19-4254(L)

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IN THE

United States Court of Appeals

FOR THE SECOND CIRCUIT

STATE OF NEW YORK, CITY OF NEW YORK, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, DISTRICT OF COLUMBIA, STATE OF HAWAII, STATE OF ILLINOIS, STATE OF MARYLAND, COMMONWEALTH OF MASSACHUSETTS, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEVADA, STATE OF NEW JERSEY, STATE OF NEW MEXICO, STATE OF OREGON, COMMONWEALTH OF PENNSYLVANIA, STATE OF RHODE ISLAND, STATE OF VERMONT, COMMONWEALTH OF VIRGINIA, STATE OF WISCONSIN, CITY OF CHICAGO, COOK COUNTY, ILLINOIS,

Plaintiffs-Appellees,

(*Caption continued on inside cover*)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

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

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PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, PUBLIC HEALTH SOLUTIONS, INC.,

Consolidated-Plaintiffs-Appellees,

—against—

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR, II, in his official capacity as SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, UNITED STATES OF AMERICA,

Defendants-Appellants,

DR. REGINA FROST, CHRISTIAN MEDICAL AND DENTAL ASSOCIATION,

Intervenors-Defendants-Appellants,

ROGER T. SEVERINO, in his official capacity as DIRECTOR, OFFICE FOR CIVIL RIGHTS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, and OFFICE FOR CIVIL RIGHTS, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Consolidated-Defendants-Appellants.

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INTEREST OF AMICI CURIAE[1]

Amici curiae (identified in the Appendix to this brief) are academics or experts who study the health of lesbian, gay, bisexual, and transgender ("LGBT") people. Scholars of public health, medicine, social sciences, public policy, and law, amici are affiliated or work with the Williams Institute, a research center at the UCLA School of Law dedicated to the rigorous study of sexual orientation and gender identity. Amici have conducted extensive research and authored numerous studies regarding LGBT people, including on the extent and effects of stigma and discrimination. Amici have a substantial interest in the subject of this litigation and submit this brief to help clarify the effects of 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"), on LGBT people. The Supreme Court and other courts have expressly relied on the Williams Institute's research, and several amici have served as expert witnesses, as noted in the accompanying Motion for Leave to File Brief as Amici Curiae.

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[1] This brief is filed with the consent of all parties, as permitted by Federal Rule of Appellate Procedure 29(a)(2). Pursuant to Local Rule 29.1(b), no party's counsel has authored this amicus brief, in whole or in part, and no party or party's counsel has contributed money that was intended to fund the preparation or submission of the brief. No person—other than amici curiae or its counsel—contributed money that was intended to fund preparing or submitting this brief.

SUMMARY OF ARGUMENT

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

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

Amici file this brief in support of Plaintiffs-Appellees and urge this court to uphold the district court's opinion in its entirety. Here, amici focus on the harms that the Rule stands to impose on LGBT people—harms that HHS failed to address with any intellectual rigor in its cost-benefit analysis. Given the Rule's

numerous other shortcomings, the district court did not reach the question whether HHS's rulemaking violated the APA on this ground, and this Court need not do so to affirm the district court.

But if this Court does reach the issue, it should conclude as an alternative ground for affirmance that HHS failed to weigh the costs that the Rule stands to impose by increasing healthcare denials based on sexual orientation or gender identity against the Rule's supposed benefits, rendering its actions arbitrary and capricious. *See, e.g.*, *Motor Vehicle Mfrs. Ass'n of the United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). The Rule is worded broadly enough to enable HHS to assert—and healthcare providers and LGBT people to believe—that healthcare can be refused on religious grounds, and HHS declined to rule out that application. Given that reality, HHS had to address the wealth of evidence in the administrative record that LGBT people face pervasive stigma and discrimination in healthcare and elsewhere; that such stigma and discrimination drive innumerable health disparities affecting LGBT people, such as higher prevalence of suicide ideation and attempts; and that such stigma and discrimination are commonly motivated by religious beliefs. This evidence shows that the Rule will likely harm LGBT people by increasing healthcare denials, which in turn damage mental and physical health and impose the additional cost of finding alternative care. HHS's improper decision to ignore or

discount this evidence, while relying on speculative benefits, is alone enough to invalidate the Rule as the product of arbitrary and capricious agency action.

