IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); *et al.*, Plaintiffs, v. United States Department of Health and Human Services, *et al.*, Defendants.	Civil Action No. 1:20-cv-11297

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTRODUCTION 1

BACKGROUND 2

LEGAL STANDARD 7

ARGUMENT 8

I. Plaintiffs Have Sufficiently Alleged Standing To Challenge The Rollback Rule. 8

A. Defendants' motion mischaracterizes Article III's requirements. 8

1. *Plaintiffs need only allege a substantial risk of harm to establish injury-in-fact.* 8

2. *The presence of a third party in a causal chain does not defeat standing.* 12

3. *A decision that will reduce Plaintiffs' injuries meets the redressability requirement.* 15

B. Plaintiffs have sufficiently alleged standing as to each challenged provision. 16

1. *The repeal of the definition of "on the basis of sex" and unlawful interpretation of that term in Title IX.* 17

2. *The narrowing of the definition of "covered entities."* 26

3. *The elimination of the uniform enforcement scheme.* 30

4. *The incorporation of Title IX's religious and abortion exemptions.* 32

5. *The removal of protections for association discrimination.* 35

6. *The elimination of the notice and taglines requirement.* 35

7. *The elimination of other non-discrimination regulations.* 37

II. Plaintiffs' Claims Are Ripe 38

TABLE OF CONTENTS—Continued

Page

III. Plaintiffs Have Stated A Claim As To Counts III And IV. 40

A. The Amended Complaint States An Equal Protection Violation..... 40

B. The Amended Complaint States A Final, Reviewable Agency Action..... 42

CONCLUSION.....44

EXHIBITS

TABLE OF AUTHORITIES

Page(s)

Cases

Adams v. Watson,
10 F.3d 915 (1st Cir. 1993) 18

Animal Welfare Inst. v. Martin,
623 F.3d 19 (1st Cir. 2010) 22

Arroyo Gonzalez v. Rossello Nevares,
305 F. Supp. 3d 327 (D.P.R. 2018) 20, 21

Attias v. Carefirst, Inc.,
865 F.3d 620 (D.C. Cir. 2017) 30

Aulenback, Inc. v. Fed. Highway Admin.,
103 F.3d 156 (D.C. Cir. 1997) 39

Bennett v. Spear,
520 U.S. 154 (1997) 13, 16, 42, 43

Block v. Meese,
793 F.2d 1303 (D.C. Cir. 1986) (Scalia, J.) 12

Bostock v. Clayton County, Georgia,
140 S. Ct. 1731 (2020) ..... *passim*

Boyden v. Conlin,
341 F. Supp. 3d 979 (W.D. Wis. 2018) 14, 15

Carey v. Population Services Int'l,
431 U.S. 678 (1977) 33

City & Cnty. of San Francisco v. Azar,
411 F. Supp. 3d 1001 (N.D. Cal. 2019) 20

Crowley Caribbean Transp., Inc. v. Pena,
37 F.3d 6717 (D.C. Cir. 1994) 44

D.H. v. Snyder,
No. 4:20-cv-335-SHR (D. Ariz. Sept. 28, 2020), ECF No. 18 11

Davis v. Fed. Election Comm'n,
554 U.S. 724 (2008) 13, 28, 29

TABLE OF AUTHORITIES—Continued

Page(s)

Dep't of Commerce v. New York,
139 S. Ct. 2551 (2019) 13, 28, 29, 30

Dep't of Homeland Sec. v. Regents of the Univ. of California,
140 S. Ct. 1891 (2020) 40, 42

District Hosp. Partners, L.P. v. Sebelius,
794 F. Supp. 2d 162 (D.D.C. 2011) 42

Edison Elec. Inst. v. EPA,
996 F.2d 326 (D.C. Cir. 1993) 44

Equal Means Equal v. Dep't of Educ.,
450 F. Supp. 3d 1 (D. Mass. 2020) 21

Equal Means Equal v. Ferriero,
No. 20-CV-10015-DJC, 2020 WL 4548248 (D. Mass. Aug. 6, 2020) 8

Erickson v. Pardus,
551 U.S. 89 (2007) 7

Ernst & Young v. Depositors Econ. Prot. Corp.,
45 F.3d 530 (1st Cir. 1995) 38

Franciscan All., Inc. v. Burwell,
227 F. Supp. 3d 660 (N.D. Tex. 2016) 4, 11, 24

Franciscan All. v. Azar,
No. 20-10093 (5th Cir., June 2, 2020) 4

Franciscan All. v. Azar,
No. 7:16-cv-00108-O, Dkt. No. 182 (N.D. Tex. Nov. 21, 2019) 4, 11

FW/PBS, Inc. v. City of Dallas,
493 U.S. 215 (1990) 26

Havens Realty Corp. v. Coleman,
455 U.S. 363 (1982) ..... *passim*

June Med. Servs. LLC v. Russo,
140 S. Ct. 2103 (2020) 12, 20, 33

Kadel v. North Carolina,
2020 WL 6101994 (4th Cir. 2020) 11, 15

TABLE OF AUTHORITIES—Continued

Page(s)

Katz v. Pershing, LLC,
672 F.3d 64 (1st Cir. 2012) 19, 26, 37

Lambert v. Hartman,
517 F.3d 433 (6th Cir. 2008) 30

Larson v. Valente,
456 U.S. 228 (1982) 16

Lujan v. Defs. of Wildlife,
504 U.S. 555 (1992) 7, 9, 12, 18, 36

Maine People's All. and Nat. Res. Def. Council v. Mallinckrodt, Inc.,
471 F.3d 277 (1st Cir. 2006) 17

Massachusetts v. U.S. Dep't of Health & Human Servs.,
923 F.3d 209 (1st Cir. 2019) ..... *passim*

McInnis-Misenor v. Maine Med. Ctr.,
319 F.3d 63 (1st Cir. 2003) 38

Merlonghi v. United States,
620 F.3d 50 (1st Cir. 2010) 7

Monsanto Co. v. Geertson Seed Farms,
561 U.S. 139 (2010) 12, 18

Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.,
463 U.S. 29 (1983) 40

Nat. Res. Def. Council v. Nat'l Highway Traffic Safety Admin.,
894 F.3d 95 (2d Cir. 2018) 13

National Park Hospitality Association v. Department of Interior,
538 U.S. 803 (2003) 40

Nevada Dep't of Human Res. v. Hibbs,
538 U.S. 721 (2003) 41

New York v. Dep't of Commerce,
351 F. Supp. 3d 502 (S.D.N.Y. 2019) 12

New York v. United States Dep't of Health & Human Servs.,
414 F. Supp. 3d 475 (S.D.N.Y. 2019) 17

TABLE OF AUTHORITIES—Continued

Page(s)

O'Shea v. Littleton,
414 U.S. 488 (1974).....10, 34, 35

Ohio Forestry Association, Inc. v. Sierra Club,
523 U.S. 726 (1998).....39

OSG Bulk Ships, Inc. v. United States,
132 F.3d 808 (D.C. Cir. 1998).....44

Powers v. Ohio,
499 U.S. 400 (1991).....20, 34

Price Waterhouse v. Hopkins,
490 U.S. 228 (1989).....25

Pub. Citizen v. Fed. Motor Carrier Safety Admin.,
374 F.3d 1209 (D.C. Cir. 2004).....17

Reddy v. Foster,
845 F.3d 493 (1st Cir. 2017).....9, 10, 23

Romer v. Evans,
517 U.S. 620 (1996).....40, 41

Rothstein v. UBS AG,
708 F.3d 82 (2d Cir. 2013).....30

Sierra Club v. Dep't of the Interior,
899 F.3d 260 (4th Cir. 2018).....16

Simon v. Eastern Kentucky Welfare Rights Organization,
426 U.S. 26 (1976).....13, 14

Singleton v. Wulff,
428 U.S. 106 (1976).....21, 33

Staub v. Proctor Hospital,
562 U.S. 411 (2011).....16

Susan B. Anthony List v. Driehaus,
573 U.S. 149 (2014).....9, 10, 38

Sutliffe v. Epping School Dist.,
584 F.3d 314 (1st Cir. 2009).....7

TABLE OF AUTHORITIES—Continued

Page(s)

Texas v. United States,
809 F.3d 134 (5th Cir. 2015), *aff'd by an equally divided Court*, 136 S. Ct. 2271 (2016) 13

Torres-Negron v. J & N Records, LLC,
504 F.3d 151 (1st Cir. 2007) 7

United States v. Virginia,
518 U.S. 515 (1996) 41

Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.,
429 U.S. 252 (1977) 42

Walker v. Azar,
No. 20CV2834FBSMG, 2020 WL 4749859 (E.D.N.Y. Aug. 17, 2020) 17, 24, 25

Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.,
No. CV 20-1630 (JEB), 2020 WL 5232076 (D.D.C. Sept. 2, 2020) ..... *passim*

Whitmore v. Arkansas,
495 U.S. 149 (1990) 25, 26

Whole Woman's Health v. Hellerstedt,
136 S. Ct. 2292 (2016) 44

Statutes

20 U.S.C. § 1681(a) 3

29 U.S.C. § 794(a) 3

42 U.S.C. § 6101 3

42 U.S.C. § 18116(a) 3

42 U.S.C. § 2000d 3

Regulations

45 C.F.R. § 92.1 *et seq.* (2020) 17

45 C.F.R. § 92.2 (2017) 32

45 C.F.R. § 92.4 (2017) 3, 5, 17, 25, 26

45 C.F.R. § 92.8 (2017) 35

TABLE OF AUTHORITIES—Continued

Page(s)

45 C.F.R. § 92.8(b) (2017).....4

45 C.F.R. § 92.201(a) (2017).....4

45 C.F.R. § 92.206 (2017).....5, 17

45 C.F.R. § 92.207 (2017).....5, 17

45 C.F.R. § 92.209 (2017).....3, 35

45 C.F.R. § 92.301 (2017).....30

45 C.F.R. § 92.301(a) (2017).....4

45 C.F.R. § 92.301(b) (2017).....4

Nondiscrimination in Health Programs and Activities,
81 Fed. Reg. 31,376 (May 18, 2016).....1, 25

Nondiscrimination in Health and Health Education Programs or Activities,
84 Fed. Reg. 27,846 (June 14, 2019).....14

Nondiscrimination in Health and Health Education Programs or Activities,
Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020)..... *passim*

Rules

Rule 12(b)(1).....7

Rule 12(b)(6).....7

Other Authorities

5B C. Wright & A. Miller, Federal Practice and Procedure § 1350 (3d ed. 2004).....7

INTRODUCTION

Defendants—the Department of Health and Human Services ("Department" or "HHS") and three of its officers—worked deliberately to undermine non-discrimination protections in healthcare through the regulatory action at issue here. In 2016, the Department adopted a rule that fleshed out the non-discrimination provision in the Affordable Care Act ("ACA"). It did so because its experience had made clear "the importance of a regulation that is prescriptive in the sense that it provides concrete guidance." Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,444 (May 18, 2016) ("2016 Rule"). HHS believed its rule did just that and would increase "compliance with Section 1557 by covered entities and the ability of individuals to assert and protect their rights under the law." *Id*. Four years later, the Department has now eschewed this "concrete guidance" in favor of a regulation that injects ambiguity into the law, adopts an unlawful interpretation of Section 1557's protections, and adds sweeping new exemptions that further erode the law's nondiscrimination protections. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule").

Defendants' principal defense now is to claim that all this effort really amounted to nothing at all. In its telling, all it did was eliminate protections and allow the statute to fill in the gaps. That is simply not true.

