UCLA School of Law Williams Institute

December 19, 2019

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Financial Resources
Room 514-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**RE: Nondiscrimination in Health and Human Services Grant Programs; Proposed Rule, 84 Fed. Reg. 63831 (RIN 0991–AC16) Notice of Nonenforcement, 84 Fed. Reg. 63809**

To Whom It May Concern:

We write to provide comments to the Office of the Assistant Secretary for Financial Resources of the U.S. Department of Health and Human Services ("HHS" or "Department") on the Notice of Proposed Rulemaking regarding the nondiscrimination provisions of the regulations governing HHS grant awards (the "Proposed Rule" or "NPRM").[1] The Proposed Rule seeks to repromulgate or revise certain provisions of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards ("UAR") currently codified at 45 C.F.R. Part 75, including the provision codified at 45 C.F.R. § 75.300(c) prohibiting the exclusion from participation in, denial of benefits to, or discrimination against otherwise eligible persons in the administration of HHS grant programs on the basis of any non-merit factors. The Proposed Rule also aims to revise the regulation codified at 45 C.F.R. § 75.300(d), which clarifies that grant recipients must treat as valid the marriages of same-sex couples under binding Supreme Court precedent (these two rules together, the "Nondiscrimination Rules"). Our comments also address the Notice of Nonenforcement of various provisions of 45 C.F.R. Part 75 including the Nondiscrimination Rules ("Nonenforcement Notice") that the Department issued alongside the NPRM.[2]

The undersigned are scholars of law, public policy, public health, and economics, among other fields, with substantial expertise related to antidiscrimination law and discrimination against lesbian, gay, bisexual, and transgender ("LGBT") people. The undersigned are affiliated with the Williams Institute at the University of California at Los Angeles School of Law. The Williams Institute is a research center dedicated to conducting rigorous and independent academic research related to sexual orientation and gender identity, including on health and other disparities facing LGBT people and discrimination related to sexual orientation and gender identity.

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[1] Office of the Assistant Secretary for Financial Resources; Health and Human Services Grants Regulation, RIN 0991-AC16, 84 Fed. Reg. 63831 (Nov. 19, 2019) ("NPRM").

[2] Notification of Nonenforcement of Health and Human Services Grants Regulation, 84 Fed. Reg. 63809 (Nov. 19, 2019) ("Nonenforcement Notice").

The Proposed Rule would undermine grantees' and beneficiaries' clarity and certainty as to the rules of the road in HHS grant programs, remove vital protections against discrimination in HHS grant programs, and contravene congressional intent and HHS's mission, all in the name of resolving purported concerns regarding the Nondiscrimination Rules' compliance with the Regulatory Flexibility Act and the Religious Freedom Restoration Act. But the Proposed Rule is a solution in search of a problem, and the scope of the discrimination it would permit – particularly against LGBT persons facing discrimination on the basis of sexual orientation or gender identity – far exceeds the scope of the Department's stated concerns and ignores remedies already available to HHS that would not effectively authorize broad discrimination against otherwise eligible beneficiaries.

In Part I, we object to the unjustified and unjustifiably short comment period of the Proposed Rule, HHS's omission of critical data in the NPRM, and the Nonenforcement Notice's subversion of the Administrative Procedure Act ("APA"), each of which deprived the public of a meaningful opportunity to comment on the Proposed Rule and HHS's proffered justifications therefor.

In Part II, we demonstrate that the Proposed Rule would be onerous for and increase confusion among HHS grantees and beneficiaries as to the applicable nondiscrimination requirements in HHS grant programs, contravene congressional intent, and create conflicts with applicable regulatory requirements and HHS's mission.

In Part III, we show that HHS's required Regulatory Impact Analysis is fundamentally flawed because it fails to account for the impact of the Proposed Rule on those beneficiaries who are currently protected by the Nondiscrimination Rules but who would, by operation of the Proposed Rule, lose protection. HHS must assess and account for the impact of the Proposed Rule on all beneficiaries and on the government in terms of increasing the risks of discrimination, and must assess and account for the impact of the Proposed Rule on LGBT beneficiaries in particular because they are especially vulnerable to discrimination that would be invited or authorized by the Proposed Rule. In addition, HHS must account for the increased costs caused by the lack of clarity offered by the Proposed Rule compared to the Nondiscrimination Rules: whereas the Nondiscrimination Rules provided crystal clear guidance to HHS, its grantees, grant beneficiaries, and others, the Proposed Rule would onerously require interested parties to review the U.S. Code, Supreme Court decisions, and the Code of Federal Regulations to determine for themselves what type of discrimination is prohibited in particular funding streams and programs. Not only is that task time consuming, it requires a level of sophistication that could be inaccessible to many stakeholders, such as children in foster care who are beneficiaries of HHS grants.

For all of these reasons, HHS should withdraw the Proposed Rule and Nonenforcement Notice in their entirety and reaffirm the applicability and enforcement of the Nondiscrimination Rules.

## I. The Proposed Rule Does Not Meet the Requirements of the Administrative Procedure Act and Should Be Withdrawn

### A. HHS Has Failed to Provide the Public with Adequate Time to Review, Assess, and Comment on the Proposed Rule

As an initial but critical matter, HHS deprived the public of a meaningful opportunity to review, assess, and comment on the Proposed Rule. In order to correct this, the Department should reopen the comment period for a minimum of 60 additional days.

The APA requires that the public have a meaningful opportunity to submit data and written analysis regarding a proposed rulemaking. Rather than provide for the 60-day comment period required by Executive Order 13,563 except in extraordinary circumstances, which HHS has not contended exist in this case, HHS permitted only 30 days of comment – and over the Thanksgiving holiday no less. HHS's unduly short deadline violates the longstanding rule that "each agency shall afford the public a meaningful opportunity to comment through the Internet on any proposed regulation, with a comment period that should generally be *at least* 60 days."[3] HHS did not provide any justification for shortening the usual comment period by half, and no good cause exists for this abbreviated period or for denying sub silencio our request to extend the comment period (submitted to the Department on December 13, 2019). The short comment period not only limited the time available for commenters to refine their comments and analysis of the Proposed Rule, but likely also prevented some individuals and organizations that would have participated in the rulemaking, had the regular amount of time been made available, from filing comments altogether.

