discrimination*, *Healthy People 2020*, *archived at* https://perma.cc/C3GG-3VKD (HHS decade-long Healthy People 2020 public health campaign); *see also* Dep't of Health & Hum. Servs., Office of Disease Prevention and Health Promotion, *Access to Health Services*, *Healthy People 2020*, *archived at* https://perma.cc/8HB4-WLZV.

[39] Dep't of Health & Hum. Servs., Ctrs. for Disease Control & Prevention, *Patient-Centered Care for Transgender People: Recommended Practices for Health Care Settings* (Apr. 1, 2020), *archived at* https://perma.cc/2BJ3-EWKD.

face health disparities linked to societal stigma [and] discrimination,"[40] which in turn increase the need for timely, high-quality healthcare.

The harms from discrimination ripple out into our communities as a whole. When our LGBTQ residents, LEP speakers, and people seeking reproductive healthcare are subjected to discrimination, the welfare of their children is also jeopardized. Discrimination against a parent or caregiver is associated with poor health outcomes for children, including potentially lasting physical, mental, socioemotional, and developmental harms.[41] The cascading costs of discrimination are especially expensive for local governments, which bear primary responsibility for managing public emergency and safety-net healthcare benefits, economic supports, child welfare systems, and emergency and transitional housing.

III. The 2020 Rule Imposes Major Administrative and Programmatic Costs on Local Governments

Many *amici* must invest heavily to help counteract the weight of healthcare discrimination against their residents, especially their LGBTQ residents. The City of Chicago funds community-based organizations that specialize in providing care for LGBTQ people who face discrimination based on multiple intersectional characteristics and operates an Office of Lesbian, Gay, Bisexual, and Transgender Health to combat health disparities confronting its

[40] Dep't of Health & Hum. Servs., Office of Disease Prevention and Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health, Healthy People 2010*, *archived at* https://perma.cc/52WS-PVMB.

[41] Eileen Condon et al., *Associations Between Maternal Experiences of Discrimination and Biomarkers of Toxic Stress in School-Aged Children*, 23 Maternal & Child Health J. 1147-51 (2019); *see also* Nia J. Heard-Garris et al., *Transmitting Trauma: A Systematic Review of Vicarious Racism and Child Health*, 199 Soc. Sci. & Med. 230-40 (2018), *archived at* https://perma.cc/T6PY-DGDJ) (longitudinal meta-analysis finding vicarious discrimination against caregivers associated with physical, mental, socioemotional, and developmental harms for children).

LBGTQ residents.[42] The City of Oakland contracts for safe spaces for its LGBTQ children and youth due to the critical need for care linkages to welcoming and supportive providers.[43] The County of Los Angeles conducts provider education on how to competently care for transgender and gender nonconforming patients and also runs an LGBTQ committee for each of its medical centers.[44] These policies make a palpable difference: LGBTQ patients consistently report that accessing care at the County's medical centers has changed their lives for the better. The City of West Hollywood spearheads an HIV Zero Initiative to reduce the spread of, and harms from, HIV/AIDS, focusing on its LGBTQ community because nearly all new HIV infections in the City are among gay and bisexual men.[45] The City and County of San Francisco runs an Office of Transgender Initiatives to advance equity for transgender and gender nonconforming people, maintaining directories of competent transgender healthcare providers.[46] Among them are the San Francisco Department of Public Health's own clinics, programs, and hospitals, which

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[42] *See* City of Chicago, Dep't Public Health, *LGBT Health, archived at* https://perma.cc/UNA2-6AL3.

[43] *See* City of Oakland, *Sustainable Oakland, Oakland Fund for Children and Youth (OFCY) Is Growing, archived at* https://perma.cc/2WD4-L5FL.

[44] *See*, LAC+USC Medical Center, *LGBTQ+ Resource Guide, archived at* https://perma.cc/VHP6-27CD; Los Angeles Cnty. Health Servs., *Friendly and Knowledgeable Providers, archived at* https://perma.cc/SR68-8GFR.

[45] *See* City of West Hollywood, *HIV Zero Strategic Plan* (Apr. 2019), *archived at* https://perma.cc/EMR2-QSPQ.