For one thing, the Department justified the Rollback Rule by adopting an interpretation of sex discrimination which Section 1557 prohibits—under which sex discrimination does not encompass discrimination on the basis of sexual orientation and gender identity. *Id.* at 37,180, 37,191. But the Supreme Court rejected that narrow interpretation *before* the Rollback Rule was published, in *Bostock v. Clayton County, Georgia*, 140 S. Ct. 1731 (2020). The Department

made no effort to justify its refusal to follow a Supreme Court precedent laid down literally days before it published its rule.

For another, the Department's logic is backwards: The 2016 Rule filled in the gaps in Section 1557 and offered clarity both for those it protects—about their rights and how to enforce them—and for those it regulates—about their obligations. The Rollback Rule eliminated this clarity, both by removing much of the 2016 Rule and by justifying its action and setting out and enforcement policy for Section 1557 based on a definition of sex discrimination that conflicts with the Supreme Court's ruling in *Bostock*.

It should be no surprise then, that the Department's bulldozing of the protections it had previously endorsed has caused harm. The Rollback Rule will lead to an increase in discrimination in healthcare and make it harder for people to access much needed care, will decrease people's ability to get relief when they experience that discrimination, and increase the demand for provision of healthcare by trusted sources like many of the Plaintiffs, thereby forcing them to divert their resources to mitigate the harms of the rule and frustrating their ability to care for their patients' health.

All of this is plain from the allegations in the Amended Complaint. Plaintiffs' standing to challenge the Rollback Rule is clear. And Defendants' arguments for dismissal of a narrow set of Plaintiffs' claims do not hold up. This Court should deny Defendants' motion to dismiss.

BACKGROUND

In 2010, Congress adopted the ACA, which contains a non-discrimination provision known as Section 1557. Am. Compl. ¶¶ 86, 92–93. Under it, "an individual shall not, on the ground prohibited under" four cross-referenced statutes "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity,

any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under [Title I of the ACA or amendments made by Title I]." 42 U.S.C. § 18116(a). Those prohibited grounds are "race, color, or national origin," *id.* § 2000d (Title VI of the Civil Rights Act of 1964), "sex," 20 U.S.C. §§ 1681(a), 1684 (Title IX of the Education Amendments of 1972), "age," 42 U.S.C. § 6101 (Age Discrimination Act of 1975), and "disability," 29 U.S.C. § 794(a) (Rehabilitation Act). "The enforcement mechanisms provided for and available under" those statutes "apply for purposes of violations of" Section 1557. 42 U.S.C. § 18116(a).

Before the ACA, healthcare providers and insurers routinely discriminated against LGBTQ+ (lesbian, gay, bisexual, transgender, queer, intersex, or gender-non-binary) people, women, people seeking pregnancy-related and reproductive care, and people seeking gender affirming care. Am. Compl. ¶¶ 88–91. Private plaintiffs and HHS's Office for Civil Rights (OCR) used Section 1557 to address this discrimination. *Id.* ¶¶ 100–105. Their efforts stemmed it, but did not end it. *Id.* ¶¶ 106–116.

To carry out Section 1557, HHS issued the 2016 Rule. As relevant, the rule covered *who* was subject to its requirements, *what* it prohibited, and *how* its prohibitions could be enforced. First, it defined the term "covered entity" to set out the entities that were subject to the rule. *See* 45 C.F.R. § 92.4 (2017). Second, it defined Section 1557's protections. Among other things, it defined discrimination on the basis of sex to include "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity." *Id.* And it covered discrimination on the basis of association with someone with a protected characteristic. *See id.* § 92.209. It also required covered entities to "take

reasonable steps to provide meaningful access to each individual with limited English proficiency" (LEP) who was eligible or likely to be served by the entity. *See id.* § 92.201(a). Third, it required covered entities to post a notice of prohibited discrimination and OCR complaint procedures, created an administrative enforcement scheme, and specified remedies. *See id.* §§ 92.8(b), 92.301(a), 92.301(b).

In 2019, HHS proposed rolling back the 2016 Rule. To explain this reversal, it pointed to a district court decision that had preliminarily enjoined five words in the Rule's definition of discrimination "on the basis of sex"—that is, as including "gender identity" and "termination of pregnancy." 2019 Proposed Rule at 27,848 (citing *Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660, 687 (N.D. Tex. 2016)). That decision, HHS said, had compelled it to question whether it had "exceeded its statutory authority." *Id.* at 27,849; *see also id.* at 27,854, 27,856–57, 27,871 (citing a Memorandum of the Attorney General (Oct. 4, 2017)).[1]

HHS, however, reached far beyond any question raised by *Franciscan Alliance* and proposed to "eliminate most of" the 2016 Rule. *Id.* at 27,872. It received over 150,000 comments on its proposal, the vast majority of which urged HHS to reconsider. Am. Compl. ¶ 166. The comments explained that the rollback would "lead to increased discrimination in healthcare," leading "people to delay or forego healthcare" resulting "in adverse health outcomes and greater overall healthcare costs." 85 Fed. Reg. at 37,165.

Before the final rule was published, the Supreme Court issued *Bostock*, affirming that "discrimination based on . . . transgender status necessarily entails discrimination based on sex"

[1] The district court later converted its preliminary injunction to a permanent vacatur of those five words. *See Franciscan All. v. Azar*, No. 7:16-cv-00108-O, Dkt. No. 182 at 2 (N.D. Tex. Nov. 21, 2019) (modifying *Franciscan All. v. Azar*, 414 F. Supp. 3d 928, 928 (N.D. Tex. 2019)). That decision is on appeal, and the parties are briefing the effect of *Bostock*. Order, *Franciscan All. v. Azar*, No. 20-10093 (5th Cir., June 2, 2020).

under Title VII. 140 S. Ct. at 1754. This interpretation flatly contradicted HHS's stated justification for its rulemaking.

Nevertheless, HHS published the Rollback Rule containing only "minor and primarily technical" changes from its proposed rule. *See* 85 Fed. Reg. at 37,160. In the teeth of the Supreme Court's holding that transgender-status discrimination is sex discrimination, the final rule deletes, among other things, the prohibition of categorical coverage exclusions for transgender-related care, 85 Fed. Reg. 37,247 (deleting provision codified at 45 C.F.R. § 92.207 (2017)), the requirement that covered entities "treat individuals consistent with their gender identity," *id*. (deleting provision codified at 45 C.F.R. § 92.206 (2017)), and the definition of "on the basis of sex," *id.* at 37,245 (deleting provision codified at 45 C.F.R. § 92.4 (2017)). It also adds sweeping religion and abortion exemptions from provisions of Title IX that are not incorporated by reference in Section 1557. 85 Fed. Reg. 37243 (codified at 45 C.F.R. § 86.18 (2020)).

In the Rollback Rule's preamble—providing the rationale for the rule and addressing comments—HHS set out how it would enforce Section 1557. Rejecting the holding of *Bostock*, it adhered to the "position . . . that discrimination 'on the basis of sex' in Title VII and Title IX does not encompass discrimination on the basis of sexual orientation or gender identity," *id.* at 37,168. And it "disavow[ed]" all prior, contrary interpretations of Section 1557, stating that it would enforce Section 1557 as if "the biological binary meaning of sex" did not encompass these forms of discrimination, *id.* at 37,178–80, 37,191, that is, using an interpretation that *Bostock* had just rejected, *see*, 140 S. Ct. at 1739.

Plaintiffs are entities and an individual that will be harmed by the Rollback Rule and challenge the rule to stop those harms. Darren Lazor is a transgender man who uses health

insurance and regularly needs to access treatment. Am. Compl. ¶¶ 20–24. Equality California (EQCA) is a membership organization that advances the health and equality of LGBTQ+ people, with over 500,000 members nationwide, including Mr. Lazor. *Id.* ¶¶ 72–77. Fenway Health, Callen-Lorde Community Health Center, and NO/AIDS Task Force, d/b/a CrescentCare (Plaintiff Healthcare Facilities) are healthcare facilities that serve LGBTQ+ people, including individuals and families with LEP. *Id.* ¶¶ 25–44. Each sues on behalf of itself, its patients, and others that use its services. *Id.* ¶¶ 30, 36, 44. The Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY), Campaign for Southern Equality (CSE), Indigenous Women Rising (IWR), and The Transgender Emergency Fund (TEF) (collectively, Plaintiff Healthcare Advocates) are organizations that provide a wide range of services, such as facilitating access to healthcare (including reproductive and pregnancy-related care) for LGBTQ+ people, Native people, and people with LEP, and those at the intersection of these communities. *Id.* ¶¶ 45–71. Each sues on behalf of itself and those who use their services. *Id.* ¶¶ 51, 60, 67, 71.

Plaintiffs claim that the Rollback Rule violates the Administrative Procedure Act. Count I claims that parts of the rule—including its narrow interpretation of discrimination on the basis of sex, incorporation of broad exemptions, and piecemeal enforcement scheme—are contrary to law, specifically the text of Section 1557 and other relevant statutes. *Id.* ¶¶ 395–406. Count II claims that the promulgation of the entire rule was arbitrary and capricious because, among other things, it contravenes *Bostock* and lacks an adequate regulatory impact analysis. *Id.* ¶¶ 407–414. Count III claims that the rule discriminates on the basis of sex without a close relationship to an important government interest and demonstrates animus toward transgender people, contrary to the Fifth Amendment's equal protection guarantee. *Id.* ¶¶ 415–423. And Count IV claims that the rule adopted unlawful enforcement policies related to discrimination on the basis of sex and

to the entities subject to its enforcement. *Id.* ¶¶ 424–427.

Defendants have moved to dismiss some, but not all, of these claims, while also questioning the Court's jurisdiction. On the jurisdictional front, Defendants argue that Plaintiffs lack standing to bring any of their claims, *see* Mot. at 10, and that Plaintiffs' challenge to the decision to remove the definition of discrimination on the basis of sex is not ripe, *id.* at 24. On the merits, Defendants argue that Count III did not sufficiently plead an equal protection claim, *id.* at 30–35, and that Count IV does not sufficiently allege final agency action with respect to the sex-discrimination enforcement policy, *id.* at 36–37. Each of these arguments fails.

LEGAL STANDARD

Rule 12(b)(1) governs Defendants' standing-related arguments. "At the pleading stage, general factual allegations . . . may suffice," *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992), because at this stage, courts "must credit the plaintiff's well-plead factual allegations and draw all reasonable inferences in the plaintiff's favor," *Merlonghi v. United States*, 620 F.3d 50, 54 (1st Cir. 2010). Where defendants raise a facial challenge to the complaint, a court asks whether plaintiffs "sufficiently alleged . . . jurisdiction." *Torres-Negron v. J & N Records, LLC*, 504 F.3d 151, 162 (1st Cir. 2007). If standing turns on factual issues, a court may consider relevant evidence. *See* 5B C. Wright & A. Miller, Federal Practice and Procedure § 1350 (3d ed. 2004).

Rule 12(b)(6) governs Defendants' merits arguments about Counts III and IV. To state a claim, a plaintiff need not plead "[s]pecific facts," so long as the complaint "give[s] the defendant fair notice of what the . . . claim is and the grounds upon which it rests." *Erickson v. Pardus*, 551 U.S. 89, 93 (2007) (internal quotation marks omitted). Here too, the court "accept[s] as true all well-pleaded facts in the complaint and draw[s] all reasonable inferences in the plaintiffs' favor." *Sutliffe v. Epping School Dist.*, 584 F.3d 314, 325 (1st Cir. 2009).