Given the far-reaching and complicated effects of the Proposed Rule and the Nonenforcement Notice, a 30-day comment period was simply inadequate to assess, let alone quantify, the full impact of the Proposed Rule. HHS awards over $500 billion in grants each year that cover a broad range of programs and services designed to promote the well-being of, among others, vulnerable children, families, older Americans, and individuals with disabilities. The Nondiscrimination Rules ensure that recipients of HHS grants are prohibited from excluding otherwise eligible persons – in other words, those Congress intended to benefit from the programs funded by the grants – from these HHS-funded programs based on any non-merit factors, including sex, religion, sexual orientation, and gender identity. The Proposed Rule would remove this broad protection that ensures all Americans can participate in HHS-funded programs on equal terms, and would in exchange give many awardees free range to reject participants on the basis of sex, religion, sexual orientation, gender identity, and/or myriad other non-merit based criteria. The exercise of determining exactly which HHS programs' nondiscrimination requirements will be altered by the Proposed Rule is exceedingly complicated, as it requires the review of all other federal statutes and regulations prohibiting discrimination

[3] Improving Regulation and Regulatory Review, Exec. Order 13,563 § 2(b), 76 Fed. Reg. 3821 at 3821-22 (Jan. 18, 2011) (emphasis added); see also Regulatory Planning and Review, Exec. Order 12,866 § 6(a)(1), 58 Fed. Reg. 51,735 at 51,740 (Sept. 30, 1993) ("[E]ach agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days.").

and an analysis of their applicability to myriad HHS funding streams, grants, and programs.[4] The NPRM provided no guidance or analysis in this regard.

As a result, the abbreviated comment period denied concerned individuals, including HHS grantees and beneficiaries, concerned organizations and individuals, states and lawmakers, and others an adequate opportunity to assess the significant impacts of the Proposed Rule, and thus denied the public a meaningful opportunity to comment. Moreover, the brief 30-day comment period likely also prevented some affected individuals and organizations from participating due to, among other reasons, limited resources, end-of-year obligations, and lack of notice. The 30-day comment period is especially unjustified given that the Proposed Rule would eliminate certain protections against discrimination and could operate to authorize denials of service to HHS grant beneficiaries who would have been protected under the Nondiscrimination Rules. The Nondiscrimination Rules have been codified in the Code of Federal Regulations since 2016, and existed as established HHS policy for some time prior to 2016.[5] Accordingly, individuals have reasonably come to rely on these protections, and the existence of such reasonable reliance militates strongly in favor of providing affected parties adequate notice and opportunity to comment, and giving more careful consideration to removal of these protections than HHS has provided in its Nonenforcement Notice and this cursory rulemaking process.

All of these reasons, in turn, mean that HHS has denied itself the benefit of rulemaking based on a fuller record of commenters' insights, concerns, and suggestions. For all of these reasons, HHS should reopen the comment period by at least an additional 60 days and provide necessary detail and data, as we next explain.

### B. HHS Has Denied the Public a Meaningful Opportunity to Participate in the Rulemaking by Failing to Provide an Adequate Explanation of its Rationale for the Proposed Rule

The reasoning behind the Proposed Rule provided by the Department in the NPRM denied the public a meaningful opportunity to participate in the rulemaking because it is vague, conclusory, and unsupported. In order to enable the public to meaningfully participate in this rulemaking and ensure that HHS does not operate with a one-sided or mistaken picture of the issues at stake in this rulemaking,[6] HHS should issue a revised Notice of Proposed Rulemaking that provides a full and adequate picture of its rationale for the Proposed Rule, including supporting arguments and documentation. As the U. S. Court of Appeals for the District of Columbia Circuit has held, it is particularly important that the administrative process be transparent, not opaque, and fairly seek comment on important issues:

> The purpose of the comment period is to allow interested members of the public to communicate information, concerns, and criticisms to the agency during the rule making process. If the notice of proposed rulemaking fails to provide an accurate

[4] See Brannon, V., Stophel, K., Nondiscrimination Requirements in Health and Human Services Grant Programs, Congressional Research Service, at 2-3 (Dec. 4, 2019) ("CRS Report").

[5] See Health and Human Services Grants Regulation, Notice of Proposed Rulemaking, 81 Fed. Reg. 45270 (2016) ("Nondiscrimination Rule NPRM").

[6] Connecticut Light and Power Co. v. NRC, 673 F.2d 525, 530-31 (D.C. Cir. 1982).

> picture of the reasoning that has led the agency to the proposed rule, interested parties will not be able to comment meaningfully upon the agency's proposals."[7]

HHS's primary rationale for removing broad non-discrimination protections for beneficiaries of HHS grant awards appears to have no connection to the Department's proposed revisions to the Nondiscrimination Rules. HHS's primary justification for declining to enforce the Nondiscrimination Rules and for proposing the modification is that HHS has "serious concerns about compliance with certain requirements of the Regulatory Flexibility Act, 5 U.S.C. 601-12" with regard to the Department's adoption of the Nondiscrimination Rules. Specifically, HHS stated that it is "concerned" whether the Department provided a sufficient rationale and certification that the rule would not have a significant economic impact on a substantial number of small entities. However, HHS did not seek comment on the extent to which compliance with the Nondiscrimination Rules have a significant economic impact on a substantial number of small entities. Nor did the Department seek comment on what impact, if any, the purported failure to provide a certification compliant with the Regulatory Flexibility Act may have had. Rather, the only justification that HHS provided as the source of its concern is the existence of "several" complaints, lawsuits, and requests for exemptions concerning the Nondiscrimination Rules and four public comments that do not discuss the economic impact of the current rule on small entities.[8] It thus appears that HHS has proffered regulatory technicalities as a pretext to repeal the Nondiscrimination Rules in a manner that bears no apparent relation to the regulatory impact concerns the Department claims to hold. The public cannot provide meaningful comment on the Proposed Rule if HHS does not provide an accurate and complete representation of the rationale underlying its proposed action.

In addition, HHS has omitted critical data necessary to assess the rationale underlying the Proposed Rule. In support of the Proposed Rule, the NPRM states:

> The Department is . . . aware that certain grantees and subgrantees that may cease providing services if forced to comply with § 75.300(c) and (d) are providing a substantial percentage of services pursuant to some Department-funded programs and are effective partners of federal and state government in providing such services.[9]

The NPRM, however, provides no facts, data, or studies in support of this assertion. Specifically, the NPRM does not disclose which Department-funded services are provided by such entities, how many such entities are currently receiving HHS awards, and the extent of the services provided by such entities. Nor did HHS provide any data with respect to any decline in participation by such entities since the Nondiscrimination Rules were adopted in 2016, or any data supporting the assertion that such a decline may accrue in the future. Without this information, the public cannot provide meaningful comment, for example, by assessing the

[7] Id.

[8] NPRM, 84 Fed. Reg. at 63831, 63832.

[9] Id. 63832.

veracity[10] and extent of the Department's claims or whether other entities could step in to provide these services.

In ostensible support of the Proposed Rule, the NPRM further states that the "existence of . . . complaints and legal actions indicates that § 75.300(c) and (d) imposed regulatory burdens and created a lack of predictability and stability for the Department and stakeholders with respect to these provisions' viability and enforcement." However, the NPRM discloses only one lawsuit, one request for exception related to the Nondiscrimination Rules, and the expression of "concern" from a small number of commenters as justification for this conclusion. In order for the public to meaningfully comment on this conclusion, HHS must provide a full and accurate picture of the complaints, legal actions, and exemption requests it has received.