Two other district courts reached the same general conclusion as the district court below and invalidated the Rule under the APA. *Washington v. Azar*, 426 F. Supp. 3d 704 (E.D Wash. 2019); *San Francisco v. Azar*, 411 F. Supp. 3d 1001 (N.D. Cal. 2019). *Washington* invalidated the Rule on the ground that amici urge here. As the court there explained, HHS acted arbitrarily and capriciously in promulgating the Rule because, among other things, "HHS disregarded the comments and evidence showing the Rule would severely and disproportionately harm certain vulnerable populations, including women; lesbian, gay, bisexual, and transgender people (LGBT individuals); individuals with disabilities; and people living in rural areas." 426 F. Supp. 3d at 721.

ARGUMENT

First principles of administrative law require agency decisionmakers to weigh the costs and benefits of agency action. *State Farm*, 463 U.S. at 43. Here, HHS failed to meaningfully weigh the harms that the Rule would impose on LGBT people against the benefits that it believed the Rule would provide. First, because the Rule could be read to allow healthcare providers to deny coverage to LGBT people (and HHS refused to rule out that application), HHS had to weigh the costs of such denials. Second, the administrative record contained a

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

I. Because the Rule is plausibly read to allow healthcare providers to deny coverage to LGBT people, HHS had to weigh the costs of such denials.

HHS left the door wide open for the Rule's terms to apply to a broad spectrum of care provided to LGBT people. Commenters made their concerns on this point clear to HHS, which dismissed them. For instance, HHS rejected commenters' requests that the Rule state that it does not authorize denials of care based on sexual orientation and gender identity. *See, e.g.*, 84 Fed. Reg. at 23,215. HHS also dismissed concerns that the Rule would disparately affect women, LGBT people, and religious minorities, responding with the vague

assertion that "[t]he terms defined in this rule do not apply to women, LGBT persons, or religious minorities in any way that differs from how Congress applied the terms in the statutes it adopted." *Id.* at 23,197. Yet HHS acknowledged that healthcare providers had asserted the right to withhold treatment to LGBT people (such as treatment for gender dysphoria) and did not explicitly deny commenters' assertions that the Rule could indeed be read this way. *Id.* at 23,205.

The breadth and vagueness of the Rule invite providers and LGBT people to believe that the Rule *does* authorize such denials—marking a departure from HHS's finding nearly a decade earlier that a similar rule would endanger access to care by the LGBT population. 76 Fed. Reg. at 9,969. HHS had to provide a "reasoned explanation" of this change of stance, *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125-26 (2018), including an assessment of each of the Rule's "arguably significant consequences" and "broader, real world impact," *Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 931 (D.C. Cir. 2017), such as the harm to LGBT people. Not only was HHS prohibited from relying on explanations that are "implausible" or "counter to the evidence before the agency," *State Farm*, 463 U.S. at 43, but it was also affirmatively required to present "good reasons" for reversing its 2011 finding, *FCC v. Fox Television*

Stations, Inc., 556 U.S. 502, 515-16 (2009). Because HHS failed to comply with these standards here, the Rule is invalid.[2]

II. The administrative record contains voluminous evidence that the Rule will likely 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 healthcare; (b) both the experience and expectation of rejection and discrimination create what is referred to in public health research as "minority stress," which decades of research shows leads to adverse health outcomes and health disparities for LGBT people; and (c) anti-LGBT discrimination in healthcare is often religiously motivated. This uncontroverted evidence shows that the Rule, to the extent it applies or is viewed as applying to LGBT people qua LGBT people,[3] stands to exacerbate discrimination, ill health, and health disparities facing this population.[4]

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[2] This Court can invalidate the Rule on this basis even though the district court did not reach the issue. *See, e.g.*, *Adirondack Transit Lines, Inc. v. United Transp. Union*, 305 F.3d 82, 88 (2d Cir. 2002).

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

[4] 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"); American Psychological Association (71056) ("APA Comment"); County of Santa Clara (54930) ("Santa

A. LGBT people face pervasive discrimination in healthcare and other settings.

LGBT people—who make up roughly 4.5% of adults in the United States, including 8.1% of millennials[5]—have faced a long, painful history of public and private discrimination in the United States. They are "among the most stigmatized, misunderstood, and discriminated-against minorities in the history of the world," *Baskin v. Bogan*, 766 F.3d 648, 658 (7th Cir. 2014), having been "prohibited from most government employment, barred from military service, excluded under immigration laws, targeted by police, and burdened in their rights to associate," *Obergefell v. Hodges*,135 S. Ct. 2584, 2596 (2015). While social acceptance and the legal rights of LGBT people in the United States have generally improved over the past few decades, ample research confirms that LGBT people continue to face persistent and pervasive violence, stigma, and discrimination at work and school, in housing and by businesses, from their

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Clara Comment"); Empire Justice Center (AR71892) ("EJC Comment"); Human Rights Watch (71217) ("HRW Comment"); Human Rights Campaign (AR70848) ("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. (The numbers in parentheses refer to the unique identifier associated with each comment on regulations.gov.)