ARGUMENT

I. Plaintiffs Have Sufficiently Alleged Standing To Challenge The Rollback Rule.

The Rollback Rule eliminates regulatory nondiscrimination protections for LGBTQ+ people, people who seek pregnancy-related and reproductive healthcare, people with LEP, and countless others. Plaintiffs allege that the rule injures them, their patients, their clients, and their members. This Court can redress Plaintiffs' injuries with an order declaring the rule unlawful, setting it aside, and enjoining its implementation. That is all Article III requires.

A. Defendants' motion mischaracterizes Article III's requirements.

Article III has three familiar requirements: (1) "a concrete and particularized injury in fact," (2) "a causal connection that permits tracing the claimed injury to the defendant's actions," and (3) "a likelihood that prevailing in the action will afford some redress for the injury." *Equal Means Equal v. Ferriero*, No. 20-CV-10015-DJC, 2020 WL 4548248, at *4 (D. Mass. Aug. 6, 2020) (internal quotation marks omitted). Plaintiffs satisfy each requirement.

1. Plaintiffs need only allege a substantial risk of harm to establish injury-in-fact.

Nearly all of Defendants' injury-in-fact arguments rest on the flawed premise that "allegations of possible future injury are not sufficient to accord a party standing" and that injury must be "certainly impending." Mot. at 10. They lean on this standard to attack the allegations of Mr. Lazor and Plaintiff Healthcare Facilities' patients and clients who fear discrimination because of the Rollback Rule. *See id.* at 10–11; *see also id.* at 15–16 (allegations that Plaintiff Healthcare Advocates must expend resources to mitigate the rule's negative effects); *id.* at 20 (allegations that IWR's clients will be harmed by the rule's fractured enforcement scheme).

The government has offered this argument before, and the First Circuit has rejected it. An "effort to recast the imminence requirement as one of near certainty does not comport with

the law." *Massachusetts v. U.S. Dep't of Health & Human Servs.* ("*Mass. v. HHS*"), 923 F.3d 209, 225 (1st Cir. 2019). All that is required is "a substantial risk that harm will occur." *Reddy v. Foster*, 845 F.3d 493, 500 (1st Cir. 2017) (citing *Susan B. Anthony List v. Driehaus*, 573 U.S. 149 (2014) and *Lujan*, 504 U.S. 555); *see also Mass. v. HHS*, 923 F.3d at 225 (observing that "[t]he Departments' brief fails to cite the 'substantial risk' standard").

Plaintiffs' allegations of injury-in-fact parallel those deemed sufficient in *Mass. v. HHS*. There, Massachusetts challenged rules that allowed exemptions from the ACA's contraceptive coverage requirement. It alleged an "imminent fiscal injury" based on a chain of actions: Some Massachusetts employers would obtain exemptions and cease providing coverage, and their employees would obtain state-funded services. *Mass. v. HHS*, 923 F.3d at 223. Massachusetts did not show that any employers had applied for exemptions, or that any employees had sought its services. *See id.* at 224–226. Even so, it had standing because "a plaintiff need not 'demonstrate that it is literally certain that the harms they identify will come about.'" *Id.* at 225 (quoting *Clapper*, 568 U.S. at 420); *see also id.* at 227 (observing that "the Supreme Court has found standing in cases involving causal chains more attenuated than this one").

Here, Plaintiffs have alleged the same chains of actions. To cite but two examples:

- Individuals' reasonable fears of renewed healthcare discrimination due to the Rollback Rule will cause them to spend time and money to identify providers that will provide non-discriminatory care. Am. Compl. ¶ 213–215, 224–228.
- The same fears will cause patients to seek out the services of Plaintiff Healthcare Facilities and Plaintiff Healthcare Advocates, who will suffer the financial and operational consequences of higher demand. Am. Compl. ¶¶ 234–235 (Fenway), 236 (Callen-Lorde), 237 (CrescentCare), 238, 229–233 (Plaintiff Healthcare Facilities); *see also* Am. Compl. ¶¶ 45–51, 240, 247 (BAGLY), 52–60, 248–256 (CSE), 61–67, 257–264 (IWR), 243–246 (TEF).[2]

[2] *See also* Decl. Stark ¶¶ 31, 37 (noting many inquiries by patients about their rights under the Rollback Rule, and describing Callen-Lorde's resources spent responding to patients' fears from the rule); Decl. Hill at ¶ 15 (noting the increased requests to evaluate health care providers

"[A]nxiety surrounding the possibility of discrimination and denial of treatment is substantially likely to provoke" each of these kinds of "behavior." *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, No. CV 20-1630 (JEB), 2020 WL 5232076, at *12 (D.D.C. Sept. 2, 2020). Plaintiffs have thus alleged a "substantial risk" that these harms "will occur," *Susan B. Anthony List*, 573 U.S. at 158 (internal quotation marks omitted), which suffices for standing purposes, *Reddy*, 845 F.3d at 500.

Defendants argue that Plaintiffs must show someone has *already* discriminated because of the Rollback Rule to establish injury. *See, e.g.*, Mot. at 10, 12 (arguing that discrimination predating the rule is irrelevant); *id.* at 18 (requiring "allegations indicating that any health insurer has changed its coverage . . . or plans" to do so). But allegations about past conduct *can* be sufficient to allege an injury in fact from a risk that conduct will recur. *See O'Shea v. Littleton*, 414 U.S. 488, 496 (1974) ("Of course, past wrongs are evidence bearing on whether there is a real and immediate threat of repeated injury."); *Mass. v. HHS*, 923 F.3d at 224 (concluding "it is highly likely that at least three employers . . . will use the expanded exemptions, based in part on their *past litigating positions* or their *past objections* . . . .") (emphasis added).

Plaintiffs allege that Mr. Lazor and the patients, members, and clients of Plaintiff Healthcare Facilities and Plaintiff Healthcare Advocates experienced discrimination in healthcare that the repealed provisions of the 2016 Rule had prohibited. *See* Am. Compl. ¶¶ 20–24, 106–116, 213–228. They also allege that such discrimination is common. *See id.* ¶¶ 90–91, 107, 111–116. Given these very real experiences with discrimination, the risk of discrimination

---

due in part to fear of discrimination by its membership); Decl. Smith at ¶ 16 (discussing increase in BAGLY's online counseling services after the Rollback Rule and clients' past discrimination).

based on the repeal, and the associated fear of that discrimination, is not the kind of "speculation," Mot. at 12–13, about future injury that makes standing questionable.[3]

And Plaintiffs have members, patients, and clients who reside and use healthcare in states where prior litigation positions show that future discrimination is likely. For example, the challengers to the 2016 Rule in *Franciscan Alliance*—who claimed the rule forced them to change their policies—included an Illinois provider and the states of Texas, Wisconsin, Arizona, Kansas, Kentucky, Louisiana, Mississippi, and Nebraska.[4] Arizona and North Carolina are relying on the Rollback Rule's deleted or modified definitions to defend transgender healthcare exclusions. *See* Opp. to Mot. for Prelim. Inj. at 15, *D.H. v. Snyder*, No. 4:20-cv-335-SHR (D. Ariz. Sept. 28, 2020), ECF No. 18; *Kadel v. North Carolina*, No. 20-1409, Br. of Appellant at 21 (4th Cir. July 30, 2020), ECF No. 27. Plaintiffs CrescentCare and Fenway have patients in Louisiana, Mississippi, and Texas; Fenway has telehealth patients in Illinois Kansas, and Wisconsin; CSE has members and provides services in North Carolina, and Mississippi; and EQCA has members in Arizona, Louisiana, Kansas, Kentucky, Mississippi, Nebraska, and Texas. *See* Am. Compl. ¶¶ 25, 37, 52; Decl. Zbur ¶ 12.

Finally, Plaintiffs need not identify particular patients of Plaintiff Healthcare Facilities, or particular clients of Plaintiff Healthcare Advocates, to establish injury. *See, e.g.*, Mot. at 20 (objecting to an "assum[ption]" that "an unnamed Native American will" face discrimination).

---

[3] Defendants' reliance on *Clapper* is misplaced. There, the plaintiffs lacked standing to challenge federal surveillance practices because they had "no actual knowledge" of the practices. 568 U.S. at 411. Their efforts to avoid surveillance did not support an injury because they were "simply the product of their fear." *Id.* at 417. In contrast, Plaintiffs need not speculate about healthcare discrimination; they have experienced it. *See, e.g.*, Am. Compl. ¶¶ 20–24, 224–228.

[4] *See Franciscan Alliance*, 227 F. Supp. 3d at 670 & n.3, 675; Br. in Support of State Plaintiffs' Renewed Motion for Summary Judgment at 50–51, 7:16-cv-00108-O (N.D. Tex. Feb. 4, 2019), ECF 133; Private Plaintiffs' Br. in Support of Their Renewed Motion for Partial Summary Judgment at 1, 12, *id.* (N.D. Tex. Feb. 4, 2019), ECF 136.

The alleged injury does not turn on which patients or clients are harmed by the Rollback Rule. *See Mass. v. HHS*, 923 F.3d at 225 & n.13 (stating "plaintiffs need not point to a specific person who will be harmed" where "the likelihood of a fiscal injury to the [plaintiff] does not turn on the identification of specific [victims]"). Plaintiff Healthcare Facilities and Healthcare Advocates will have to expend resources so long as *any* client or patient turns to them for services because of the Rollback Rule. *See id*. at 225 (noting that the farmers in *Monsanto* had not identified "particular alfalfa plants that had been, or would necessarily be, pollinated by bees who carried the genetically engineered gene at issue"); *see also Whitman-Walker*, 2020 WL 5232076 at *21 (holding "physicians *can* invoke the rights of unknown potential [LGBTQ] patients," just as courts "have long permitted abortion providers to invoke the rights of their actual *or potential patients* in challenges to abortion-related regulations" (quoting *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2118, (2020) (plurality opinion) (citing cases))).

2. The presence of a third party in a causal chain does not defeat standing.

As to causation, Defendants argue that standing cannot exist if the connection between the Rollback Rule and Plaintiffs' injuries includes a third party's actions. *See* Mot. at 11–12, 15, 19. This broad assertion finds no support in the case law.

Courts have made clear that Defendants' argument "is impossible to maintain, of course." *Block v. Meese*, 793 F.2d 1303, 1309 (D.C. Cir. 1986) (Scalia, J.) (explaining that if "there is no standing to sue [for] action . . . which harms the plaintiff only through the reaction of third persons," then many common suits would be barred, such as "libel actions or suits for inducing breach of contract"). The correct rule is that causation may not exist where the connection between a challenged action and injury rests on the "*independent* action of some third party." *Lujan*, 504 U.S. at 560 (emphasis added) (internal quotation marks omitted). But if "statistical analysis, common sense, or record evidence" support an inference that third parties will react to a

challenged government action in a predictable way, then the causation requirement is met. *New York v. Dep't of Commerce*, 351 F. Supp. 3d 502, 576 (S.D.N.Y. 2019), *aff'd in part, rev'd in part and remanded sub nom. Dep't of Commerce v. New York*, 139 S. Ct. 2551 (2019).[5]

The Supreme Court concluded as much in *Department of Commerce v. New York*. There, the plaintiffs challenged the Department of Commerce's plan to include a citizenship question on the 2020 census and alleged the following chain of causation: The Department would include the question; residents would decline to complete the census for fear of immigration-related consequences; and underreporting would cause plaintiffs to lose federal funds. *See* 139 S. Ct. 2551, 2565–66 (2019). The plaintiffs showed "that third parties will likely react in *predictable* ways." *Id*. at 2566 (emphasis added). This moved their allegations from ones that rested "on mere speculation about the decisions of third parties"—that would not suffice—to ones that rested "instead on the predictable effect of Government action on the decisions of third parties"—that did. *Id.*; *accord Bennett v. Spear*, 520 U.S. 154, 169 (1997) (approving of standing based on an "injury produced by determinative or coercive effect upon the action of someone else"); *see also Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734–735 (2008).