The NPRM also implies that, on the basis of these inadequately described complaints, legal actions, and exemption requests HHS is concerned that the Nondiscrimination Rule conflicts with the U.S. Constitution and the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb *et seq.* ("RFRA"), by indicating that others have expressed such concerns.[11] However, the NPRM does not clearly state whether HHS is abandoning the Nondiscrimination Rules because it believes the rules conflict with the U.S. Constitution or RFRA; nor does it provide any reasoning to show that such alleged conflicts exist. The public cannot meaningfully comment on these concerns if HHS does not express whether such concerns are the basis of the Proposed Rule and provide an explanation of these alleged conflicts.

Finally and crucially, HHS has provided no detail or data with respect to the impact of the Proposed Rule on beneficiaries who currently are protected from discrimination under the Nondiscrimination Rules – including on the bases of sexual orientation, gender identity, and sex – but would lose protections under the Proposed Rule. Nor has HHS estimated the impact of the Proposed Rule on these individuals in violation of HHS's obligations to conduct a full and fair Regulatory Impact Analysis, as we discuss further below. Absent these data and information, which HHS is in the best position to provide, commenters were deprived of a meaningful opportunity to comment on the Proposed Rule. HHS must provide all of the aforementioned information and data in order to comply with APA requirements; any rule adopted pursuant to this inadequate process is otherwise invalid.

### C. The Notice of Nonenforcement Is an Impermissible End-Run Around the Requirements of the APA and an Inappropriate Remedy to Address Purported Regulatory Flexibility Act Failings in the 2016 Final Rule

In conjunction with the Proposed Rule, HHS released the Nonenforcement Notice stating that it would no longer enforce the protections codified in Nondiscrimination Rules. It premised

[10] See, e.g., New York v. United States Department of Health and Human Services, – F. Supp. 3d –, 2019 WL 5781789, at *40 (S.D.N.Y. Nov. 6, 2019) ("In fact, upon the Court's review of the complaints on which HHS relies, virtually none address the Conscience Provisions at all, let alone indicate a deficiency in the agency's enforcement capabilities as to these laws. And HHS, in this litigation, admitted that only a tiny fraction of the complaints that its Rule invoked as support were even relevant to the Conscience Provisions.").

[11] NPRM, 84 Fed. Reg. at 63832.

this action on "serious concerns" with the 2016 Final Rule's compliance with the requirements of the Regulatory Flexibility Act.[12]

The Nonenforcement Notice is effectively a unilateral rescission of the Nondiscrimination Rules, and circumvents the requirements of the APA that the promulgation or amendment of rules of general applicability, such as the Nondiscrimination Rules, be conducted through notice-and-comment rulemaking proceedings.[13] Although agency exercises of enforcement discretion are generally presumed to be unreviewable by courts, such discretion is not boundless.[14] As the U.S. Court of Appeals for the District of Columbia Circuit has explained, there exists a clear distinction between "single-shot non-enforcement decisions" more likely to be unreviewable under *Heckler v. Chaney* and an agency's "general enforcement policy" that is more susceptible to judicial review.[15] In particular, an agency's non-enforcement policy is reviewable where the agency "articulate[s] [the policy] in some form of universal policy statement."[16] This is because:

> By definition, expressions of broad enforcement policies are abstracted from the particular combinations of facts the agency would encounter in individual enforcement proceedings. As general statements, they are more likely to be direct interpretations of the commands of the substantive statute rather than the sort of mingled assessments of fact, policy, and law that drive an individual enforcement decision and that are, as *Chaney* recognizes, peculiarly within the agency's expertise and discretion. Second, an agency's pronouncement of a broad policy against enforcement poses special risks that it 'has consciously and expressly adopted a general policy that is so extreme as to amount to an abdication of its statutory responsibilities,' a situation in which the normal presumption of non-reviewability may be inappropriate.[17]

Here, HHS has announced a broad, general policy of non-enforcement that is inconsistent with its statutory and regulatory obligations as demonstrated below, and is also inconsistent with the requirements of the APA. The general presumption that agency exercises of enforcement discretion are not reviewable thus does not apply in the case of the Nonenforcement Notice.

Moreover, the Nonenforcement Notice fails to address, or even acknowledge, the availability of other remedies concerning the Department's stated concerns regarding the 2016 Final Rule's compliance with the Regulatory Flexibility Act. The Regulatory Flexibility Act provides the appropriate remedy to adjudge perceived infirmities in an agency's analyses and certifications under that statute. 5 U.S.C. § 611 provides that "a small entity that is adversely affected or aggrieved by final agency action is entitled to judicial review of agency compliance

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[12] Nonenforcement Notice, 84 Fed. Reg. at 63811.

[13] 5 U.S.C. § 553(b)-(c).

[14] 5 U.S.C. § 701(a); see also Heckler v. Chaney, 470 U.S. 821 (1985).

[15] Crowley Caribbean Transportation v. Pena, 779 F.2d 683, 685 (D.C. Cir. 1985).

[16] Id. at 676.

[17] Id. at 677 (citations omitted).

with the requirements" of the Regulatory Flexibility Act. There is no indication in the record, in the NPRM, or in the Nonenforcement Notice that any such aggrieved party availed itself of this remedy. HHS likewise has not countenanced the availability of case-by-case exemptions from HHS regulations in those "unusual circumstances" justifying departure from generally applicable requirements for certain "non-Federal entities subject to the requirements" of the UAR, or why this tool is inadequate to address any perceived impact on affected small entities arising from the 2016 Final Rule.[18] HHS cannot now seek to remedy alleged failings in the 2016 Final Rule's Regulatory Flexibility Act analysis – which failings were not timely raised by any party with a right to challenge such analysis – by sidestepping its APA obligations to promulgate or amend rules only after the public has been afforded notice and an opportunity to comment.

## II. HHS Should Abandon the Proposed Rule and Rescind its Notice of Nonenforcement Because Broadly Authorizing Discrimination Undermines the Mission of HHS, Does Not Fulfill the Requirements of the UAR, Undermines the Efficacy of HHS Grants and Conflicts with Congressional Intent, and Particularly Risks Increasing Discrimination Against LGBT Beneficiaries

### A. The Proposed Rule Would Authorize Broad Discrimination in HHS Grant Programs

On December 12, 2016, HHS adopted 47 C.F.R. § 75.300(c), which clarified and enhanced the Department's prior adoption of the UAR published on December 19, 2014.[19] The rule states:

> It is a public policy requirement of HHS that no person otherwise eligible will be excluded from participation in, denied the benefits of, or subjected to discrimination in the administration of HHS programs and services based on non-merit factors such as age, disability, sex, race, color, national origin, religion, gender identity, or sexual orientation. Recipients must comply with this public policy requirement in the administration of programs supported by HHS awards.

The rule provides a clear and uniform prohibition against discrimination based on any non-merit factor across most HHS grant programs.[20] Similarly, in 2016 HHS adopted 45 C.F.R. § 75.300(d), which provides: "In accordance with the Supreme Court decisions in *United States v. Windsor* and in *Obergefell v. Hodges*, all recipients must treat as valid the marriages of same-sex couples. This does not apply to registered domestic partnerships, civil unions or similar formal relationships recognized under state law as something other than a marriage." This rule makes clear that HHS grantees must treat same-sex married couples equally with heterosexual married couples in their provision of HHS-funded services.