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

families of origin, and in healthcare. *See* Brief of Amici Curiae Ilan H. Meyer, PhD et al. ("Meyer Brief") 11-12, *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719 (2018) (No. 16-111), *cited in and appended to* Williams Institute Comment.

The discrimination that LGBT people face also pervades their healthcare experience. According to the Institute of Medicine ("IOM," now the Health and Medicine Division of the National Academies), which operates under a congressional charter and provides independent, objective analysis of scientific research, "LGBT individuals have reported experiencing refusal of treatment by health care staff, verbal abuse, and disrespectful behavior, as well as many other forms of failure to provide adequate care," including the "outright denial of care" on numerous occasions. IOM, *The Health of Lesbian, Gay, Bisexual, & Transgender People,* at 62 (2011), *cited in* Williams Institute Comment at 8.

Surveys included in the administrative record reveal widespread healthcare discrimination against LGBT people. In a recent nationally representative survey, 8% of LGB people and 29% of transgender people who had visited a healthcare provider *in the preceding year* reported experiencing an outright refusal of care because of their sexual orientation or gender identity. Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care* (2018), *cited in* Lambda Comment at 11, 13. In another

nationally representative survey of LGBTQ people, 16% of all respondents said they had experienced some form of discrimination while going to a doctor or health clinic, and 22% of transgender respondents said they have avoided doctors or healthcare for fear of discrimination. NPR et al., *Discrimination in America: Experiences and Views of LGBTQ Americans*, 2, 10 (2017), *cited in* APA Comment at 2-3. According to another large survey, almost 56% of LGB respondents and 70% of transgender respondents reported experiencing at least one of several forms of healthcare discrimination. Lambda Legal, *When Health Care Isn't Caring* ("Lambda Survey") 5 (2014), *cited in* Lambda Comment at 10-12; *see also* S.E. James et al., *The Report of the 2015 U.S. Transgender Survey* 97 (2016), *cited in* NCTE Comment at 4. And a recent qualitative study documented numerous instances of discrimination and mistreatment against LGBTQ people in healthcare settings. Human Rights Watch ("HRW"), *"All We Want Is Equality": Religious Exemptions & Discrimination Against LGBT People in the United States* 20-26 (2018), *cited in* HRW Comment at 3.

B. Stigma and discrimination cause health disparities between LGBT and non-LGBT populations.

Healthcare denials harm LGBT people's health, wellbeing, and dignity. A person who is denied care must, at a minimum, experience the inconvenience and expense of seeking alternative providers. This is especially difficult for those living in communities where alternatives are not readily available. *See, e.g.*,

Mirza & Rooney, *supra* (nearly a fifth of LGBT individuals reported it would be "very difficult" or "not possible" to find the same type of service at a different provider, with higher percentages among LGBT people living outside metropolitan areas).[6] Where delayed care impacts physical or mental health, those repercussions could result in needless suffering, disability, or death. Discrimination related to sexual orientation or gender identity can also psychologically damage the victim, because it conveys a strong symbolic message of disapprobation of something core to that person's identity. Williams Institute Comment at 9; Meyer Brief 15.

Beyond these immediate impacts, healthcare refusals can also cause LGBT people—including not only those who experience discrimination firsthand but also those who learn about discrimination against others in the community—to defer or outright avoid needed care in order to minimize the risk of discriminatory encounters. IOM, *supra*, at 63. According to one nationally representative survey, "8 percent of all LGBTQ people—and 14 percent of those who had experienced discrimination on the basis of their sexual

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

orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff." Mirza & Rooney, *supra*; *see also* Lambda Survey at 12-13. This chilling effect results in disparities in LGBT people's use of healthcare. Lesbians, for example, are less likely than straight women to get preventive services for cancer, and transgender individuals face barriers to accessing HIV prevention and care. *See* Office of Disease Prevention & Health Promotion ("ODPHP"), *Lesbian, Gay, Bisexual, & Transgender Health*, *cited in* Williams Institute Comment at 10; IOM, *supra*, at 222-25.