Defendants' contrary argument relies on a misreading of *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976). *See* Mot. at 11, 12, 14. There, indigent persons and their representatives challenged an Internal Revenue Services (IRS) ruling that gave

[5] *See also Mass. v. HHS*, 923 F.3d at 227 (finding standing where "[t]he Commonwealth's cause and effect chain [wa]s predicated on *probable* market behavior" (internal quotation marks and alterations omitted)); *Nat. Res. Def. Council v. Nat'l Highway Traffic Safety Admin.*, 894 F.3d 95, 104–105 (2d Cir. 2018) (finding "the agency's own pronouncements," as well as "[c]ommon sense and basic economics," showed that an "increased penalty has the potential to affect [third parties'] business decisions and compliance approaches" (internal quotation marks omitted)); *Texas v. United States*, 809 F.3d 134, 156 (5th Cir. 2015) (finding that DAPA would "enable[]" third parties "to apply for driver's licenses" and having "little doubt that many would do so"), *aff'd by an equally divided Court*, 136 S. Ct. 2271 (2016).

favorable tax treatment to non-profit hospitals that offered only emergency room services to indigent patients, alleging the ruling "'encourag[ed]' the hospitals to deny services." *Simon*, 426 U.S. at 33. The Court questioned whether IRS rulings would affect decisions about whether to offer services to indigent patients, reasoning it was "just as plausible" that the "financial drain" from offering services might drive the decision. *Id*. at 43. The link between the ruling and any denial of services was thus "unadorned speculation." *Id*. at 43–44. All *Simon* shows is that causation is not met *if* a plaintiff does *not* show a third-party's response to government action is predictable.

Here, by contrast, the allegations provide a predictable, common sense, and record-based link between the Rollback Rule and the alleged injuries. The 2016 Rule was promulgated to address specific harms from discrimination in healthcare; Plaintiffs have suffered those kinds of harms from past discrimination; and the repeal of the 2016 Rule's protections is likely to lead to a return of discrimination. *See* Am. Compl. ¶¶ 190–264, 298–303; *see also infra* at 17, 18, 23, 28, 31, 34. For example, it costs insurers money to reimburse healthcare providers for the costs of providing gender-affirming care. Some insurers will thus predictably choose to forgo covering gender-affirming care in order to avoid this cost. *Cf. Mass. v. HHS*, 923 F. 3d at 227 (causal chain based "on *probable* market behavior" (internal quotation marks and alterations omitted)).

Defendants acknowledged this commonsense result of their action during the rulemaking process, which only bolsters the case for causation. The Rollback Rule recognizes that "entities may have changed their policies and procedures at the outset of the 2016 Rule." 85 Fed. Reg. 37,225; *see also Nondiscrimination in Health and Health Education Programs or Activities*, 84

Fed. Reg. at 27,876 (2019 proposed rule) (similar).[6] And it recognizes that some entities will make changes, though it is "uncertain as to the total number." 85 Fed. Reg. at 37,225; *see also id.* ("[S]ome covered entities may no longer incur costs associated with processing grievances related to gender identity discrimination under Title IX, because such claims will not be cognizable under this final rule."). Thus, Defendants themselves have "done much of the legwork in establishing that there is a substantial risk," *Mass. v. HHS*, 923 F.3d at 224–225, that third parties will react to the Rollback Rule in a way that injures Plaintiffs.

3. A decision that will reduce Plaintiffs' injuries meets the redressability requirement.

As to redressability, Defendants argue that the requirement is not met because "a favorable judgment here would not ensure that these third-party providers would refrain from engaging in the conduct plaintiffs dislike." Mot. at 14, *see also, e.g., id.* at 11, 13, 14–15. As with its other standing-related theories, they seek to impose a higher requirement than Article III mandates. All that Article III requires is that Plaintiffs allege that a favorable decision would reduce their alleged injuries, which Plaintiffs have done.

Defendants argue that this Court could not change the *status quo* because a limited portion of the 2016 Rule had been vacated and because the statute itself might still protect against discrimination. *See* Mot. at 11, 13. Not so. This Court can redress Plaintiffs' injuries. Plaintiffs alleged that the Rollback Rule will, among other things, cause confusion among healthcare providers and insurers regarding their legal obligations under Section 1557, embolden

[6] On this front, Defendants were correct. *See, e.g., Boyden v. Conlin*, 341 F. Supp. 3d 979, 989 (W.D. Wis. 2018) (noting that Wisconsin rescinded its exclusion for gender reassignment surgery from its state health insurance plan after the 2016 Rule); *see also id.* at 991–992 (noting that Wisconsin reinstated the exclusion after *Franciscan Alliance*); Br. for Equality North Carolina as Amicus Curiae Supporting Plaintiffs-Appellees and Affirmance, *Kadel v. North Carolina*, 2020 WL 6101994 (4th Cir. 2020) (noting a similar pattern for North Carolina).

providers and insurers to discriminate against persons on the basis of protected characteristics, and make it more difficult for patients to communicate with providers. *See* Am. Compl. ¶¶ 279, 298, 317, 328, 338. And Plaintiffs alleged that these effects will harm them: Discrimination leads to delayed care or no care at all, *id.* ¶ 167, and the fear of discrimination does too, *id.* ¶ 230, and both of these consequences drive people towards entities like Plaintiff Healthcare Providers and Healthcare Advocates, which will force them to divert resources and strain their capacity, *id.* ¶¶ 233, 242. An order from this Court declaring the Rollback Rule unlawful and enjoining its provisions would discourage providers and insurers from discriminating on the basis of protected characteristics, reduce the confusion regarding legal obligations under Section 1557, and make it easier for patients to communicate with providers. All of this would redress the injuries to Plaintiffs and their patients, clients, and members.

Moreover, a plaintiff "need not show that a favorable decision will relieve his every injury." *Larson v. Valente*, 456 U.S. 228, 243 n.15 (1982). Thus in *Massachusetts v. EPA*, the Supreme Court rejected the EPA's argument that "its decision not to regulate greenhouse gas emissions . . . contributes so insignificantly to petitioners' injuries that [it] cannot be haled into federal court," explaining that EPA's argument "rests on the erroneous assumption that a small incremental step . . . can never be attacked in a federal judicial forum." 549 U.S. 497, 523–524 (2007). A remedy that "will not by itself reverse" the injury still meets the redressability requirement if it "reduced [the injury] to some extent." *Id.* at 525–526 (emphasis omitted).[7]

[7] Likewise, a remedy that solves one cause of the injury, but not all causes, still meets the redressability requirement. *See Sierra Club v. Dep't of the Interior*, 899 F.3d 260, 284 (4th Cir. 2018) ("[S]tanding does not require the challenged action to be the sole or even immediate cause of the injury"); *see also Bennett*, 520 U.S. at 168–169 (similar). Defendants appear to conflate causation with proximate causation. *See, e.g.*, Mot. at 14–15. But "proximate causation" is "not a requirement of Article III standing." *Lexmark Int'l*, 572 U.S. at 134 n.6. And, even if it were,

B. Plaintiffs have sufficiently alleged standing as to each challenged provision.

Plaintiffs allege that the Rollback Rule—in its entirety and also several provisions specifically—is arbitrary and capricious and contrary to law, and at least one Plaintiff has standing to challenge each specific provision at issue.[8]

1. The repeal of the definition of "on the basis of sex" and unlawful interpretation of that term in Title IX.

Plaintiffs have standing to challenge the deletion of the definition of "on the basis of sex" and specific prohibitions in the 2016 Rule. *See* 45 C.F.R. §§ 92.4, 92.206, 92.207 (2017); 45 C.F.R. §§ 92.1–92.105 (2020). The provisions will cause them or their patients, clients, or members to incur costs to avoid discrimination and will lead to an increased demand on the resources of Plaintiff Healthcare Facilities and Plaintiff Healthcare Advocates.

Mr. Lazor: Mr. Lazor has standing to challenge these provisions of the Rollback Rule for at least two reasons. *First*, Plaintiffs allege that Mr. Lazor has experienced past discrimination in healthcare on the basis of his transgender status and that the Rollback Rule increases the risk that he will face this discrimination in the future. *See* Am. Compl. ¶¶ 20–24, 190, 199–201, 213–215; *Maine People's All. and Nat. Res. Def. Council v. Mallinckrodt, Inc.*, 471 F.3d 277, 284 (1st Cir. 2006) (finding standing where defendant created "a probabilistic increase in a risk that the [plaintiff] would in any event have had to run"); *see also, e.g., Walker*

---

it would be enough to allege that the relief will reduce the injuries because an event can have more than one proximate cause. *See, e.g., Staub v. Proctor Hospital*, 562 U.S. 411, 420 (2011).

[8] If Defendants are arguing that Plaintiffs must allege standing as to each provision of the Rollback Rule to obtain vacatur of the entire rule, they are wrong. The question of the scope of relief goes to the merits, not standing, and vacatur may be appropriate where, as here, the APA violations are "numerous, fundamental, and far-reaching," or "call[] into question the validity and integrity of the rulemaking venture itself." *New York v. United States Dep't of Health & Human Servs.*, 414 F. Supp. 3d 475, 577 (S.D.N.Y. 2019); *see also Pub. Citizen v. Fed. Motor Carrier Safety Admin.*, 374 F.3d 1209, 1217 (D.C. Cir. 2004) (vacating rule where the errors "permeated the entire rulemaking process" (internal quotation marks omitted)).

v. Azar, No. 20CV2834FBSMG, 2020 WL 4749859, at *6 (E.D.N.Y. Aug. 17, 2020) (finding similarly situated plaintiffs had standing to challenge Rollback Rule).

Second, Plaintiffs allege that Mr. Lazor has standing because he will likely incur costs due to that increased risk of discrimination and his fear of discrimination. The emergency room closest to his home is at the hospital that previously denied him treatment and discriminated against him. *See* Am. Compl. ¶ 213. The Rollback Rule increases his fears of discrimination and substandard treatment were he to return to that hospital. *Id*. For that reason, if he were to experience a medical emergency, he would ask a friend or family member to drive him to an emergency room half an hour away. *Id*.; *see also Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 155 (2010) (finding standing based on costs to mitigate risk of crop infection).

Plaintiff Healthcare Facilities: Plaintiff Healthcare Facilities have standing for three reasons. *First*, Plaintiffs allege that they have standing because they are subject to the Rollback Rule. As regulated entities, they can challenge HHS's promulgation of regulations in violation of the APA. *See* Am. Compl. ¶¶ 25 (Fenway), 31 (Callen-Lorde), 37 (CrescentCare); *see also Lujan*, 504 U.S. at 560–561 (noting "there is ordinarily little question" that a regulated entity has standing to challenge an allegedly illegal statute or rule under which it is regulated).