[46] City & Cnty. of San Francisco, *Transgender Healthcare, archived at* https://perma.cc/JB7T-259D; City & Cnty. of San Francisco, *Office of Transgender Initiatives, archived at* https://perma.cc/Y6YZ-RE9G. Many more *amici* invest in services to redress healthcare discrimination against their LGBTQ residents. Borough of State College promotes COVID-19 resources that document health disparities facing LGBTQ people. Borough of State College, *Coronavirus Response Hub, archived at* https://perma.cc/R3LQ-MHNB . Howard County coordinates outreach, community engagement work, and complaint investigations to serve its LGBTQ residents. *See* Howard County, *Howard County Joins Amicus Brief Protecting LGBTQ+ Community from Healthcare Discrimination* (Aug. 12, 2020), *archived at* https://perma.cc/S8FP-G27H; Howard County Office of Human Rights, *How to File a Complaint, Case Processing & Services, archived at* https://perma.cc/T4XZ-PBAF.

provide San Franciscans with quality health care, including Gender Health SF, which has provided eligible uninsured transgender San Franciscans with access to gender affirming surgeries, education, and preparation services since 2012.[47]

Even in jurisdictions with deep commitments to inclusivity, discrimination against LGBTQ people in healthcare persists. The County of Santa Clara, for example, has long been a leader in supporting LGBTQ rights—becoming the first county in the nation to establish an office dedicated to serving the LGBTQ community.[48] The County's Office of LGBTQ Affairs has delivered trainings on how to provide LGBTQ-competent care to thousands of healthcare providers, and San José, the largest city in the County, earns a 100% score on the Human Rights Campaign's municipal equality index.[49] Yet nondiscrimination in healthcare in the County remains a major need and focus. The County regularly receives complaints about providers who deliberately call patients by the wrong names and the wrong pronouns, ask unnecessary questions about patients' genitals, house people in residential treatment settings in ways that threaten their safety, and block access to gender-affirming care. The County's Gender Health Center was never meant to be the only point of service for transgender, nonbinary, and gender expansive County residents, yet all too often it must serve as just that due to discrimination elsewhere. Further, until recently, many primary care providers in the County who serve high numbers of at-risk LGBTQ patients believed they had no LGBTQ patients, and thus failed to

[47] San Francisco Dep't Pub. Health, *Gender Health SF*, *archived at* https://perma.cc/FEX7-HHBM.

[48] *See* Cnty. of Santa Clara, *About the Office of LGBTQ Affairs*, *archived at* https://perma.cc/K2HX-3GZ2.

[49] Human Rights Campaign, *San José, California 2019 Municipal Equality Index Scorecard*, *archived at* https://perma.cc/4PL6-L2EQ.

offer their patients appropriate holistic care and critical medications and screenings to prevent costly lifelong conditions such as HIV/AIDS.

When private healthcare providers discriminate or fail to combat prevailing health-related stigmas, local governments that run safety-net health systems incur greater direct costs. Use of *amici*'s nonjudgmental and highly-subsidized sexually transmitted disease (STD) clinics increases—even for patients who have health insurance and primary care providers.[50] Outreach campaigns to combat rampant stigma become necessary—such as Houston's multi-million dollar HIV prevention *I am Life*™ marketing campaign addressing young LGBTQ people of color, who are hardest hit by Houston's HIV/AIDS epidemic in part due to pervasive stigma surrounding LGBTQ sexual health.[51] In local government clinics, patient wait times lengthen and staff's obligations balloon. Supported by the transformation of care that the ACA enabled, the County of Santa Clara slashed patient wait times for primary care appointments from 53 days to fewer than 48 hours.[52] Yet in the months since the 2020 Rule was finalized, patient fear, anxiety, and confusion have swelled, and so too has demand for the County's Gender Health Center's

[50] Like most local public health departments, the County of Santa Clara Public Health Department runs a sexually transmitted disease (STD) clinic that offers confidential and culturally competent anonymous STD and HIV/AIDS testing and treatment, which the County subsidizes with $1 million each year. *See* Salinsky, *supra* note 17 at 15 (57% of local public health departments provide treatment for sexually transmitted diseases). Hundreds of LGBTQ patients—many of whom are insured—rely on the County STD clinic's confidential services, likely reflecting fear of discrimination and stigma from their own healthcare providers. *See* Karen W. Hoover et al., *Continuing Need for Sexually Transmitted Disease Clinics After the Affordable Care* Act, 105 Amer. J. Public Health S690, S694 (2015), *archived at* https://perma.cc/BJ54-38MZ (many insured patients use STD clinics' highly confidential services due to ongoing stigma). And these confidential services cost the County hundreds of thousands of dollars in subsidy each year.