Not only do healthcare refusals worsen LGBT people's healthcare access and use, but they also exacerbate health disparities facing the LGBT population, including disproportionately high prevalence of psychological distress, depression, anxiety, substance-use disorders, and suicidal ideation and attempts—many of which are two to three times greater among sexual and gender minorities than the non-LGBT majority. *See generally* ODPHP, *supra*; IOM, *supra*, at 4-5; Williams Institute Comment at 7-10; Meyer Brief 20-24. HHS has also recognized that LGBT youth face higher rates of homelessness and that "[e]lderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers." ODPHP, *supra*; *see also* IOM, *supra*, at 4-5.

Substantial research identifies anti-LGBT stigma and discrimination as the drivers of health disparities between LGBT and non-LGBT populations. According to ODPHP, an office within HHS itself, "[r]esearch suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights" and that "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination." ODPHP, *supra*; *see* CDC, *Stigma & Discrimination* (last visited Sept. 3, 2019), *cited in* Williams Institute Comment at 9. Likewise, "[c]ontemporary health disparities based on sexual orientation and gender identity are rooted in and reflect the historical stigmatization of LGBT people." IOM, *supra*, at 32. And although that "historical stigmatization" might be thought to affect older LGBT people more acutely, LGBT youth experience it as well. As IOM has observed, "the disparities in both mental and physical health . . . are seen between LGBT and heterosexual and non-gender-variant youth," owing to "experiences of stigma and discrimination during the development of [the LGBT youths'] sexual orientation and gender identity and throughout the life course." *Id.* at 142.

The relationship between stigma and health is clearly articulated in the "minority stress" research literature included in the record, which establishes that stigma and prejudice negatively impact the health of LGBT people. The

minority stress model—which IOM has recognized to be a core perspective for understanding LGBT health, *id.* at 20—describes how LGBT people experience chronic stress stemming from their stigmatization. While stressors, such as loss of a job or housing, are experienced by LGBT and non-LGBT people alike, LGBT people are uniquely exposed to stress arising from anti-LGBT stigma and prejudice. This prejudice leads LGBT people to experience *excess* stress exposure compared with non-LGBT people (all else equal), which elevates the risk for many mental and physical health problems such as depression, anxiety, and substance-use disorders. *See* Meyer Brief 12-24; Williams Institute Comment at 7-10.

When an LGBT person is denied healthcare because of sexual orientation or gender identity, that is a type of minority stress that has both tangible (e.g., needing to find new a provider) and symbolic (e.g., the personal rejection and reverberation of social disapprobation) effects. And healthcare denials—or threats of healthcare denials—increase expectations of future rejection and discrimination among LGBT people. Expectations of rejection and discrimination are stressful even without a specific event because they are based on what the LGBT person has learned from repeated exposure to a stigmatizing social environment. For example, when an LGBT person seeks healthcare knowing that rejection and discrimination in healthcare settings could occur,

that person will likely experience stress in deciding whether even to seek the needed service, whether to come out to the provider, whether to bring a spouse who may "out" the patient, and, generally, how and from whom to disguise their LGBT identity. LGBT people thus vigilantly strive to protect themselves from mistreatment in healthcare settings. To avoid discrimination, many LGBT people will delay or altogether skip obtaining care. *See* Meyer Brief 12-24; Williams Institute Comment at 7-10.

C. Anti-LGBT discrimination is often religiously motivated.

While many people and institutions of faith welcome and affirm LGBT people—and many LGBT people are themselves people of faith—the administrative record contains many examples of anti-LGBT discrimination undertaken in the name of religion. According to HHS, "[m]ultiple comments provided lists of various incidents in which providers declined to participate in a service or procedure to which they had a religious or moral objection." 84 Fed. Reg. at 23,252; *see also, e.g.*, Lambda Comment at 14-17; NCLR Comment at 9-11; HRW, *supra*, at 20-26.