Second, Plaintiffs allege that Plaintiff Healthcare Facilities have standing because these provisions of the Rollback Rule will negatively affect their organizational activities. *See Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379, (1982) (An organization has standing to sue where a defendant's conduct has "perceptibly impaired" its activities.). The rule will increase demand for their medical services, straining their resources. *See* Am. Compl. ¶¶ 233, 241; *see also Adams v. Watson*, 10 F.3d 915, 923 (1st Cir. 1993) (noting that "standard principles of 'supply and demand' [have been] routinely credited by courts" in "a variety of [standing] contexts").

The rule will also increase the need for internal staff training, patient education, patient navigation services, legal services, and other non-reimbursable services. *See* Am. Compl. ¶¶ 233, 238 (all Plaintiff Healthcare Facilities) 234–235 (Fenway), 236 (Callen-Lorde), 237, 241 (CrescentCare), 239–240 (BAGLY). These facilities operate on limited budgets and serve patients without regard to their ability to pay, so the increased demand will require additional resources and diversion of limited resources. *See* Am. Compl. ¶¶ 234–235 (Fenway), 236 (Callen-Lorde), 237 (CrescentCare), 238 (all Plaintiff Healthcare Facilities); *see also Katz v. Pershing, LLC*, 672 F.3d 64, 76 (1st Cir. 2012) ("[A] relatively small economic loss—even an identifiable trifle—is enough to confer standing." (internal quotation marks omitted)).

These provisions will also negatively affect the organizational activities of Plaintiff Healthcare Facilities by diminishing their ability to provide effective care for their patients. *See* Am. Compl. ¶¶ 25–27 (Fenway), 31–33 (Callen-Lorde), 37–42 (CrescentCare). Because fear of discrimination will cause their patients to delay, avoid, or be unable to obtain necessary care or support services from other health care providers or decline to disclose their LGBTQ+ status to these other providers, patients will come to Plaintiff Healthcare Facilities with more acute medical conditions that will be more difficult and costlier for the Plaintiff Healthcare Facilities to treat. *See* Am. Compl. ¶¶ 229–233; *see also Whitman-Walker*, 2020 WL 5232076 at *10 (finding organizational standing for similarly situated healthcare facilities to challenge Rollback Rule because the Rule would "forc[e] them to deliver costlier and more difficult treatment to a growing number of patients"). This "*fear* of discrimination at the hands of third parties—regardless of whether such discrimination ultimately occurs—will cause individuals to turn to Plaintiff organizations for care, thereby necessarily generating financial and operational burdens that impair Plaintiffs' ability to provide services." *Whitman-Walker*, 2020 WL 5232076 at *12

(internal quotations and alterations omitted). The Rollback Rule will thus also diminish Plaintiff Healthcare Facilities' ability to fulfill other aspects of their organizational missions, beyond providing effective care for their patients. *See* Decl. Stark at ¶¶ 12–13, 34–36.

Third, Plaintiffs allege that Plaintiff Healthcare Facilities have third-party standing, on their patients' behalf, to challenge these provisions. Third-party standing exists where the litigant has "a sufficiently concrete interest in the outcome of the issue in dispute," and "a close relation to the third party," and where there is "hindrance to the third party's ability to protect his or her own interests." *Powers v. Ohio*, 499 U.S. 400, 410–411 (1991) (internal quotations omitted).

Plaintiff Healthcare Facilities meet those requirements. *See Whitman-Walker*, 2020 WL 5232076 at *22 (D.D.C. Sept. 2, 2020) (finding standing for similarly situated healthcare facilities to challenge the Rollback Rule). They have a concrete interest in the outcome of the dispute because they provide many services that will be affected by the Rollback Rule. *See June Med. Servs.*, 140 S. Ct. at 2118–19 (observing that courts "have long permitted" healthcare providers "to invoke the rights of their actual or potential patients in challenges to . . . regulations" related to healthcare procedures offered by the provider). Plaintiff Healthcare Facilities also have a close relationship with their patients. Indeed, because "most of the medical procedures at issue here such as . . . gender-affirming surgery . . . cannot be safely secured without the aid of a physician," the "rights of the individual physician plaintiffs and their patients here are . . . closely intertwined." *City & Cnty. of San Francisco v. Azar*, 411 F. Supp. 3d 1001, 1011 (N.D. Cal. 2019). And finally, these patients are hindered from asserting their rights because they face barriers to asserting claims—many have limited financial resources, limited English proficiency, would be endangered by publicly disclosing their LGBTQ+ status, and/or

would be endangered by publicly disclosing the treatments or services they seek. *See* Am. Compl. ¶¶ 29 (Fenway), 34–35 (Callen-Lorde), 43 (CrescentCare); Decl. Twilbeck ¶¶ 13, 30, 34; *also compare, e.g.*, *Arroyo Gonzalez v. Rossello Nevares*, 305 F. Supp. 3d 327, 333 (D.P.R. 2018) (observing that disclosure of a transgender person's status "exposes transgender individuals to a substantial risk of stigma, discrimination, intimidation, violence, and danger"), *with Singleton v. Wulff*, 428 U.S. 106, 117 (1976) (observing that women affected by abortion restrictions "may be chilled . . . by a desire to protect the very privacy of [their] decision from the publicity of a court suit").

Plaintiff Healthcare Advocates: Plaintiffs allege that Plaintiff Healthcare Advocates have standing to challenge the Rollback Rule's inaccurate definition of "on the basis of sex," and related provisions because these provisions will impair their activities and missions. *See* Am. Compl. ¶¶ 45–51, 247 (BAGLY), 52–60, 248–256 (CSE), 61–67, 257–264 (IWR), 243–246 (TEF). In particular, the Rollback Rule will increase service demand, leading to a drain on resources. *See id.* at ¶¶ 240 (BAGLY), 249–254 (CSE), 257, 261, 264 (IWR), 243–246 (TEF); *see also Havens*, 455 U.S. at 379 (explaining that an organization has standing to sue where there has been an "injury to the organization's activities," accompanied by a "drain on the organization's resources"). For example, "BAGLY has seen an increase of young people accessing its counseling since the Rollback Rule was announced." Am. Compl. ¶ 240. "To expand its mental health services, BAGLY would need to hire an additional therapist and rent a larger space to accommodate more sessions, both of which would be major, unanticipated expenses for BAGLY." *Id.* "BAGLY has limited financial resources to dedicate to its healthcare services, and it does not anticipate a major increase in funding during this time of economic recession." *Id.* Those are precisely the sort of allegations that this Court concluded

were missing in *Equal Means Equal v. Dep't of Educ.*, 450 F. Supp. 3d 1, 8 (D. Mass. 2020).

The Rollback Rule will also negatively affect the organizational activities of Plaintiff Healthcare Advocates because, in order to address the rule's harmful effects and the confusion it engenders, they will be required to spend and divert already limited resources to help LGBTQ+ people navigate the discriminatory barriers to the care they will encounter. *See* Am. Compl. ¶ 239, 247 (BAGLY), 248 (CSE); *cf. Havens*, 455 U.S. at 379 ("If, as broadly alleged, [defendants'] steering practices have perceptibly impaired [plaintiff organization's] ability to provide counseling and referral services for low-and moderate-income homeseekers, there can be no question that the organization has suffered injury in fact."). For example, CSE "facilitates access to healthcare for LGBTQ+ people through cultural competency trainings for healthcare service providers" and through "*Pop-Up Resource Clinics* that educate LGBTQ+ people about their rights." Am. Compl. ¶ 56. Indeed, "[i]n a number of these trainings, [CSE] has used materials prepared by HHS about the providers' obligations to provide safe and affirming care to LGBT Southerners." *Id.* However, because of the Rollback Rule's inaccurate definition of "on the basis of sex," and related provisions, CSE "anticipates diverting additional staffing and funding resources towards their training programs and hiring a [part-time] consultant." *Id.* ¶ 252.

Membership Organizations: Plaintiffs allege that the Membership Organizations have standing, on their members' behalf, to challenge the Rollback Rule's definition of "on the basis of sex," and related provisions. *See id.* at ¶¶ 72–77, 224–228 (EQCA); ¶¶ 52–60, 254–256 (CSE). A "plaintiff organization may sue based on injuries to its members' interests . . . if (1) at least one of its members would have standing to sue as an individual, (2) the interests at stake are germane to the organization's purpose, and (3) individual members participation is not necessary to either the claim asserted or the relief requested." *Animal Welfare Inst. v. Martin*, 623 F.3d 19,

25 (1st Cir. 2010) (internal quotation marks omitted).

EQCA meets all three criteria. Its members would have standing to sue as individuals. Indeed, one of EQCA's members—Mr. Lazor—is suing in an individual capacity here, Am. Compl. ¶ 77, and several other members will suffer similar harms, *id*. at ¶¶ 224–228. The interests at stake in this litigation are germane to EQCA's purpose of "combatting discrimination and injustice on the basis of sexual orientation and gender identity, and to protecting the fundamental rights of those within the LGBTQ+ community and the vulnerable communities of which they are a part." *Id*. at ¶ 72. Finally, the participation of EQCA's members is not necessary to either the claim asserted or the relief requested.

CSE also meets this standard. CSE member, Stephe Koontz, has suffered discrimination by health care providers because she is transgender, causing her financial costs and emotional distress. Decl. Koontz at ¶¶ 2–12, 14, 16-18, 20–24. Her reasonable fears that she will face discrimination again are exacerbated by the Rollback Rule. *Id.* at ¶ 26. CSE regularly advocates for its members facing such discrimination. Decl. Beach-Ferrara at ¶¶ 11–12, 26, 29. The relief Plaintiffs request would benefit all such members equally, so their individual participation is not necessary to present the claim or obtain relief.

Defendants' arguments to the contrary—regarding future injury, third-party causation, and the *Franciscan Alliance* decision—are foreclosed by the allegations in the Complaint and the applicable law. *First*, Defendants argue that "allegations of possible future injury are not sufficient to accord a party standing." Mot. at 10, *see also id*. at 15–16. As explained, *see supra* at 8–10, standing allegations can rest on a claim that "there is a substantial risk that harm will occur." *Reddy*, 845 F.3d at 500. And Plaintiffs have alleged that, because of the Rollback Rule, there is a substantial risk that they will be harmed. *See supra* at 17–22.

Second, Defendants argue that "a plaintiff must show that the defendant's conduct—rather than that of a third party—caused its injuries, and that a decision in the plaintiff's favor will redress those injuries." Mot. at 11, 14–15. The involvement of third parties presents no barrier to standing. Common sense, Defendants' own analysis, and regulated entities' litigation positions all show that it is substantially likely that some providers and insurers will respond to the Rollback Rule by discriminating against Plaintiffs, their members, their patients, and their clients. *See supra* at 12–15.

Third, Defendants argue that Plaintiffs "cannot show redressability" because "the gender identity and termination of pregnancy provisions were vacated from the 2016 Rule by another court before this Rule was finalized." Mot. at 13 (citing *Franciscan Alliance*, 227 F. Supp. at 687).[9] Defendants are mistaken. Plaintiffs need only allege that an order from this Court would reduce the alleged injuries and have alleged that vacating the Rollback Rule will reduce healthcare providers' and insurers' confusion regarding their obligations under Section 1557. *See supra* at 15–16. Moreover, Defendants do not acknowledge that a ruling vacating the Rollback Rule would also reject the agency's unlawful interpretation of "sex" discrimination in the preamble. 85 Fed. Reg. 37,178–80, 37,191. Thus, even if HHS does not re-promulgate the 2016 Rule's definition, a decision by this court striking down HHS's policy as contrary to law would *require* HHS to enforce Section 1557 consistent with the interpretation that discrimination on the basis of sex includes discrimination based on gender identity, rather than its unlawful interpretation.