[51] Houston Health Dep't, *Houston Health Department Launches I am Life™ Campaign to Educate Audiences about Preventing HIV Through PrEP, Treatment as Prevention (TasP) to End HIV Transmission* (May 2, 2019), *archived at* https://perma.cc/7PMX-7K9L.

[52] Cal. Ass'n of Pub. Hosps. & Health Sys., *Impact of Medi-Cal Expansion: Santa Clara Valley Health & Hospital System* 1 (2017), *archived at* https://perma.cc/XN93-EKAP.

services. Since June 19, 2020, the Center has seen nearly three times as many patients in acute mental health crisis. Although the Center is not set up to offer specialty mental health services, its medical director now describes it as a *de facto* provider of this higher level of care. The greater patient volume and care needs strain staff, increase patient wait times, and divert resources from other critical functions.

Local governments are often obligated to expend more when health insurers expend less by denying medically necessary coverage. The ACA mandates that most government hospitals must maintain financial assistance policies for medically necessary care provided to poor patients.[53] States from California to Texas to Florida substantially expand on this financial assistance mandate, requiring that local governments fund free or discounted medically necessary care for their indigent residents who lack health insurance coverage.[54] Thus when patients lose coverage for gender-affirming care or pregnancy-related care, local government health systems frequently help foot the very expensive bill for the care patients need. For example, in 2019 and 2020 in the County of Santa Clara's highly cost-efficient health system,[55] a

[53] 26 U.S.C. § 501(r).

[54] *See, e.g.*, Cal. Health & Safety Code § 127400 *et seq.* (requiring that healthcare providers offer free or discounted care to patients whose family incomes are below 350% of the Federal Poverty Level whenever the patient lacks insurance for a given medically necessary service); Cal. Welf. & Inst. Code § 17000 (obligating counties to provide health services to their indigent residents); Fla. Stat. § 154.011 (requiring that Florida counties provide primary care services to County residents with incomes below 100% of the federal poverty level); Tex. Health & Safety Code Ann. § 61.022 (mandating that Texas counties provide medical services to their indigent residents who lack other sources of care); Texas Constit. art. 9, § 4 (providing that Texas "county-wide Hospital Districts … shall assume full responsibility for providing medical and hospital care to needy inhabitants of the county").

[55] *See* Cal. Ass'n of Pub. Hosps., *Is Medi-Cal Working? Absolutely—Check the Facts* 2 (Mar. 21, 2018), *archived at* https://perma.cc/62PL-57JV (detailing the "extremely efficient" cost landscape in California public hospitals).

single visit for inpatient gender-affirming care cost an average of $18,780.[56] Under its charity and indigent care program, the County must cover 100% of the costs of such medically necessary services for its residents with incomes below 400% of the Federal Poverty Level who lack insurance for these services.[57] Offering gender-affirming care may barely increase costs for employers and insurers, where expenditures may be counterbalanced by the other members of the insurance pool.[58] However, if employers and insurers cease to cover such care, the County of Santa Clara, New York City, San Francisco, and other *amici* that offer gender-affirming care for their residents may have to shoulder these costs using taxpayer money earmarked to serve the uninsured.[59] Without broadly available supportive healthcare, local governments' indirect costs also mount. In *amici*'s experience, access to gender-affirming and LGBTQ-friendly care facilitates engagement with much needed primary and preventative care. For example, for the Houston Health Department, the dearth of gender-affirming care presents a major barrier to care for the 26,000 people with HIV/AIDS in Houston/Harris County.[60] By contrast, access to

[56] In addition to the costs of an inpatient hospital stay, inpatient gender-affirming care may include the costs of a mastectomy, mammaplasty, nipple/areola reconstruction, breast reconstruction, urethroplasty, orchiectomy, vulvectomy, hysterectomy, and/or testicular prosthesis.