HHS now proposes to amend 45 C.F.R. § 75.300(c) so that it instead reads:

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[18] 45 C.F.R. § 75.102(a).

[19] Nondiscrimination Rule NPRM.

[20] Some HHS programs are excluded from the Nondiscrimination Rule but it broadly applies to most programs. See CRS Report at 2.

> It is a public policy requirement of HHS that no person otherwise eligible will be excluded from participation in, denied the benefits of, or subjected to discrimination in the administration of HHS programs and services, to the extent doing so is prohibited by federal statute.[21]

HHS further proposes to revise 47 C.F.R. § 75.300(d) to read "HHS will follow all applicable Supreme Court decisions in administering its award programs."[22]

The scope of the Proposed Rule, and the discrimination that would be prohibited under it, is unclear because it does not expressly specify certain protected classes, but instead vaguely refers back to federal statutes and the entire body of Supreme Court jurisprudence. The Proposed Rule does not take into account operative regulations or lower court decisions that may also apply, creating more confusion and uncertainty. This is because the Proposed Rule does not clarify whether the prohibition on discrimination is limited only to discrimination "expressly" barred by federal statute, and both court decisions and agencies' implementing regulations are by definition interpretations of statute. Thus, where a court of competent jurisdiction has interpreted a statute to bar discrimination that the statute on its face does not address, or where an agency has adopted regulations barring discrimination in keeping with its statutory authority and Congress's direction, it is unclear whether under the Proposed Rule the court's decision and the agency's regulations would be properly understood as identifying discrimination that is "prohibited by federal statute."

The Proposed Rule would thus leave to grantees, beneficiaries, and HHS the job of having to review and synthesize the U.S. Code, Supreme Court decisions, lower court decisions, and applicable regulations to determine what types of discrimination are prohibited in a particular program or service and which are not. Such a process would be onerous for grantees, beneficiaries, and the agency itself, and deprives all of these stakeholders of the clarity of the Nondiscrimination Rules. For example, the Nondiscrimination Rules provide clarity and certainty that when HHS funding is present, grantees may not discriminate against same-sex married couples – addressing a very real concern. But under the Proposed Rule, how the Department will treat this issue is unclear and would require grantees and beneficiaries to review Supreme Court decisions to try to determine for themselves what the law is. Not only would the Proposed Rule be onerous in these ways, it would also require a sophisticated level of research and analysis that could be inaccessible to many beneficiaries, such as some young and older people.

According to the Congressional Research Service, overarching civil rights laws, such as Title VI of the Civil Rights Act of 1964, would "*likely* protect against discrimination in HHS grant programs on the basis of race, color, national origin, disability, or age."[23] But federal statutes only prohibit discrimination on the basis of sex and religion in some, but not all, HHS programs.[24] And very few federal statutes expressly prohibit discrimination based on sexual

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[21] NPRM, 84 Fed. Reg. at 63835.

[22] Id.

[23] CRS Report at 4 (emphasis added).

[24] Id.

orientation and gender identity.[25] Accordingly, the Proposed Rule would allow discrimination based on religion and sex in some HHS programs in which such discrimination is currently prohibited by operation of the Nondiscrimination Rules, and would authorize discrimination based on gender identity or sexual orientation in even more HHS grant programs in which such discrimination is currently prohibited by the Nondiscrimination Rules. Under the Proposed Rule, only a few programs would continue to prohibit discrimination on the basis of political affiliation or beliefs,[26] and the Proposed Rule would remove discrimination protections for all other non-merit based factors (*e.g.*, marital status). The overall effect of the Proposed Rule would be to authorize broad discrimination in the administration of HHS programs, on a variety of bases, without reason or justification.

### B. The Proposed Rule Conflicts with Congressional Intent and the UAR, and Will Substantially Complicate Efforts to Ensure Compliance with Nondiscrimination Requirements

The Nondiscrimination Rules clearly and faithfully serve congressional intent by ensuring that HHS grant awards are efficiently and effectively administered in a way that directs grant-supported services to eligible beneficiaries without reference to factors beyond the eligibility requirements enacted by Congress in creating HHS grant programs. Had Congress wished to further limit access to grant-supported services beyond those eligibility requirements, it would have done so.[27] Congress did not, and it is thus clear that Congress's intent was to provide support to all beneficiaries meeting the eligibility criteria. This clear intent is furthered by the Nondiscrimination Rules' prohibition against considering any non-merit factors in the administration of HHS grants. By contrast, the Proposed Rule would, except as prohibited by a patchwork of federal statues, arrogate to HHS grantees the authority to determine whether an eligible beneficiary may in fact receive the benefit of congressionally appropriated HHS grant support in reliance on factors beyond those established by Congress. Such an outcome would plainly undermine Congress's intent in creating the HHS grant programs, and the Proposed Rule should therefore be withdrawn.

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[25] The Supreme Court is presently considering the question of whether Title VII's protections against employment discrimination based on sex encompass discrimination based on sexual orientation and gender identity. See Bostock v. Clayton County, Ga., No. 17-1618; Altitude Express v. Zarda, No. 17-1623; R.G. & G.R. Harris Funeral Homes v. EEOC, No. 18-107. Should the Court hold that Title VII prohibits discrimination on the basis of sexual orientation and/or gender identity, such disposition will alter the ramifications of the Proposed Rule as to sexual orientation and gender identity discrimination, at least where sex discrimination protections statutorily exist in HHS grant programs. But the NPRM only invites confusion and uncertainty in this regard because the Proposed Rule's reference to "Supreme Court decisions" does not specify whether such a decision needs to specifically involve a particular statute covering HHS grants or whether the Department will take into account decisions of the Court that are clearly relevant to all HHS grants. Again, HHS grantees and beneficiaries are left to figure it out for themselves because HHS has offered no guidance in the NPRM.

[26] See CRS Report at 12.

[27] See, e.g., 2A Norman Singer & Shambie Singer, Sutherland Statutes and Statutory Construction § 47:23 (8th Ed. 2018) (discussing the well-established principle of statutory construction expression unius est exclusio alterius).

Furthermore, under section 200.300 of the UAR,[28] HHS must manage and administer federal grants in a manner that ensures programs are implemented in "full accordance with U.S. statutory and public policy requirements . . . prohibiting discrimination." The Proposed Rule fails to meet this objective by purporting to prohibit discrimination in HHS grant programs only where such discrimination is barred by federal statute, ignoring public policy requirements that go beyond statutory requirements. HHS is further required to "communicate to the [federal grant recipient] all relevant public policy requirements."[29] The Proposed Rule is an utter failure to communicate any relevant public policy requirements prohibiting discrimination. The Proposed Rule is vague as it refers grant recipients to a thicket of federal statutes that are program- and circumstance-dependent and subject to changing court interpretations. In order to accurately determine the Department's applicable nondiscrimination policy, a federal grant recipient would need to conduct a detailed analysis of all federal statutes, implementing regulations, and applicable court decisions to identify which, if any, nondiscrimination statutes apply to which grant programs.[30] The Proposed Rule thus does not simplify, but rather would significantly complicate grantees', beneficiaries', and the government's efforts to ensure compliance with nondiscrimination requirements applicable to HHS programs. Notably, even the Congressional Research Service was not able to conclusively or comprehensively determine the scope of discrimination prohibited under the Proposed Rule. Indeed, CRS identified significant room for error in their own review of the federal non-discrimination statutes applicable to HHS programs.[31] By contrast, the Nondiscrimination Rules provide clear and straightforward guidance for grantees, beneficiaries, and Department employees: discrimination on the basis of any non-merit factor, in any program, is expressly prohibited.