What is more, Plaintiffs' claim "is not confined to the 'gender identity' language" in the Rollback Rule's definition of discrimination on the basis of sex. *Whitman-Walker*, 2020 WL

[9] The district court order has been appealed. *See supra* n.1.

5232076, at *14. Plaintiffs "also contest HHS's elimination of the 2016 Rule's definition of sex discrimination as including discrimination based on sex stereotyping," and "*Franciscan Alliance*, notably, did not vacate this latter definitional provision; the court's opinion never even mentioned it." *Id.* (citing *Franciscan Alliance II*, 414 F. Supp. 3d 928); *Walker*, 2020 WL 4749859, at *7 (finding redressability because "*Franciscan Alliance* did not address the concept of 'sex stereotyping'"). Plaintiffs further challenge HHS's elimination of the terms "pregnancy, false pregnancy, . . . or recovery therefrom, childbirth or related medical conditions," from the definition of "on the basis of sex," 81 Fed. Reg. at 31,467 (codified at 45 C.F.R. § 92.4 (2017)), which were undisturbed by the vacatur of "termination of pregnancy" from that definition, *Franciscan Alliance II*, 414 F. Supp. 3d 928. If this Court enjoins the deletion of the definition of discrimination on the basis of sex, "Plaintiffs would be left with the 2016 Rule's prohibition against discrimination based on sex stereotyping" and against discrimination based on "pregnancy," "childbirth," and related conditions. *Whitman-Walker*, 2020 WL 5232076, at *14. This "would clearly redress at least some of their injury." *Id.*; *see also Walker*, 2020 WL 4749859, at *7.[10]

Defendants resist the reasoning of the two district courts that have found redressability here, arguing that they "fail to explain why the 2020 Rule in any way affects coverage of 'sex stereotyping.'" Mot. at 13. The Rollback Rule itself states all that is needed. *See* 85 Fed. Reg. at 37,183–86. In response to a comment about *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989), and *Oncale v. Sundowner Offshore Oil Services*, Inc., 523 U.S. 75 (1998)—two of the Supreme Court's sex stereotyping precedents—HHS responded that it believes "that, unlike

[10] The *Whitman-Walker* opinion did not address redressability of the deletion of terms related to pregnancy or childbirth from the definition of "on the basis of sex" because that litigation did not raise claims related to deletion of those protections.

stereotypes, . . . the biological binary of male and female, may, and often must, play a part in the decisionmaking process—especially in the field of health services." 85 Fed. Reg. at 37,184–85 (internal quotation marks omitted). Thus, Defendants' argument that the Rollback Rule does not affect protections against sex stereotyping, *see* Mot. at 13–14, relies on their view that sex stereotyping does not include discrimination on the basis of gender identity. That view is wrong. The parties' disagreement on this front speaks to the *merits* of Plaintiffs' challenge; it does not speak to Plaintiffs' standing. Defendants impermissibly conflate the two. *See Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990) ("Our threshold inquiry into standing in no way depends on the merits of [the plaintiff's] contention that particular conduct is illegal." (internal quotation marks omitted)).

2. The narrowing of the definition of "covered entities."

The Rollback Rule's narrowed definition of "covered entities" will consume Plaintiff Healthcare Facilities' budgets, force Plaintiff Healthcare Advocates to divert limited resources to help people navigate barriers to care, and make it harder for individuals to access care.[11] *Compare* 45 C.F.R. § 92.4 (2017), *with* 85 Fed. Reg. 37,244–45 (to be codified at 45 C.F.R. § 92.3(b), (c)).

Plaintiff Healthcare Facilities: Plaintiffs allege that Plaintiff Healthcare Facilities rely, in part, on insurance reimbursement to fund their operations and the Rollback Rule will reduce the reimbursements that Plaintiff Healthcare Facilities receive for the care that they provide. *See* Am. Compl. ¶¶ 234–235 (Fenway), 236 (Callen-Lorde), 237, 241 (CrescentCare); *see also id.*

[11] Defendants break up their analysis of the Rollback Rule's narrowed definition of "covered entities" into two parts, focusing first on the narrowed definition's effect on "federal entities," *see* Govt. Br. at 16–17, and then turning to the definition of "health program or activity," *id.* at 17–18. These two parts are in one provision of the Rollback Rule and can be analyzed as one. *See FW/PBS, Inc. v. City of Dallas*, 493 U.S. 215, 233–236 (1990).

¶¶ 211, 223. As the Amended Complaint explains, the Rollback Rule exempts certain insurers from compliance with Section 1557's prohibition of discrimination. As a result, some insurers will stop reimbursing Plaintiff Healthcare Facilities for certain services, including for example, gender-affirming care. Because Plaintiff Healthcare Facilities provide care even when their patients cannot afford to pay for care—whether due to being uninsured or underinsured—and because many of Plaintiff Healthcare Facilities' have limited financial resources, Healthcare Facilities expect that the Rollback Rule's exemption of insurers will cause Healthcare Facilities to provide more unfunded care. This type of "economic loss … is enough to confer standing." *Katz*, 672 F.3d at 76; *also compare Whitman-Walker*, 2020 WL 5232076, at *16 (finding healthcare facility had standing to challenge Rollback Rule's elimination of the 2016 Rule's prohibition on categorical coverage exclusions for gender-affirming care because facility would "obtain reduced reimbursements from insurers that scale back their coverage of such treatment"). Furthermore, Plaintiff Healthcare Facilities will need to expend more resources understanding, explaining, claiming and appealing denials of this decreased coverage.

Plaintiff Healthcare Advocates: Plaintiffs allege that BAGLY has standing to challenge the Rollback Rule's narrowing of the definition of "Covered Entities" for much the same reason as Plaintiff Healthcare Facilities. As the Amended Complaint explains, BAGLY also seeks insurance reimbursement for its insured clients, and it expects that the Rollback Rule's narrowing of the definition of "Covered Entities" will reduce the revenue that it can recover through insurance coverage. *See* Am. Compl. ¶¶ 211, 223. This narrowed definition will also add to BAGLY's administrative and financial burden because 12% of BAGLY's clients are on insurance plans of parents who do not live in Massachusetts. *Id.* ¶ 239. BAGLY will need to expend additional administrative resources to sort out which out-of-state patients have coverage

for the gender-affirming care they obtain through BAGLY, now that there is no standard federal mandate of coverage. *See id.* ¶ 239; *see also Havens*, 455 U.S. at 379.

The Amended Complaint also alleges that the Rollback Rule's narrowing of the definition of "covered entities" will negatively affect the organizational activities of all Plaintiff Healthcare Advocates. In order to counteract the Rollback Rule's harmful effects and the confusion it causes, some Plaintiff Healthcare Advocates will be required to spend and divert already limited resources to help LGBTQ+ people navigate the discriminatory barriers to care they will encounter. *See* Am. Compl. ¶¶ 239, 240, 247 (BAGLY), 248 (CSE); *see also Havens*, 455 U.S. at 379. For example, CSE has standing to challenge this provision because it "frequently provides advocacy and healthcare navigation and/or referrals to attorneys who specialize in health insurance appeals" for members who "contact [CSE] about health insurance denials for gender-affirming care." Am. Compl. ¶ 55. Similarly, TEF has standing to challenge this provision because the Amended Complaint states that TEF "assists clients who have been denied insurance coverage for needed care in navigating those denials with their health plans." *Id.* ¶ 69.

Certain Plaintiff Healthcare Advocates will also struggle with entities other than insurers who fall outside the Rollback Rule's narrowed definition. Plaintiffs allege that the Indian Health Service (IHS) is the primary source of healthcare for most of IWR's clients, and that the "legacy of forced sterilizations, historically underfunded services, and cultural ignorance contributes to Indigenous people's fear of discrimination when seeking reproductive and pregnancy-related healthcare, particularly at facilities operated by IHS." *Id.* ¶ 222. Plaintiffs also allege that, by excluding IHS, the rule's narrowed definition will burden the ability of Indigenous people to access pregnancy-related and reproductive healthcare, exacerbate their fears of discrimination,

and cause more Native people to turn to IWR's Midwifery Fund and Abortion Fund to finance their care. *Id.* ¶¶ 260–264. "By straining [IWR]'s finances and operations, the Rollback Rule undermines [IWR]'s ability to achieve its broader mission of supporting culturally safe health options through its various other programs." *Id.* ¶ 264; *see Havens*, 455 U.S. at 379.

Defendants recycle many of their arguments against Plaintiffs' standing to challenge the sex-discrimination provisions of the Rollback Rule. The arguments are no more convincing in this context. *First*, they argue that Plaintiffs cannot meet Article III's causation requirement because the chain of causation involves the actions of a third party. *See* Mot. at 18. That is wrong. *See supra* at 12–15; *see also Davis*, 554 U.S. at 734–735; *Dep't of Commerce*, 139 S. Ct. at 2564–66. Plaintiff's allegations, common sense, and Defendants' own cost-benefit analysis support finding that insurers will likely respond to the rule in a way that harms Plaintiffs. *See supra* at 13–15.

Second, Defendants raise their third-party causation argument in a slightly different form to attack IWR's allegation that the Rollback Rule "signals that the law does not protect against pregnancy discrimination in the Indian Health Service . . . and opens the door to further discrimination against Native people." Mot. at 17. In Defendants' view, "[a] 'signal' is not a concrete injury to IWR." *Id.* But, the "signal" referenced in the Amended Complaint is not Plaintiffs' alleged injury. The injury is pregnancy discrimination against the Native people that IWR serves. The "signal" referenced in the Amended Complaint is the causal link between the Rollback Rule and the IHS providers who will discriminate against IWR's Native clients. And because that causal link is backed by a long history of "inconsistent, discriminatory, and substandard reproductive and pregnancy-related healthcare at IHS facilities—the primary source of healthcare for most IWR's clients," *see* Am. Compl. ¶ 258, the effects of the Rollback Rule

are sufficiently predictable to meet Article III's causation requirement, *see supra* at 12-15, 28; *see also Davis*, 554 U.S. at 734–735; *Dep't of Commerce*, 139 S. Ct. at 2564–66.

Third, Defendants briefly argue that "the fact that government entities like the IHS may not discriminate on the basis of sex as a result of the Equal Protection Clause, only adds to the speculation regarding the impact of the Rule on any Plaintiff." Mot. at 17. To the extent Defendants argue that the Plaintiffs cannot prove traceability here because the chain of causation depends on the intervening acts of third parties that are *unlawful*, Defendants cite no authority to support that argument. Nor could they. Again, plaintiffs can rely on the "predictable" actions of third parties, which are sufficient to prove standing "even if" those third parties act "unlawfully" or contrary to Government requirements. *Dep't of Commerce*, 139 S. Ct. at 2566.[12]

3. The elimination of the uniform enforcement scheme.

Plaintiffs have sufficiently alleged that it will be more difficult for Plaintiffs' patients and clients to bring claims of intersectional discrimination because of the elimination of this scheme. *Compare* 45 C.F.R. § 92.301 (2017), *with* 85 Fed. Reg. 37,245 (to be codified at 45 C.F.R. § 92.5).