[57] Cnty. of Santa Clara Health Sys., *Healthcare Access Program*, CSCHS #715.0 (adopted Apr. 21, 2020); *see also* NYC Health + Hospitals, *About NYC Care*, *archived at* https://perma.cc/Z93H-JYFS (offering low-cost and no-cost services to New York City residents who do not qualify for any health insurance plan available in New York State and who cannot afford health insurance based on government guidelines).

[58] *See* Comment of Lambda Legal, HHS-OCR-2019-0007-154936 at 5 (Aug. 13, 2019).

[59] *See, e.g.*, NYC Health + Hospitals, *Partners in LGBTQ Healthcare*, *archived at* https://perma.cc/XAM6-MFDB (describing the many supportive services offered by the NYC Health + Hospitals for LGBTQ patients, including gender-affirming care); San Francisco Dep't of Pub. Health, *Gender Health SF*, *archived at* https://perma.cc/R8NH-Z7UA (describing San Francisco's Gender Affirming Surgery Access Program).

[60] *See* Houston Health Dep't, *Houston Community Health Improvement Plan 2018–2021* at 34-35 (2020), *archived at* https://perma.cc/6NE6-UJX2.

gender-affirming care is protective for the overall health and wellbeing of *amici*'s transgender residents in an array of significant ways.[61]

The 2020 Rule also imposes major costs on *amici* and our residents due to its rollback of the language access regulations that help LEP patients secure meaningful healthcare. By relaxing the standards governing oral interpretation and written translation services provided by covered entities and eliminating notices alerting patients of no-cost language access services, the 2020 Rule jeopardizes the health of our LEP patients. The 2020 Rule itself acknowledges that it could diminish "access to, and utilization of, health care for non-English speakers."[62] Yet it rejects this risk based on anonymous anecdotes,[63] and it ignores and downplays evidence presented by commenters that language barriers impede access to health insurance, decrease healthcare utilization, compromise the quality of care, and increase the risk of adverse outcomes for LEP people.[64] The 2020 Rule's language access repeals are all the more dangerous now, when failing to identify even one person infected with COVID-19 can have a devasting communal impact, and when xenophobia means many patients fear going to the doctor. Indeed, San Francisco launched a massive multilingual outreach campaign about COVID-19 healthcare

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[61] *See, e.g.*, Yale Sch. of Public Health, *Transgender Individuals at Greater Risk of Mental Health Problems* (Aug. 24, 2020), *archived at* https://perma.cc/5GJT-2BC6 (transgender people who undergo "gender-affirming surgery [a]re significantly less likely to seek mental health treatment for depression and anxiety disorders," among other things).

[62] 85 Fed. Reg. at 37,232.

[63] HHS rejects extensive evidence establishing that LEP patients require more language access assistance, not less, because "anecdotally, … utilization of translation services did not appreciably rise" under the 2016 Rule. 85 Fed. Reg. at 37,233. Yet anecdotes about utilization are not evidence of utilization or need, and they do not supply a reason for disregarding HHS' prior factual determinations and undoing requirements on which many LEP patients relied. *See F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (when an agency policy "rests upon factual findings that contradict those which underlay its prior policy," the agency must provide a "more detailed justification").

[64] *See, e.g.*, Comment of City of New York, HHS-OCR-2019-0007-150529 at 11 (Aug. 13, 2019); Comment of City of Oakland, HHS-OCR-2019-0007-151126 (Aug. 13, 2019).

resources, publishing and delivering over 3 million signs in a city of 881,000 people, all of them translated.[65] Yet despite flyering every part of the city, San Francisco's 911 system has seen a rise in calls for dead or nearly dead patients, especially within its LEP communities. Repeal of the 2016 Rule's language access provisions, which provide a lifeline to healthcare for millions of LEP patients, will only heighten the urgent public health crisis facing our cities, counties, and communities.