As recognized by the Department, "regulatory language that makes compliance more predictable and simpler for federal grant recipients is generally consistent with the concept of controlling regulatory costs and relieving regulatory burdens."[32] The Nondiscrimination Rule, as opposed to the Proposed Rule, more effectively and efficiently meets this objective. In addition to providing clear guidance to grant recipients, the Nondiscrimination Rule is easier for HHS employees to administer as it creates uniformity between HHS grants and service contracts. When it was adopted, the Nondiscrimination Rule codified for all HHS grants the non-discrimination policy that was already applicable for all HHS service contracts through the HHS Acquisition Regulation, codified at 48 C.F.R. § 352.237-74.[33] Conversely, the Proposed Rule would subject HHS grants and HHS service contracts to different nondiscrimination requirements, undermining clarity and consistency in the regulatory regime under which grantees and subgrantees operate.

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[28] 2 C.F.R. § 200.300.

[29] Id.

[30] CRS Report at 3, 6 (describing methodology used to examine Proposed Rule and the limitations of that methodology).

[31] Id.

[32] NPRM, 84 Fed. Reg. at 63833.

[33] Nondiscrimination Rule NPRM, 81 Fed. Reg. at 45271.

To the extent the Proposed Rule would make compliance with HHS regulations simpler for any party, it would only be those potential grant recipients that are interested in excluding otherwise eligible beneficiaries from government-funded programs in reliance on non-merit based factors. As demonstrated herein, however, making it easier for federal grant recipients to exclude otherwise eligible beneficiaries from grant programs on such bases would contravene congressional intent and HHS's own mission, and thus is not an appropriate objective for HHS to pursue.

### C. The Proposed Rule Undermines the Mission of HHS Because It Puts the Interests of Some Federal Grants Recipients Ahead of the Interests of the Intended Beneficiaries of HHS Programs

The mission of HHS is to "to enhance and protect the health and well-being of all Americans."[34] In the administration of HHS grant programs, this mission is best accomplished by ensuring that otherwise eligible individuals are not excluded from HHS programs on the basis of any factor that is not related to the criteria or objective of the program. The purpose and effect of the Proposed Rule, however, is to provide potential federal grant recipients with greater flexibility to discriminate against otherwise eligible persons such that they are excluded from receiving the benefits of HHS programs. Accordingly, the Proposed Rule directly conflicts with HHS's mission. The Department claims that it needs to allow federal grant recipients to discriminate in the administration of HHS programs because requiring some grant recipients to abstain from discrimination could cause them to leave the program.[35] The Department does not provide any evidence in support of this assertion. Even if this assertion were true, it provides no justification for eliminating the protections of the Nondiscrimination Rules. To eliminate the protections of the Nondiscrimination Rules on the basis that it is necessary to accommodate the wishes of potential grantees who are unwilling or unable to serve eligible beneficiaries in a nondiscriminatory manner is to prioritize the wishes of a subset of potential grantees over the needs of eligible beneficiaries and the efficient and effective provision of service to eligible beneficiaries, in contravention of congressional intent and HHS's mission.

### D. The Proposed Rules Would Reduce the Effectiveness of HHS Programs by Preventing Benefits from Reaching Their Intended Beneficiaries

By providing a clear and uniform policy across HHS programs that grantees may not discriminate on non-merit factors, including those specified, the Nondiscrimination Rules provide certainty to HHS, its grantees, grant beneficiaries, and the public. By contrast, the Proposed Rule would introduce a complicated patchwork of rules as provided by numerous statutes and Supreme Court decisions. Identifying and parsing those statutes and decisions can be challenging even for sophisticated stakeholders, but the focus on statutes and Supreme Court decisions fails to account for the fact that some nondiscrimination protections applicable to specific HHS programs are contained in regulation or are impacted by lower court decisions. For example, whereas the Family Violence Prevention and Services Act prohibits grantees from

[34] HHS, "About HHS," available at https://www.hhs.gov/about/index.html (last accessed Dec. 19, 2019).

[35] See NPRM, 84 Fed. Reg. at 63832.

discriminating on the bases of age, disability, sex, race, color, national origin, or religion,[36] discrimination on the bases of gender identity, sexual orientation, and immigration status are prohibited by regulation.[37] Under the Proposed Rule, it is unclear how HHS will treat this regulation and others like it. The NPRM furthermore states that HHS will "establish enforcement priorities with respect to those programs,"[38] suggesting that HHS may not prioritize or may disregard certain regulatory protections. In short, the Proposed Rule replaces a clear policy that provided predictability to HHS grantees and beneficiaries as well as the agency itself with a complicated and shifting thicket of policies that stakeholders will be required to identify, parse, and navigate themselves. Moreover, grantees may now be subject to different requirements in different programs that they administer, creating more, not less, work for grantees to ensure compliance.

By putting in place a complicated set of policies that is aimed at limiting current protections from discrimination, the Proposed Rule is likely to reduce the effectiveness of HHS grants and programs because discrimination on the basis of non-merit factors by grantees, by definition, limits beneficiaries' ability to access programs and services to which they are otherwise entitled. By contrast, the NPRM asserts that the Nondiscrimination Rules "reduce[] the effectiveness of programs" by, for example, "reducing foster care placements."[39] HHS has provided no data to back-up this assertion, such as the number of placements that did not occur because of the Nondiscrimination Rules. Rather, HHS states only that "[s]ome non-Federal entities have expressed concerns," and that "[s]ome members of the public have submitted comments to the Department." Such vague assertions are an insufficient foundation on which to conclude that the Nondiscrimination Rules reduce the effectiveness of HHS programs.

Contrary to HHS's assertion, moreover, experience from numerous states indicates that if a child welfare agency was deterred from making foster care placements because it did not want to comply with the Nondiscrimination Rules, other agencies could step in[40] – a reality the NPRM does not concern itself with. Furthermore, child welfare professionals recognize that discrimination by child-placing agencies reduces the number of families available for children, including those families headed by LGBT people.[41] Further to this point, while federal data demonstrates that same-sex couples with children are more likely to be raising foster or adopted children than different-sex parents,[42] and while decades of research find that the children of gay

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[36] 42 U.S.C. § 10406(c)(2).

[37] 45 C.F.R. § 1370.5.

[38] NPRM, 84 Fed. Reg. 63832.