[12] Federal courts routinely find standing where the plaintiff's chain of causation depends on the intervening acts of third parties that are unlawful. For example, in data breach cases, courts have found that customers have standing to bring claims against the companies that failed to safeguard their data—even though the illegal actions of a hacker or "thief would be the most immediate cause of plaintiffs' injuries." *Attias v. Carefirst, Inc.*, 865 F.3d 620, 629 (D.C. Cir. 2017); *Lambert v. Hartman*, 517 F.3d 433, 437–438 (6th Cir. 2008) (rejecting the argument that the intervening "criminal act of a third party" defeated standing where the plaintiff "link[ed] the act of identity theft" to the personal information divulged by the defendant). Similarly, in terrorist financing cases, courts have found standing against banks—even though the most immediate cause of injury is the unlawful actions of terrorists. *See, e.g., Rothstein v. UBS AG*, 708 F.3d 82, 93–94 (2d Cir. 2013) (concluding that "plaintiffs' injuries in bombings and rocket attacks conducted by Hizbollah and Hamas were fairly traceable to UBS's provision of U.S. currency to Iran").

Plaintiff Healthcare Facilities: Plaintiffs allege that Plaintiff Healthcare Facilities have standing, on their own and on their patients' behalf, to challenge the Rollback Rule's elimination of the uniform enforcement scheme. As the Complaint explains, "[t]he Rollback Rule's harms are magnified for those at the intersection of impacted communities, such as Black transgender women; disabled Latinx immigrants; or Indigenous pregnant people." Am. Compl. ¶ 14. Plaintiff Healthcare Facilities serve diverse populations that include people who have experienced intersectional discrimination in the past and are likely to experience intersectional discrimination in the future. Plaintiff Healthcare Facilities have limited resources to provide assistance with coverage denials, case management, and legal services to their patients in order to remedy discriminatory treatment and health care coverage. *Id.* ¶¶ 236, 237; Decl. Stark ¶¶ 23, 31; Decl. Riener at ¶¶ 15, 25; Decl. LaPointe at ¶¶ 29, 33. And the Rollback Rule's lack of clarity about remedies for intersectional discrimination, and elimination of avenues for administrative relief, will make it more difficult for patients, and Plaintiff Healthcare Facilities that help them, to assert patient rights under Section 1557 and obtain redress. *See* Am. Compl. ¶¶ 316–317. For the reasons explained above, *see supra* at 18–21, Plaintiff Healthcare Facilities have standing to seek a remedy for this injury on their own and on their patients' behalf. *See Whitman-Walker*, 2020 WL 5232076, at *22 (finding standing for similarly situated healthcare facilities to challenge Rollback Rule on behalf of their patients).

Plaintiff Healthcare Advocates: The Amended Complaint also adequately alleges that Plaintiff Healthcare Advocates have standing to challenge the elimination of the uniform enforcement scheme. As is true of Plaintiff Healthcare Facilities, Plaintiff Healthcare Advocates serve diverse populations that include people who have experienced intersectional discrimination in the past and are likely to experience intersectional discrimination in the future. IWR, for

example, serves Native women across the country. *See* Am. Compl. ¶ 62, 65. Its Abortion Fund has served 172 people from Indigenous communities or tribes across the country, Decl. Lorenzo ¶ 4, and the sex education program has served approximately 3,000 people, *id.* ¶ 12. Native women experience high rates of intersectional discrimination in health care: 23% of Native people report experiencing anti-Native discrimination when going to a doctor or health clinic, and 29% of Native women report experiencing discrimination because they are women when going to a doctor or health clinic. *Id.* ¶ 25. Likewise, 98% of the youth that BAGLY serves are LGBTQ+, and BAGLY provides group therapy for young people with disabilities, for transgender femmes, and another for all women, where participants regularly discuss their experiences of discrimination when attempting to access health care. *See* Decl. Sterling Stowell at ¶ 14; Decl. Smith ¶ 17. The Rollback Rule's lack of clarity about remedies for intersectional discrimination, and its elimination of administrative remedies, will make it more difficult for the clients of Plaintiff Healthcare Advocates who experience intersectional discrimination to assert their rights under Section 1557 and obtain redress. *See* Am. Compl. ¶¶ 316–317. The elimination of the uniform enforcement scheme thus does not only cause "confusion," Mot. at 20, but it will also make it less likely that those who experience discrimination can obtain relief.

4. The incorporation of Title IX's religious and abortion exemptions.

Plaintiffs have alleged standing because these provisions will increase demand for the services of Plaintiff Healthcare Facilities and IWR, and because these provisions will make it more difficult for clients to access care. *Compare* 45 C.F.R. § 92.2 (2017), *with* 85 Fed. Reg. 37,243–44, 37,245 (to be codified at 45 C.F.R. §§ 86.18, 92.6)).

Plaintiff Healthcare Facilities: Plaintiff Healthcare Facilities have standing to challenge the Rollback Rule's incorporation of Title IX's religious and abortion exemptions because those provisions will negatively affect the organizational activities of Plaintiff Healthcare Facilities.

See Havens, 455 U.S. at 379. Just as was true of the Rollback Rule's inaccurate definition of "on the basis of sex," and related provisions, its incorporation of these exemptions will increase demand for Plaintiffs' services. *See* Am. Compl. ¶¶ 233, 241. For example, Plaintiffs allege that CrescentCare provides reproductive health and gender affirming services, *see id.* ¶¶ 38–40, and that the Rollback Rule will increase discrimination against their patients, *id.* ¶ 233. As a result, Plaintiffs allege that CrescentCare "will experience increased strain on their resources and capacity" from patients seeking care at their facilities, where they do not need to fear discrimination. *Id.*; *see also Whitman-Walker*, 2020 WL 5232076, at *15 (finding healthcare facility had standing to challenge Rollback Rule's incorporation of Title IX's religious exemption because "HHS's newly and explicitly incorporated religious exemption will cause patients to fear discrimination at the hands of religiously affiliated providers," and that "apprehension, in turn, further contributes to increased demand for the services of the health-provider Plaintiffs and their accompanying financial and operational injuries").

Plaintiff Healthcare Advocates: Plaintiffs allege that IWR has standing to challenge these provisions. The provisions will cause IWR to expend more resources on services for abortion, midwife, and doula care, on more expensive abortion care later in pregnancy, on clients' travel and related expenses to the few clinics that provide abortion care later in pregnancy, and on staff labor to provide information and resources to clients about abortion care. *See* Am. Compl. ¶¶ 222, 257–264. The provisions will also threaten the life and health of its clients who are denied abortion care, coverage, and information. *Id.* Plaintiffs have thus alleged that IWR has standing to challenge the provisions. *See Havens*, 455 U.S. at 379.

Plaintiffs have also adequately alleged that IWR has standing on behalf of its clients to challenge these provisions. *See* Am. Compl. ¶¶ 67, 222; *see also Carey v. Population Services*

Int'l, 431 U.S. 678 (1977) (distributors of contraceptives had standing to raise rights of prospective purchasers); *accord June Med. Servs.* 140 S. Ct. at 2118, 2139 n.4 (plurality and concurrence) (reaffirming third-party provider standing). For example, Plaintiffs allege that IWR provides critical information about pregnancy options and abortion care that is often not otherwise available to Indigenous people, and also helps them access abortion care by paying clinics for the procedure and by providing clients the necessary funds to cover lodging, gas, food, childcare, and related travel expenses. *See* Am. Compl. ¶¶ 67, 222. Plaintiffs also allege that IWR's clients "face financial, linguistic, and geographic barriers to care" and "face stigma in accessing abortion care." *Id.* ¶ 63; *see also Singleton*, 428 U.S. at 117 (noting that "obstacles" to asserting abortion rights include "a desire to protect the very privacy of her decision from the publicity of a court suit"). Many "live in rural areas, usually on reservations," from which they would have to "drive distances from over 2 hours to about 10 hours to access abortion care." Am. Compl. ¶ 63. Most have "limited financial resources and are either uninsured or lack insurance coverage of abortion." *Id.* And some "are represented by elders, for whom English is not their first language." *Id.* These allegations show that IWR is injured by the incorporation of Title IX's religious and abortion exemptions, that it has a close relationship with its clients, and that its clients are hindered in protecting their own interests. *See Powers*, 499 U.S. at 410–411.

In response, Defendants incorrectly assert that the allegations about the injury caused by the Rollback Rule's incorporation of Title IX's religious and abortion exemptions are "not particularized to any of the named plaintiffs." Mot. at 22. But as just shown, CrescentCare and IWR *have* alleged particularized injury from these provisions. Moreover, these allegations are not grounded in simple assertions that individuals will experience discrimination. They are grounded in Plaintiffs' and their patients' own past experiences, which are probative evidence of

"a real and immediate threat of repeated injury." *O'Shea*, 414 U.S. at 496; *see supra* at 28. For example, IWR's "clients have expressed fear that they will be discriminated against for having had an abortion by a hospital or IHS facility." Am. Compl. ¶ 222. Additionally, "due in part to inadequate resources, and in part to anti-abortion bias," Indigenous people who can become pregnant "are also denied access to abortion care and information about abortion at IHS facilities even where the Hyde Amendment—which restricts federal funding of abortion—does not apply, including cases of life endangerment, rape, and incest." *Id.* IWR's clients thus have already experienced discriminatory denials of reproductive health care and information, and discrimination because of their reproductive health histories will predictably be exacerbated by the incorporation of Title IX's exemptions. *See Mass. v. HHS*, 923 F.3d at 224–225.

5. The removal of protections for association discrimination.

Plaintiffs have alleged that EQCA and IWR have standing to challenge the elimination of this provision, 45 C.F.R. § 92.209 (2017).

Defendants incorrectly state that Plaintiffs made no allegations of injury from the removal of protection for claims of discrimination based on association. Mot. at 22. Rather, Plaintiffs alleged that two EQCA members previously suffered discrimination by healthcare providers and insurers based upon association with their transgender daughter, and thus reasonably fear that they will face such discrimination again—in the form of, for example, denials of care, higher out-of-pocket costs, and more—because of the Rollback Rule. Am. Compl. ¶ 225; Decl. Zbur ¶ 21. These allegations show "a real and immediate threat" of association-based discrimination. *O'Shea*, 414 U.S. at 496. By removing express protections against that discrimination, the Rollback Rule undermines their ability to obtain administrative or judicial redress under Section 1557. This suffices to establish EQCA's standing on this front.

Plaintiffs also alleged that many of IWR's clients are from Native American communities and are represented by grandparents or other elders for whom English is not their first language. Am. Compl. ¶ 63. Discrimination against IWR's clients' representatives by healthcare providers based on the representatives' race, age, or LEP would prevent those clients from receiving the care that they need and would deter their ability to assert their rights under Section 1557 and obtain redress. Without a way to challenge discrimination, these clients will be harmed.

6. The elimination of the notice and taglines requirement.

Plaintiffs have alleged that Plaintiff Healthcare Facilities have standing to challenge the elimination of these provisions, *see* 45 C.F.R. § 92.8 (2017), because they are regulated entities and because the provisions will harm their organizational activities by causing patients who initially seek care elsewhere to come to Plaintiff Healthcare Facilities worse off than they would be otherwise because of communication difficulties.

First, Plaintiffs allege that Plaintiff Healthcare Facilities have standing to challenge these provisions because the Amended Complaint states that they are regulated entities who must comply with Section 1557 and associated regulations. *See* Am. Compl. ¶¶ 29 (Fenway), 35 (Callen-Lorde), 43 (CrescentCare); *see also Lujan*, 504 U.S. at 560–561.