IV. The 2020 Rule Undermines the Trust Necessary for Healthy Communities

The primary and preventative healthcare access transformation that the ACA enabled depends on trust—the trust that it takes to seek care, early and proactively; the trust that it takes to undergo intimate examination and treatment; and the trust to listen and comply with a doctor's instructions. Discrimination in healthcare shatters that trust. So much more must be done before even our most inclusive health systems offer truly welcoming supportive care that earns the trust of all our patients. The 2020 Rule, however, eliminates even the hope that nondiscriminatory care is a shared goal. It directly harms our residents, communities, and local governments and frays the fragile trust that *amici* invest so much to create. These harms are all the more urgent and irreparable in the midst of a pandemic in which our collective health so clearly depends on that of our neighbors.

V. HHS Arbitrarily and Capriciously Ignores and Understates the 2020 Rule's Costs and Harms

Contrary to all of the foregoing, HHS contends that the 2020 Rule will have "minimal" practical effect because Defendants already made some of the 2016 Rule ineffective by failing to

[65] *See* City & Cnty. of San Francisco, *Outreach Toolkit for Coronavirus (COVID-19)*, *archived at* https://sf.gov/outreach-toolkit-coronavirus-covid-19; U.S. Census Bureau, Quick Facts: San Francisco City, California, *archived at* https://perma.cc/QXU6-PJPB .

appeal orders partially enjoining and then vacating it,[66] because some states, localities, and covered entities may protect patients anyway,[67] and because the ACA contains other patient protective provisions.[68] And it suggests that "State and local governments are best equipped to balance the multiple competing considerations involved in" nondiscrimination protections.[69]

None of these reasons holds up. Defendants' unreviewable earlier decision not to appeal a partial vacatur of the 2016 Rule cannot now insulate Defendants' rule change from judicial review.[70] That many states, localities, and covered entities protect all their patients signals the significance of such laws—not their superfluity. And Defendants implausibly ignore the uncontested significance of federal leadership, and the practical reality that the federal government is so often the standard setter and the HHS Office of Civil Rights (OCR) is "the lead enforcement agency."[71] Most of all, even if some states and local governments offer comparable protections to the 2016 Final Rule, others do not.

Defendants' failure to assess the costs of denied or delayed care as a result of discrimination constitutes a fundamental error in the rulemaking process. *See Dep't of Homeland Sec.*, 140 S. Ct. at 1915. For example, denial of abortion care, which the 2020 Rule

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[66] The same court that declared the entire 900-page omnibus ACA unconstitutional and invalid because of a single sentence also partially enjoined and vacated the 2016 Rule. *See Texas v. United States*, 340 F. Supp. 3d 579 (N.D. Tex. 2018), *affirmed in part, reversed in part*, 945 F.3d 355, *cert granted*, Nos. 19-1019 & 19-840 (U.S. 2020); *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 696 (N.D. Tex. 2016) (partially enjoining the 2016 Rule); *Franciscan All., Inc. v. Azar*, 414 F. Supp. 3d 928, 947 (N.D. Tex. 2019) (partially vacating the 2016 Rule).

[67] 85 Fed. Reg. at 37,225.

[68] *Id.* at 37,182.

[69] *Id.* at 37,195.

[70] *See supra* note 686.

[71] 81 Fed. Reg. at 31,378.

enables, has long term financial and health consequences. People who are denied abortion care are much more likely to face long-term financial insecurity—they are four times more likely to live at or below the poverty line and three times more likely to be unemployed[72]—which has compounding impacts on public health and the safety-net services provided by local governments. Further, people denied abortion care services who go on to give birth are more likely to suffer serious complications such as preeclampsia and death, more likely to stay in abusive relationships, and more likely to report mental health concerns such as anxiety.[73]

By incorporating the religious exemption from Title IX, the 2020 Rule further impedes access to a panoply of healthcare services that religiously affiliated hospitals may decline to provide.[74] But the costs to both patients and safety-net providers operated by local governments are largely ignored by Defendants. Many communities, particularly rural communities, rely upon

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[72] Comment of NARAL Pro-Choice America, HHS-OCR-2019-0007-138414 at 7 (Aug. 13, 2019); *see also* Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. H. 407 (2018), *archived at* https://perma.cc/4ACL-7K9Q (people denied abortion were more likely to be have household incomes below the poverty line than people who received abortion for up to four years following the denial of care).