[39] Id.

[40] See, e.g., Brief of Massachusetts et al. as Amici Curiae in Support of Philadelphia, Fulton v. City of Philadelphia, 922 F.3d 140 (3d Cir. 2019).

[41] See, e.g., Brief for Voice for Adoption, the North American Council on Adoptable Children, the National Association of Social Workers, and the Child Welfare League of America as Amici Curiae Supporting Affirmance In Favor of Defendants-Appellees 8, Fulton v. City of Philadelphia, 922 F.3d 140 (3d Cir. 2019). ("[a]llowing foster agencies to deny certification to same-sex couples on the basis of LGBTQ status shrinks the pool and hinders the primary goals of foster care placement").

[42] https://williamsinstitute.law.ucla.edu/wp-content/uploads/Parenting-Among-Same-Sex-Couples.pdf.

and lesbian parents have similar outcomes to those of heterosexual parents,[43] the Proposed Rule would remove protections for LGBT prospective parents. LGBT people provide adoptive and foster homes for all types of children, but they can be especially beneficial source of good homes for LGBT youth in the foster system, who are significantly overrepresented among foster youth and who face higher levels of mistreatment or longer roads to permanent placement.[44]

In addition, the Proposed Rule would invite and authorize discrimination on the bases of sexual orientation and gender identity, among other bases, in a variety of important programs. For example, pursuant to the Proposed Rule, programs under the Older Americans Act such as meals-on-wheels, senior centers, and transportation services would likely be authorized to discriminate on the bases of sexual orientation and gender identity. That is because the Older Americans Act neither expressly prohibits sexual orientation or gender identity discrimination nor prohibits sex discrimination. Yet any discrimination against an older person for a non-merit reason would contravene congressional intent for the Older Americans Act. Even where sex discrimination is prohibited in HHS grants, such as via Title IX, it is unclear whether and to what extent the Department will enforce those protections for LGBT people. For example, if a Headstart program receiving HHS funding discriminates against an LGBT youth or a child with same-sex parents, the Proposed Rule (in conjunction with the Administration's view that Title IX does not prohibit sexual orientation and gender identity discrimination) would appear to authorize that discrimination, even though such discrimination in no way further the goals of Headstart. While any final rule should protect against such discrimination, as the Nondiscrimination Rules currently do, HHS must at the very least address these and similar possibilities across the grant programs governed by the Proposed Rule, as well as take them into account as costs in the Regulatory Impact Analysis.

### E. The Proposed Rule Especially Risks Harming LGBT People

The Proposed Rule would invite discrimination on a variety of characteristics, depending on the particular program, but would particularly remove protections against discrimination on the bases of sexual orientation and gender identity.[45] And the Administration has repeatedly stated that it does not consider existing protections against sex discrimination to cover discrimination based on gender identity and sexual orientation. Removing the Nondiscrimination Rules' protections against discrimination based on sexual orientation and gender identity invites and may authorize discrimination against LGBT people – even where such discrimination is recognized by courts as sex discrimination in violation of federal law.

The removal of protections against sexual orientation and gender identity is especially dangerous because discrimination and prejudice against LGBT people remain pervasive across

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[43] See, e.g., https://williamsinstitute.law.ucla.edu/research/mental-health-kids-lesbian-parents/; https://williamsinstitute.law.ucla.edu/wp-content/uploads/lgb-parent-families-july-2014.pdf.

[44] See, e.g., Bianca D.M. Wilson & Angeliki A. Kastanis, Sexual and Gender Minority Disproportionality and Disparities in Child Welfare: A Population-based Study, 58 Child. & Youth Servs. Rev. (2015); Bianca D.M. Wilson et al., The Williams Institute, Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles (2014), http://williamsinstitute.law.ucla.edu/wpcontent/uploads/LAFYS_report_final-aug-2014.pdf.

[45] CRS Report at 1, 2.

the United States, including in health care and human services.[46] Indeed, the Department has had long had before it – in, for example, rulemakings such as those concerning Section 1557 of the Affordable Care Act, Health People 2020, and research publications of the Institute of Medicine and Centers for Disease Control and Prevention – ample research documenting such discrimination and its pernicious effects on LGBT's health and well-being.[47] Discrimination against LGBT people can take many forms, including the outright denial of care or services[48] and negative treatment by program staff.[49] According to the Institute of Medicine, "LGBT

[46] See, e.g., Testimony of Jocelyn Samuels, Executive Director of the Williams Institute, UCLA School of Law, submitted to the Committee on the Judiciary, U.S. House of Representatives, regarding the Equality Act (Apr. 10, 2019) (expert opinion and collecting sources on health care discrimination), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Samuels-Equality-Act-Testimony.pdf; Testimony of Gary Harper, Professor of Public Health at the University of Michigan, and colleagues, submitted to the Committee on the Judiciary, U.S. House of Representatives, regarding the Equality Act (Apr. 4, 2019) (expert opinion and collecting sources on health care discrimination), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Harper-Equality-Act-Testimony.pdf; NPR, Robert Wood Johnson Foundation, & Harvard T.H. Chan School of Public Health, Discrimination in America: Experiences and Views of LGBTQ Americans 1 (Nov. 2017), https://www.npr.org/documents/2017/nov/npr-discrimination-lgbtq-final.pdf (hereinafter "NPR Report") (showing that 16% of LGBTQ survey respondents reported being personally discriminated against because of LGBTQ status when going to the doctor or health clinic); Lambda Legal, When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV (2010), https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf (documenting for example that, in a survey of 4,916 LGBT people, "[m]ore than half of all respondents reported that they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive").

[47] Very recently, researchers at Cornell University conducted a systematic review of all peer-reviewed articles published in English before October 2018 that assessed the effects of discrimination on the health of LGBT people in the U.S., and found that "[o]ut of 300 peer-reviewed studies . . . 95% found that discrimination is associated with mental and physical health harms for LGBT people." https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-scholarly-research-say-about-the-effects-of-discrimination-on-the-health-of-lgbt-people/. We incorporate into this comment each and every study reviewed therein.

[48] Institute of Medicine, The Health of Lesbian, Gay, Bisexual, and Transgender People (2011), https://www.ncbi.nlm.nih.gov/books/NBK64806/; Human Rights Watch,"You Don't Want Second Best": Anti-LGBT Discrimination in US Health Care 22-23 (2018), https://www.hrw.org/report/2018/07/23/you-dont-want-second-best/anti-lgbt-discrimination-us-health-care (citing interviews where LGBTQ people described being turned away when seeking services including check-ups, fertility treatments, counseling, yeast infections, access to HIV-preventive medications, and an evaluation of a six-day-old child); Shabab Ahmed Mirza & Caitlin Rooney, Ctr. for Am. Progress, Discrimination Prevents LGBTQ People from Accessing Healthcare (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/ (documenting that 8% of LGB respondents and 29% of transgender respondents who had visited a doctor or health care provider said that, in the prior year, a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation or gender identity, respectively); Lambda Legal, supra, at 10 ("Almost 8 percent of LGB respondents reported that they had been denied needed health care because of their sexual orientation. Over a quarter of all transgender respondents (nearly 27 percent) reported being denied care . . . .").