Among those incidents are outright denials of care. In 2015, for instance, a Michigan doctor refused to treat a same-sex couple's infant based on her religious views about the parents' sexual orientation. *See* Abby Phillip, *Pediatrician Refuses to Treat Baby with Lesbian Parents & There's Nothing Illegal About*

It, Wash. Post, Feb. 19, 2015, *cited in* Santa Clara Comment at 5. In 2000, a doctor refused on religious grounds to perform donor insemination for lesbians. *See N. Coast Women's Care Med. Grp., Inc. v. Super. Ct. (Benitez)*, 189 P.3d 959, 963-64 (Cal. 2008), *cited in* Lambda Comment at 14. Similarly, an Alabama clinic refused a lesbian couple fertility services because of the doctor's "religious belief that he only treats straight married couples." HRW, *supra*, at 21. And in 2015, a transgender man was denied a medically necessary hysterectomy because the religiously affiliated hospital where the physician had admitting privileges did not permit gender-transition care. *See* Complaint, *Conforti v. St. Joseph's Healthcare Sys.*, No. 2:17-cv-0050 (D.N.J. Jan. 5, 2017), *cited in* Lambda Comment at 16.

In addition to outright denials of care, anti-LGBT proselytizing and harassment is common in healthcare settings. "One of the most common stories about hostility and harassment" among over 13,000 public comments and stories collected from individuals in this rulemaking "included unwanted proselytizing by hospital or clinic staff." HRC Comment at 2. A different commenter relayed the story of a transgender person who reported their transgender status because it is "a relevant piece of medical information," only to have the doctor immediately respond, "'I believe the transgender lifestyle is wrong and sinful.'" NCTE Comment at 10. According to another: "Since coming out, I have avoided seeing my primary physician because when she

asked me my sexual history, I responded that I slept with women and that I was a lesbian. Her response was, 'Do you know that's against the Bible, against God?'" Lambda Comment at 15. This Court has seen similar stories firsthand, including the case of a nurse consultant who "visited the home of a same-sex couple, one of whom was in the end stages of AIDS," and proselytized against "the 'homosexual lifestyle.'" *Knight v. Conn. Dep't of Pub. Health*, 275 F.3d 156, 161 (2d Cir. 2001), *cited in* Lambda Comment at 15.

The administrative record here also includes incidents where healthcare providers urged conversion therapy on LGBT people. One commenter relayed the story of a gay man whose doctor told him "that it was not medicine [he] needed but to leave [his] 'dirty lifestyle.'" Lambda Comment at 15. The doctor told the man he had put other patients "in touch with ministers who could help gay men repent and heal from sin, and he even suggested that [the man] simply needed to 'date the right woman' to get over [his] depression"—and "even went so far as to suggest that his daughter might be a good fit for [him]." *Id.* The same comment described another case in which a religious-counseling student intended to practice conversion therapy on her LGBT clients, violating the

applicable professional code of ethics. *Keeton v. Anderson-Wiley*, 664 F.3d 865, 868-69 (11th Cir. 2011), *cited in* Lambda Comment at 14.[7]

D. The Rule will likely exacerbate discrimination and health disparities facing LGBT people.

The Rule is expressly designed to expand the circumstances in which healthcare providers can deny care. According to HHS, "as a result of this rule, more individuals, having been apprised of those rights, will assert them." 84 Fed. Reg. at 23,250. In other words, the Rule will cause even more providers to refuse to treat patients—including LGBT patients—on the basis of religious objections. The Rule thus increases the risk and expectation that LGBT people will be denied healthcare. More incidents of discrimination will increase stress related to seeking healthcare, causing LGBT people to avoid seeking care and thereby further reducing the number of LGBT people who have access to healthcare. Although these effects were documented in the administrative record, *supra* Part II.A-C, HHS brushed them aside, concluding that the Rule will "produce a net increase in access to health care." 84 Fed. Reg. at 23,246.

[7] According to recent estimates outside of the administrative record, roughly 698,000 LGBT adults have received, and tens of thousands of youth will receive, conversion therapy from licensed healthcare professionals or from religious or spiritual advisors before they reach the age of 18. Christy Mallory et al., *Conversion Therapy & LGBT Youth,* at 1 (2019).

HHS cannot have it both ways. By expanding the protections available for those who would deny medical care, HHS is necessarily decreasing the availability of care for those who seek the denied services. *See Washington,* 426 F. Supp. 3d at 721; *San Francisco*, 411 F. Supp. 3d at 1012. In turn, the Rule risks reducing the health and wellbeing of LGBT people and exacerbating health disparities between LGBT and non-LGBT populations.