[73] Comment of Ctr. for Reproductive Rights, HHS-OCR-2019-0007-150549 at 13-14 (Aug. 13, 2019) (citing Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, Annals of Internal Medicine (2019). Without adequate contraceptive access in our communities, *amici* incur greater costs providing pregnancy, delivery, and early childhood care. *See, e.g.*, Jennifer J. Frost et al., Guttmacher Inst., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact* (2019), *archived at* https://perma.cc/8VBC-UNRW. Indeed, most counties fund or support safety-net health centers that provide free or reduced-fee services to patients. *See* Guttmacher Inst., *Fact Sheet: Publicly Supported Family Planning Services in the United States* (2019), *archived at* https://perma.cc/C534-UQW7 (82% of U.S. counties had at least one safety-net health center providing family planning services in 2015).

[74] The Ethical and Religious Directives that guide most Catholic hospitals restrict access to, or entirely forbid providing, abortion care, contraceptive care (including vasectomy and tubal ligation), in vitro fertilization, emergency contraceptives, and standard treatment protocols for ectopic pregnancy and many types of miscarriage due restrictions on abortion. *See generally* U.S. Conf. of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (2018), *archived at* https://perma.cc/S4RW-EEYS.

religiously affiliated healthcare providers as their only hospital.[75] As of 2016, approximately 18.5% of hospitals in the United States were religiously affiliated and 10 of the top 25 hospital systems were Catholic hospitals[76]—potentially disconnecting entire communities from access to healthcare.

Were the 2020 Rule's practical effects actually minimal, Defendants' decision to rewrite the law to exclude from legal protection people who face widespread discrimination would be concerning in its own right—an impermissible decision by the federal government to "deem a class of persons a stranger to its laws." *See Romer v. Evans*, 517 U.S. 620, 635 (1996). Instead, however, the 2020 Rule's real-world effects are adverse and significant, creating and compounding harmful and costly health disparities, even in jurisdictions that are committed to pluralism and respect for everyone. HHS is well aware of the increased costs, as it explained in the 2016 Rule that its regulations would result in significant reductions in the costs of uncompensated care,[77] which are costs that are shared by federal, state, and local governments with state and local governments contributing approximately 36% of government funded uncompensated care costs.[78]

The 2020 Rule's many provisions eliminate nondiscrimination protections in healthcare for people who are frequently denied care, exclude many health insurance and non-ACA health

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[75] *See* Anna Maria Barry-Jester & Amelia Thomson-DeVeaux, *How Catholic Bishops Are Shaping Health Care In Rural America*, FiveThirtyEight, (July 25, 2018), *archived at* https://perma.cc/FNQ9-P2GQ.

[76] Maryam Guiahi et al., *Patient Views on Religious Institutional Health Care*, JAMA NETWORK OPEN, 2(12) (Dec. 27, 2019), *archived at* https://perma.cc/76EY-B35C.

[77] 81 Fed. Reg. at 31,461 (explaining that the nondiscrimination protections in the 2016 Rule would contribute to a decrease in payments by the federal government for uncompensated care costs).

[78] Comment of 22 States, HHS-OCR-2019-0007-142194 at 17 (Aug. 13, 2019); *see also* John Holahan et al., Kaiser Family Found., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, *archived at* https://perma.cc/GEP9-SXUU.

programs from nondiscrimination obligations, enable health insurers to categorically exclude healthcare coverage for transgender people, exempt religious entities from nondiscrimination obligations in healthcare, eliminate critical translation and interpretation obligations in healthcare, and invite denials of care for pregnancy-related conditions, among other things. Separately and together, the 2020 Rule exacts massive harms on *amici*, our residents, and communities—harms which Defendants underestimate and largely ignore.

CONCLUSION

Amici urge the Court to vacate the 2020 Rule in its entirety.

Dated: September 17, 2020

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CERTIFICATE OF SERVICE

I hereby certify that on September 17, 2020, the foregoing document was filed with the Clerk of the Court, using the CM/ECF system, causing it to be served on all counsel who have entered an appearance.

Dated: September 17, 2020

/s/ Kimberly Ide
Kimberly Ide

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