[49] Institute of Medicine, supra, at 62 ("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."); Mirza & Rooney, supra (documenting that 9% of LGB respondents and 21% of transgender respondents said that a doctor or other health care provider used harsh or abusive language when treating them); Lambda Legal, supra, at 5 ("Just over 10 percent of LGB respondents reported that health care professionals used

individuals face discrimination in the health care system that can lead to an outright denial of care or to the delivery of inadequate care. There are many examples of manifestations of enacted stigma against LGBT individuals by health care providers. LGBT individuals have reported experiencing refusal of treatment by health care staff, verbal abuse, and disrespectful behavior, as well as many other forms of failure to provide adequate care."[50] The Proposed Rule's impact on LGBT people is also pernicious because LGBT people are more likely to need and participate in public benefit programs.[51] Contrary to popular stereotypes about the affluence of the LGBT community, research also demonstrates higher rates of poverty, food insecurity, and unemployment among LGBT people compared to non-LGBT people.[52]

Discrimination and stigma lead many LGBT people to delay or avoid seeking health care or other important services.[53] The detrimental effect of this discrimination on LGBT health is compounded because LGBT people already face a higher risk of experiencing physical and mental health issues stemming from stigma and prejudice.[54] Discrimination based on sexual

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harsh language toward them; 11 percent reported that health professionals refused to touch them or used excessive precautions; and more than 12 percent of LGB respondents reported being blamed for their health status."); id. at 5-6 ("Nearly 21 percent of transgender and gender nonconforming respondents reported being subjected to harsh or abusive language from a health care professional, and almost 8 percent reported experiencing physically rough or abusive treatment from a health care professional. Over 20 percent of transgender and gender-nonconforming respondents reported being blamed for their own health conditions.").

[50] Institute of Medicine, supra, at 62.

[51] https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/; see also https://www.mathematica.org/our-publications-and-findings/projects/human-services-for-low-income-and-at-risk-lgbt-populations.

[52] See, e.g., Williams Inst., LGBT Demographic Data Interactive (Jan. 2019), https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/#density; M.V. Lee Badgett et al., Williams Inst., New Patterns of Poverty in the Lesbian, Gay, and Bisexual Community (2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGB-Poverty-Update-Jun-2013.pdf; Taylor N. T. Brown et al., Williams Inst., Food Insecurity and SNAP Participation in the LGBT Community (July 2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Food-Insecurity-and-SNAP-Participation-in-the-LGBT-Community.pdf.

[53] Human Rights Watch, supra, at 20 (citing interviews with LGBTQ people who described how mistreatment by providers deterred them from seeking care); Institute of Medicine, supra, at 62 ("Fear of stigmatization or previous negative experiences with the health care system may lead LGBT individuals to delay seeking care."); id. at 63-64 (discussing "internalized stigma" and other personal barriers to care); Mirza & Rooney, supra (documenting that 8% of all LGBTQ people surveyed—and 14% of those who had experienced discrimination on the basis of their sexual orientation or gender identity in the past year—avoided or postponed needed medical care because of disrespect or discrimination from health care staff and that, among transgender people, 22% reported such avoidance); cf. Lambda Legal, supra, at 13 ("Overall, nine percent of LGB respondents are concerned about being refused medical services when they need them. Over half of transgender respondents and 20 percent of respondents living with HIV share this concern.").

[54] See, e.g., Human Rights Watch, supra, at 5 (citing surveys showing "LGB people were at heightened risk of psychological distress, drinking, and smoking, and lesbian and bisexual women were at heightened risk of having multiple chronic conditions" and transgender people were more likely than cisgender people to "be overweight, be depressed, report cognitive difficulties, and forego treatment for health problems"); J. Kates et al., Henry J. Kaiser Family Foundation, Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. 5 (May 2018), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US (finding that LGB individuals are more likely to "rate their health as poor, have more chronic conditions, and have higher prevalence and earlier onset of disabilities" and "report more

orientation or gender identity is a "minority stressor" that can profoundly harm the health and well-being of LGBT people who are directly subject to these refusals of service. Discrimination does not have to occur in the health care and health coverage context specifically to negatively impact health and well-being; rather discrimination in employment, housing, public accommodations, and other settings have all been connected to the health disparities facing the LGBT people.[55]

Stress related to being part of a group that is systematically subject to stigma and discrimination affects overall health, which HHS has recognized with respect to LGBT people. For example, in stating that the LGBT population requires special public-health attention, HHS explained that "[p]ersonal, family and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals."[56] Healthy People 2020, HHS's science-based initiative setting 10-year goals and objectives for improving population health, reports that "[s]ocial determinants affecting the health of LGBT individuals largely relate to oppression and discrimination."[57] Similarly, the Centers for Disease Control and Prevention ("CDC") report that homophobia, stigma, and discrimination can negatively affect the physical and mental health of gay and bisexual men, as well as the quality of the health care they receive.[58] The CDC also reports that discrimination and social stigma may help explain the high risk for HIV infection among transgender women,[59] among other health concerns facing transgender people. HHS's Office of Women's Health has recognized that discrimination and stigma may lead lesbians and bisexual women to have higher rates of depression and anxiety than other women, as well as to be less likely than other women to get routine mammograms and clinical breast exams.[60] With respect to LGBT youth, the Institute of Medicine (now called the National Academies of Sciences, Engineering, and Medicine), which operates under a congressional charter and provides independent, objective analysis of scientific research, has observed that "the disparities in both mental and physical health that are seen between LGBT and heterosexual and non-gender-variant youth are influenced largely by their experiences of

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asthma diagnoses, headaches, allergies, osteoarthritis, and gastro-intestinal problems than heterosexual individuals.")

[55] See, e.g., Pizer et al., supra, at 734-42 (discussing research documenting that workplace discrimination negatively affects the income and health of LGBT people).

[56] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health, http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25 (last visited Aug. 12, 2019).

[57] Id.

[58] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Gay and Bisexual Men's Health, Stigma and Discrimination, http://www.cdc.gov/msmhealth/stigma-and-discrimination.htm (last visited Aug. 12, 2019).

[59] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, HIV Among Transgender People, http://www.cdc.gov/hiv/group/gender/transgender/index.html (last visited Aug. 12, 2019).