III. HHS's treatment of the evidence of harm to LGBT patients was arbitrary and capricious.

HHS arbitrarily and capriciously concluded that the Rule will improve access to healthcare and quality care. 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). First, HHS failed to reasonably assess the Rule's costs in terms of harms to patients (LGBT or otherwise). HHS's analysis falls far short even of the least burdensome approach to addressing unquantifiable costs set forth in the agency's *Guidelines for Regulatory Impact Analysis*. HHS, *Guidelines for Regulatory Impact Analysis* ("*Guidelines*") 51 (2016). Although the *Guidelines* are not binding, HHS recognizes that they "reflect[] a well-established and widely-used approach . . . that is an essential component of policy development." *Id.* at 1. And whether considered under the *Guidelines* or on its own, HHS's failure to account for these costs demonstrates that the rule is arbitrary and capricious and violates the APA.

Second, HHS applied inconsistent evidentiary standards that allowed the agency to dismiss foreseeable harms while relying on speculative benefits. HHS's "'internally inconsistent' treatment of the anecdotal evidence—relying on it when it supports the rule, but dismissing it when it does not—renders the rulemaking process arbitrary and capricious." *Washington*, 426 F. Supp. 3d at 721; *see Bus. Roundtable v. SEC*, 647 F.3d 1144, 1148-49 (D.C. Cir. 2011) (agency cannot "inconsistently and opportunistically" frame the rule's effects); *Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1198 (9th Cir. 2008) (agency "cannot put a thumb on the scale by undervaluing the benefits and overvaluing the costs").

A. HHS improperly disregarded evidence of foreseeable harm to patients.

"Agencies have long treated cost as a centrally relevant factor when deciding whether to regulate," and "any disadvantage could be termed a cost." *Michigan v. EPA*, 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 apply to "denials of care based on, for example, inability to pay the requested amount." *Id.* In doing so, HHS improperly equated harm from healthcare denials based on the operation of the healthcare market with harm from denials of care based on LGBT status.

This conclusion is contrary to the minority stress research provided to HHS. While a denial of care based on an inability to pay is a general stressor that LGBT and non-LGBT people alike might experience, a denial of care related to a person's status as a sexual or gender minority is a prejudice that imposes unique tangible and symbolic harms on the LGBT victim, and has more severe health implications than a denial unrelated to prejudice. HHS therefore ignored evidence showing that denial of treatment to LGBT people comes with a unique additional harm beyond the denial itself. In short, by equating the reasons for denial, HHS factored a significant cost out of the equation.

Though HHS seemed to partially acknowledge this reality by conceding two additional harms to patients—harm caused by a provider refusing to provide even a referral and the possibility that "others in the community to which the patient belongs may be less willing to seek medical care"—that would not occur for someone who is unable to pay, *id.,* it deemed irrelevant commenters'

voluminous evidence of patient rejections. HHS ignored this evidence because commenters did not "establish[] a causal relationship between this rule and how it would affect health care access, and [did not] provid[e] any data the Department believes enables a reliable quantification of the effect of the rule on access to providers and to care." *Id. at* 23,250. And while HHS acknowledged that the LGBT population "face[s] health care disparities of various forms," it deemed that evidence irrelevant because commenters did not "explain the extent to which such disparities are the product of the lawful exercise of religious beliefs or moral convictions." *Id.* at 23,251-52.

HHS thus improperly shifted the burden of evaluating the evidence presented to commenters. The agency, not commenters, must "quantify anticipated present and future benefits and costs as accurately as possible." Exec. Order No. 13,563 § 1(c), 76 Fed. Reg. 3821 (Jan. 18, 2011). Agencies should also consider not just "direct cost . . . in complying with the regulation," but also "any adverse effects" the Rule might have on "health and safety." Exec. Order No. 12,866 § 6(a)(3)(C)(ii), 58 Fed. Reg. 51,735 (Sept. 30, 1993). As *Washington* correctly stated, this failure to adequately account for costs reflects arbitrary and capricious decisionmaking. 426 F. Supp. 3d at 721.