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

stigma and discrimination during the development of their sexual orientation and gender identity and throughout the life course."[61]

The disparities between health outcomes for LGBT and non-LGBT people have been well-documented. For example, in Healthy People 2010 and Healthy People 2020, which set health priorities for the country,[62] HHS found that LGBT people face these health disparities:

- LGBT youth are 2 to 3 times more likely to attempt suicide;
- LGBT youth are more likely to be homeless;
- Lesbians are less likely to get preventive services for cancer;
- Gay men are at higher risk of HIV and other STDs, especially among communities of color;
- Lesbians and bisexual females are more likely to be overweight or obese;
- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals;
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers;
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.[63]

The evidence of discrimination against, health disparities and barriers to health care and human services facing, and the more general economic and social vulnerabilities of, LGBT people underscore the significance of preserving the Nondiscrimination Rules. By contrast, the Proposed Rule, if finalized, stands to worsen anti-LGBT discrimination and related health disparities, especially for LGBT people living in states without protections against sexual orientation and gender identity discrimination.[64]

## III. The Proposed Rule Fails to Satisfy the Department's Obligations with Respect to Regulatory Impact Analyses

Under Executive Orders 12866 and 13563, HHS is required to fully analyze the costs and benefits of the Proposed Rule.[65] But HHS has failed to satisfy this obligation by not assessing and accounting for the foreseeable costs of the Proposed Rule to all beneficiaries of HHS grant programs and LGBT beneficiaries in particular, and to the government in terms of increased discrimination, as well as the substantial costs associated with beneficiaries and grantees having

[61] Institute of Medicine, supra.

[62] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health, http://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health?topicid=25 (last visited Aug. 12, 2019).

[63] Id.

[64] Williams Inst., LGBT People in the U.S. Not Protected by State Nondiscrimination Statutes (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Equality-Act-April-2019.pdf.

[65] Exec. Order No. 12,866 §§ 6-7, 58 Fed. Reg. 51,735 (Oct. 4, 1993); Exec. Order No. 13,563 § 1(c), 76 Fed. Reg. 3821 (Jan. 21, 2011).

to undertake the onerous task of assessing what types of discrimination are prohibited in particular programs and services. HHS has also made inaccurate and unsupported assumptions underlying the asserted benefits of the Proposed Rule. HHS further offered only conclusory, unsupported statements in determining that that the Proposed Rule would have no impact on family well-being, in derogation of its responsibilities under the Treasury and General Government Appropriations Act of 1999. The broad scope of this Proposed Rule demands a much more robust, evidence-based, overall analysis.

### A. HHS Must Assess and Account for the Impact of the Proposed Rule on Beneficiaries and the Government from the Risks of Increased Discrimination

The Proposed Rule is expressly designed to narrow the circumstances in which participants in HHS programs are prohibited from discriminating against otherwise eligible persons on the basis of non-merit factors. By definition, this narrowing would permit what has heretofore been unlawful discrimination.[66] This clear and obvious consequence of the Proposed Rule notwithstanding, HHS's discussion of the costs of the Proposed Rule does not even mention the impact the rule would have on the very people who are presently protected by the Nondiscrimination Rule: beneficiaries.

While the Department is obligated "to use the best available techniques to quantify anticipated present and future benefits and costs as accurately as possible,"[67] it made no effort to analyze either present or future costs implicated by the Nondiscrimination Rules and the Proposed Rule. In fact, as noted above in Part I, HHS did not even provide minimal data that might permit commenters to weigh in on the costs and necessity of the Proposed Rule, such as: which Department-funded services are provided by entities that have objected to the Nondiscrimination Rules, how many such entities are currently receiving HHS awards, the extent of the services provided by such entities, any data with respect to any decline in participation by such entities since the Nondiscrimination Rules were adopted in 2016, or any data supporting the assertion that such a decline may accrue in the future. Nor has HHS offered any data or estimated the number of or type of beneficiaries who would be subject to discrimination under the Proposed Rule but not under the Nondiscrimination Rules. HHS should withdraw the Proposed Rule for these reasons alone.

Yet even without these data, because the Proposed Rule is expressly designed to narrow the nondiscrimination requirements applicable to HHS grant programs, it is certain that if any grantees avail themselves of the increased freedom to discriminate provided by the Proposed Rule, some number of beneficiaries will be denied protection that they would otherwise receive. HHS must therefore consider the full impact of the Proposed Rule on beneficiaries. To the extent

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[66] Cf. Order Granting Pls.' Mot. For Summ. J.; Denying Defs.' Mot. to Dismiss, Wash. v. Azar, No. 2:19-cv-00183, at 24-25 (E.D. Wash. Nov. 21, 2019) (finding HHS's "provider conscience" rule to have been adopted arbitrarily and capriciously) ("the Rule is arbitrary and capricious because 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.").

[67] Exec. Order No. 13,563 § 1(c).

that there is uncertainty about the costs of the Proposed Rule with respect to increased discrimination, the Department should follow White House guidance to conduct "additional research prior to rulemaking" to address significant uncertainties about net benefits, because "[t]he costs of being wrong may outweigh the benefits of a faster decision."[68] Even if some of those harms are uncertain or challenging to quantify, their magnitude is significant and not zero.[69]

### B. HHS Failed to Conduct the Required Analysis of the Proposed Rule's Impact on Family Well-Being under the Treasury and General Government Appropriations Act of 1999

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires that agencies determine whether any regulation "may affect family well-being."[70] This analysis must include whether "the action strengthens or erodes the stability or safety of the family and, particularly, the marital commitment," whether "the action helps the family perform its functions," and whether "the action increases or decreases disposable income or poverty of families and children."[71] Despite these clear commandments, HHS merely stated in a conclusory fashion that "[t]he Department has determined that these proposed regulations will not have an impact on family well-being, as defined in the Act."[72] In so doing, the Department has committed precisely the act it contends requires the non-enforcement and amendment of the Nondiscrimination Rules—summarily making an assertion about the conclusions of statutorily required regulatory impact analysis without providing any support whatsoever for such conclusions. Moreover, and as described above, the Proposed Rule is likely to disproportionately and harmfully affect LGBT beneficiaries of HHS programs, including same-sex married couples and LGBT youth presently protected against discrimination in the provision of services under the Nondiscrimination Rules. It is thus clear that the Department's finding is inconsistent with the requirements of Section 654, and further evinces the need for HHS to withdraw the Proposed Rule unless and until it conducts a meaningful regulatory impact analysis that assess and accounts for the likely effects of the Proposed Rule on all HHS program beneficiaries, including LGBT beneficiaries.

## IV. Conclusion

For the foregoing reasons, HHS should leave the Nondiscrimination Rules in place and withdraw the Proposed Rule and Nonenforcement Notice. Indeed, the Proposed Rule raises serious concerns under the APA, 5 U.S.C. § 706(2)(A). At the very least, HHS should conduct a full regulatory impact analysis that analyzes the potential harm to beneficiaries and the government due to increased discrimination and the costs of increased confusion and lack of clarity, then open a new comment period of at least 60 days after providing that analysis and the

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[68] Office of Mgmt. & Budget, Exec. Office of the President, Circular A-4 at 39 (Sept. 17, 2003).

[69] See, e.g., Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin., 538 F.3d 1172, 1200 (9th Cir. 2008).

[70] Pub. L. 105–277, div. A, § 101(h) [title VI, § 654], codified at 5 U.S.C. § 601 note.

[71] Id.

[72] NPRM, 84 Fed. Reg. at 68385.

data and information requested above to the public, permitting commenters to submit additional or revised comments.

Respectfully submitted,

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