HHS cannot justify this failure by claiming that the evidence does not explicitly show a causal relationship between the Rule and harm to LGBT

people. Ideally, commenters might have been able to "isolat[e] the impact of the exercises of religious belief or moral conviction attributable to this rule specifically." 84 Fed. Reg. at 23,251. But the lack of such data does not relieve HHS's obligation to fully and fairly consider the evidence before it—evidence establishing that the Rule stands to increase healthcare denials to all types of patients and that the Rule risks exacerbating the discrimination in healthcare and health disparities that LGBT people face. If insufficient evidence was available, HHS should have conducted "additional research prior to rulemaking," because "[t]he costs of being wrong may outweigh the benefits of a faster decision." Office of Mgmt & Budget, Exec. Office of the President, Circular A-4, at 39 (Sept. 17, 2003). HHS did not even purport to weigh the costs of error against the benefits of speed.

Nor may HHS simply disregard costs that are uncertain or difficult to quantify. *See, e.g.*, *Ctr. for Biological Diversity*, 538 F.3d at 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"). While the Rule may result in "a range of values" for the costs to patients, that value "is certainly not zero" and must be "accounted for." *Id.* at

1200.[8] Yet HHS failed even to follow the *Guidelines*' least burdensome approach for "nonquantifiable effects"—an approach that entails categorizing effects in a table and then roughly indicating the direction and magnitude of the impact of each effect. *Guidelines* at 50. Instead, HHS simply stated that the unquantified costs were "compliance procedures and compliance reporting and seeking of alternative providers of certain objected-to medical services or procedures." 84 Fed. Reg. 23,227. By "offer[ing] an explanation for its decision that runs counter to the evidence before [it]"—evidence of significant costs to LGBT people—HHS transgressed bedrock rules of agency decisionmaking. *State Farm*, 463 U.S. at 43; *see, e.g.*, *Competitive Enter. Inst. v. Nat'l Highway Traffic Safety Admin.*, 956 F.2d 321, 326-27 (D.C. Cir. 1992) (agency failed to consider impact on safety).

HHS's discounting of the evidence of potential harms to patients is even more arbitrary given the agency's 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, it cannot plausibly assert that the Rule creates no barriers to care. HHS's arbitrariness is more pronounced still given the agency's recognition in 2011 that the exercise

[8] Even when presented with reliable data on certain metrics related to providers' moral objections to abortion, because the data provided a range instead of "a single measure," HHS dismissed it wholesale without considering the impact of any values within the range. 84 Fed. Reg. at 23,252 n.346.

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 to provide any "reasoned explanation" for disregarding these findings underlying the 2011 rule. *Fox*, 556 U.S. at 515-16; *see* S.A. 96-97; *Washington*, 426 F. Supp. 3d at 721.

HHS's dismissive approach is apparent in its analogy between harms to patients that would result from healthcare denials and the costs to building and apartment owners of "ensur[ing] that facilities are accessible to persons with disabilities." 84 Fed. Reg. 23,251. Unlike patients seeking care, landlords are not innocent third parties: their facilities and practices create barriers for people with disabilities. And much more is at stake for patients here than mere inconvenience and expense. Being denied healthcare can be devastating. In turn, the minority stress associated with healthcare denials compounds that harm, can cause avoidance of necessary care in the future, and contributes to health disparities for the LGBT population. *See supra* at 18-19. HHS's inapt analogy reveals a lack of concern for patients denied care, contrary to HHS's mission "to enhance the health and well-being of all Americans." HHS, *Introduction: About HHS* (last visited July 30, 2020).

B. HHS improperly inflated the benefits of the Rule.

In contrast to its treatment of the vast evidence of the Rule's foreseeable harms to patients, HHS concluded—based on scant or nonexistent 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. This conclusion defies logic. It is "elementary" that if more medical providers can deny care, access to care will decrease or the quality of care will deteriorate—"especially for those individuals in vulnerable populations who will the target of religious and moral objections," such as LGBT people. *Washington*, 426 F. Supp. 3d at 721. HHS's contention that overall care will increase because providers who otherwise would have withdrawn from the medical field will now stay, if true, still does not address the availability of the particular services to which providers have religious objections. HHS is thus left with the determination that the Rule will increase access to healthcare and quality of care when the administrative record shows the opposite. That "illogical" conclusion is "arbitrary and capricious." *GameFly, Inc. v. Postal Regulatory Comm'n*, 704 F.3d 145, 148 (D.C. Cir. 2013) (quotation marks omitted).[9]

[9] *Cf. California v. Azar*, 950 F.3d 1067 (9th Cir. 2020) (finding that HHS's cost benefit analysis was not arbitrary and capricious because HHS "reasonably concluded," based on available evidence, that the harms cited by commenters

HHS cannot bridge that logical gap through its unsupported contention that overall care will increase because providers who otherwise would have withdrawn from their professions will now stay in the medical field. HHS reached this conclusion even though it admitted it was "not aware of a source for data on the percentages of providers who have religious beliefs or moral convictions against each particular service or procedure that is the subject of this rule," 84 Fed. Reg. at 23,252; even though there were "no empirical data on how previous legislative or regulatory actions to protect conscience rights have affected access to care or health outcomes," *id.* at 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. HHS's "conjecture" about increased overall care "cannot substitute for [the] reasoned explanation" the APA requires. *Graphic Commc'ns Int'l Union, Local 554 v. Salem-Gravure Div. of World Color Press, Inc.*, 843 F.2d 1490, 1494 (D.C. Cir. 1988).

"would not develop"). This case differs significantly from *California*, which involved a different rule. First, plaintiffs in that case were not asserting that the challenged rule redefined terms in the statute it purported to interpret; here, HHS has incorrectly interpreted the language of the provider-conscience laws. *San Francisco*, 411 F. Supp. 3d at 1024-25. Second, unlike in *California*, HHS here failed to adequately consider the reliance interests engendered by its prior rules. *See* S.A. 101; *see also DHS v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1915 (2020) (agency's action was arbitrary and capricious, in part because it failed "to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing concerns").

The data disparity highlights the flaws in HHS's reasoning. For example, in concluding that the Rule will have a positive impact on the recruitment and retention of healthcare professionals, HHS cited only two sources: a 2009 convenience-sample survey of members of the Christian Medical Association and a letter from the American Association of Pro-Life Obstetricians and Gynecologists. *See* 84 Fed. Reg. at 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 would impose on vulnerable patients, as well as over comments from the American Medical Association, among other professional associations, that the Rule "would undermine patients' access to medical care and information." AMA Comment at 1; *see, e.g.*, *Gen. Chem. Corp. v. United States*, 817 F.2d 844, 857 (D.C. Cir. 1987) (conclusion arbitrary and capricious where supporting analysis was "internally inconsistent").

Even when HHS conceded that an asserted benefit could not be quantified, it still assigned that benefit a significant value—unlike its treatment of foreseeable harms to patients. HHS concluded that the Rule would benefit patient care, despite admitting that it knew of no "data that provides a basis of quantifying" those benefits. *See, e.g.*, 84 Fed. Reg. at 23,249-50. Unable "to monetize the benefits of respect for [healthcare providers'] conscience," HHS

was left to assert, in conclusory fashion, that those benefits "are clearly significant." *Id.* at 23,250.

HHS's unsupported assertions did not end there. It surmised, without citing a shred of evidence, that some patients, "out of respect for the beliefs of providers, may want a service but not take any offense, nor deem it any burden on themselves, for the provider to not provide that service to them." *Id.* at 23,251. It went further still in supposing that "[s]ome patients may even value the health care provider's willingness to obey his or her conscience, because the patient feels that provider can be trusted to act with integrity in other matters as well." *Id.* at 23,251. Such "speculation" is "arbitrary and capricious." *Latronica v. Local 1430 Int'l Bhd. of Elec. Workers Pension Fund*, __ F. App'x __, 2020 WL 3526393, at *2 (2d Cir. June 30, 2020) (summary order); *accord, e.g.*, *Sorenson Commc'ns, Inc. v. FCC*, 755 F.3d 702, 708 (D.C. Cir. 2014) (agency action based on "sheer speculation" is arbitrary and capricious).

In sum, the scant data on which HHS relied to estimate the benefits of the Rule cannot be squared with HHS's treatment of the vast evidence of the Rule's harms. *See Washington*, 426 F. Supp. 3d at 721. 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.

CONCLUSION

For the reasons above, the Court should affirm the district court's decision and vacate the Rule in its entirety.

Dated: New York, New York
August 3, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the word limit of Local Rule 29.1(c) and Local Rule 32.1(a)(4)(A) because, excluding the portions exempted by Fed. R. App. P. 32(f), this brief contains 6,854 words. This brief also complies with the typeface requirements of Fed. R. App. P. 32 (a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Calisto MT font.

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CERTIFICATE OF SERVICE

I hereby certify that on August 3 , 2020, this brief was filed electronically with the Clerk of the Court for the United States Court of Appeals for the Second Circuit through the Court's CM/ECF system. I certify that all participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

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