Second, Plaintiffs allege that Plaintiff Healthcare Facilities have standing to challenge the Rollback Rule's elimination of the notice and taglines requirement because they provide patients education, navigation, and legal services (including support for remedying discriminatory healthcare coverage or provision of services) and accommodate patients with LEP through the use of translation services and through bilingual staff. *See* Am. Compl. ¶¶ 29 (Fenway), 35 (Callen-Lorde), 43 (CrescentCare). As the Amended Complaint explains, the Rollback Rule's elimination of the notice and taglines requirement will cause patients to "be less informed about applicable civil rights protections" and cause patients who seek care elsewhere to come to

Plaintiff Healthcare Facilities worse off than they would otherwise be because of communication difficulties. *See id.* ¶¶ 12, 113, 190, 206–207, 242; *see also Whitman-Walker*, 2020 WL 5232076, at *17 (finding that healthcare facility had standing to challenge the elimination of the notice and tagline requirements because it would have to provide "costlier and more difficult treatment" to patients who had received inadequate care elsewhere).

Defendants' sole response is that allegations that Plaintiffs serve LGBTQ+ people, including individuals and families with LEP, are insufficient to establish organizational standing. *See* Mot. at 23. But, again, Plaintiffs allege that the Rollback Rule's elimination of the notice and taglines requirement will cause patients who unsuccessfully seek care elsewhere because of communication difficulties to come to Plaintiff Healthcare Facilities. *See* Am. Compl. ¶¶ 12, 113, 190, 206–207, 242; *see also Havens*, 455 U.S. at 379. When patient care is delayed, the result is a patient pool with more severe conditions that are less responsive to treatment and require more expensive to treat. *See* Am. Compl. ¶¶ 12, 113, 190, 206–207, 242. Furthermore, Plaintiff Healthcare Facilities have limited financial resources they can dedicate to providing healthcare services, including the resultant non-reimbursable costs associated with increases in patient volumes. *See* Decl. Riener at ¶¶ 20–21; Decl. Lapointe at ¶¶ 27, 35.

7. The elimination of other non-discrimination regulations.

Plaintiffs have sufficiently alleged that Plaintiff Healthcare Facilities have standing to challenge these provisions. *See* 85 Fed. Reg. 37,221–22 (listing amended provisions). The Rollback Rule eliminates protections against gender identity and sexual orientation discrimination in regulations that implement statutes other than Section 1557, such as Medicaid State Plans, Programs for All-Inclusive Care for the Elderly (PACE), and the ACA state health insurance marketplaces and plans. *See* Am. Compl. ¶ 339. The elimination of these protections will cut into the budgets of these facilities because they rely, in part, on insurance reimbursement

to fund their operations. *See id.* ¶¶ 234–235 (Fenway), 236 (Callen-Lorde), 237, 241 (CrescentCare); *see also id.* ¶¶ 211, 223. This type of "economic loss . . . is enough to confer standing." *Katz*, 672 F.3d at 76; *see also Whitman-Walker*, 2020 WL 5232076, at *16 (finding that healthcare facility had standing to challenge Rollback Rule's elimination of the prohibition on categorical coverage exclusions for gender-affirming care because it would "obtain reduced reimbursements from insurers that scale back their coverage").

II. Plaintiffs' Claims Are Ripe.

Defendants argue that Plaintiffs' challenge to the Rollback Rule's elimination of the definition of "on the basis of sex" is not ripe.[13] They suggest that they might—maybe—act in line with Plaintiffs' view of the proper interpretation of Section 1557 at some point. Mot. at 24. A possibility of future lawfulness does not make a challenge to past lawlessness unripe.[14]

This challenge is fit for review. The decision to remove the definition of discrimination on the basis of sex in the Rollback Rule was both contrary to law—because it conflicts with Section 1557 and other statutes—and arbitrary and capricious—because HHS offered no reasoned basis for removing it after *Bostock* undermined HHS's stated rationale. Am. Compl. ¶¶ 396–397, 408–412. This is a challenge to an already promulgated regulation, not to "uncertain and contingent events that may not occur as anticipated or . . . at all." *McInnis-Misenor v. Maine Med. Ctr.*, 319 F.3d 63, 70 (1st Cir. 2003). Defendants admit, moreover, that

[13] Defendants' refer to "several of HHS's other decisions" but they discuss only one in detail: the decision to decline to define on the basis of sex. Mot. at 24. Their arguments as to other claims rest "on the same principles" and so are wrong for the same reasons. Mot. at 29.

[14] Defendants invoke the so-called *prudential* ripeness factors. Mot. at 25 (discussing fitness for review and hardship from delay). Where plaintiffs meet Article III's requirements, declining jurisdiction "on grounds that are prudential . . . is in some tension with . . . the principle that a federal court's obligation to hear and decide cases within its jurisdiction is virtually unflagging." *Susan B. Anthony List*, 573 U.S. at 167 (internal quotation marks omitted).

this is a "purely legal" challenge, Mot. at 26, the kind that courts "exhibit a greater willingness to decide." *Ernst & Young v. Depositors Econ. Prot. Corp.*, 45 F.3d 530, 536 (1st Cir. 1995).

Defendants' arguments to the contrary are either merits arguments or are irrelevant to ripeness. They argue that this Court should decline to hear this challenge because "HHS denies" adopting an interpretation of discrimination on the basis of sex. Mot. at 27. The allegations show otherwise. *See supra* at 24–25. But in any event, this denial speaks to the merits, not ripeness. If Defendants truly adopted no interpretation at all, the Rollback Rule would be the definition of arbitrary, as it gives protected people and regulated entities no clarity on their rights and obligations. But the denial says nothing about whether the Rollback Rule is fit for review.

Defendants further argue that if Section 1557 compelled the 2016 Rule's definition of discrimination on the basis of sex, then they would have to comply with it, whether it is in the regulation or not. Mot. at 27–28. That also goes to the merits, whether Defendants acted arbitrarily in deleting the definition. It does not stop this Court from answering the question now.

This case is nothing like *Aulenback, Inc. v. Fed. Highway Admin.*, 103 F.3d 156 (D.C. Cir. 1997). *See* Mot. at 27. There, plaintiffs challenged a training manual, but the agency had "not had an opportunity to explain, in an authoritative way, the purpose of the Manual and how it is used." *Aulenback*, 103 F.3d at 167. Here, the preamble explains Defendants' interpretation of Section 1557, and there is an administrative record on which to assess the rule's legality.

Defendants also suggest this case might be advisory because *future* litigation—such as a hypothetical private suit under Section 1557—might generate judicial opinions about the meaning of Section 1557. Mot. at 29. But Plaintiffs' claims are that the *Rollback Rule* is

unlawful and harms them now—the possibility that it may also harm other, future plaintiffs does not render Plaintiffs' claims unripe, and Defendants cite no case for that proposition.

As to hardship, Defendants repackage their injury-in-fact arguments. They argue that Plaintiffs allege that "nothing more than abstract confusion" follows from the Rollback Rule. *Id.* at 25. This is wrong. *See supra* at 17–37 (alleging injuries from discrimination). Nor do the cases Defendants rely on support declining jurisdiction. In *Ohio Forestry Association, Inc. v. Sierra Club*, 523 U.S. 726, 734 (1998), an organization challenged a forestry plan that would have *no* effect until it was implemented by later permitting actions that could be challenged. And in *National Park Hospitality Association v. Department of Interior*, 538 U.S. 803, 811 (2003), the plaintiffs challenged the position an agency stated it *would* take *if* certain disputes arose, before any dispute had arisen. Neither involved a challenge like this one: to the deletion of regulatory protections where Plaintiffs allege concrete harms from the deletion.

Defendants' ripeness argument would insulate from judicial review *any* decision to delete regulatory protections. That is because all regulations with the force of law implement statutory text, and it is difficult to imagine a statutory requirement that could not be addressed in *some* judicial forum. And so the upshot of Defendants' view is that no rescission of regulatory protections could be reviewed. This is not the law. *See, e.g.*, *Dep't of Homeland Sec. v. Regents of the Univ. of California*, 140 S. Ct. 1891, 1910 (2020) (reviewing rescission); *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 34, (1983) (same).

III. Plaintiffs Have Stated A Claim As To Counts III And IV.

A. The Amended Complaint States An Equal Protection Violation.

Count III claims that the Rollback Rule violates the equal protection guarantee of the Fifth Amendment because it discriminates on the basis of sex and is motivated by animus toward transgender people. Defendants argue that the Rollback Rule does not discriminate because it

merely makes Section 1557—not regulations—the source of any protections and that Plaintiffs' allegations do not amount to animus. Both of these arguments are wrong.

First, Plaintiffs alleged that the Rollback Rule amounts to sex-based discrimination that is subject to, and fails, heightened scrutiny. Discrimination on the basis of sexual orientation or because a person is transgender is discrimination on the basis of sex. *See Bostock*, 140 S. Ct. at 1743. The Rollback Rule unconstitutionally singled out regulatory protections for LGBTQ+ individuals for elimination, in direct defiance of a Supreme Court opinion. *See supra* at 4–5; *see also Romer v. Evans*, 517 U.S. 620, 635 (1996) (describing laws "singling out" a group "not to further a proper legislative end but to make them unequal to everyone else" as impermissible). And Defendants' insistence that the Rollback Rule innocuously repeats Section 1557 and does nothing more is belied by the preamble's statements that the rule is justified because the 2016 Rule should not have covered discrimination against LGBTQ+ persons. *See* 85 Fed. Reg. 37,175, 37,180, 37,183, 37,191, 37,194, 37,198. In other words, the Rollback Rule is premised on a view that *Bostock* was wrong and Defendants will not apply it when implementing Section 1557. Defendants' new litigation position does not change this. *See United States v. Virginia*, 518 U.S. 515, 533 (1996) ("The justification [for sex-based classifications] must be genuine, not hypothesized or invented *post hoc* in response to litigation.").

Second, Plaintiffs allege unconstitutional animus.[15] Plaintiffs allege an administration-wide pattern of eliminating protections for transgender persons that shows a "campaign of consistent, repeated anti-transgender sentiments, advocacy, and comments by the Administration

[15] Because Defendants' actions were motivated by animus, they fail to satisfy rational basis review, let alone the heightened scrutiny that applies in cases of sex discrimination. *See Romer*, 517 U.S. at 632 (action motivated by "animus . . . lacks a rational relationship to legitimate state interests"); *Nevada Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 730 (2003) ("[M]easures that differentiate on the basis of gender warrant heightened scrutiny . . . .").

as a whole." Am. Compl. ¶ 365; *id.* ¶¶ 366–376. They also allege that HHS specifically pursued that campaign. *Id.* ¶¶ 380–384. They then allege that Roger Severino, who directs the HHS office that promulgated the Rollback Rule "has consistently exhibited such animus." *Id.* ¶ 377. He did so before assuming that role when commenting on whether the very statute cross-referenced in Section 1557 prohibits LGBTQ+ discrimination, *id.* ¶¶ 377–378, in other contexts, *id.* ¶ 379, and while in office at OCR, where he dismissed claims of discrimination as "hypothetical" even though his own agency had received such claims, *id.* ¶ 388. And Plaintiffs allege that the Rollback Rule contains statements—such as misgendering transgender persons and asserting dishonestly that transgender persons are a threat to young children—that evidence animus. *Id.* ¶¶ 391, 393. That the Government puts forth other justifications, *see* Mot. at 31–32, does not defeat the Equal Protection claim. Agency action is unconstitutional even if it rests on discriminatory animus only in part. *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 265 (1977).

Defendants' attempt to dismiss these allegations, Mot. at 33–34, lacks a basis in precedent. Had Plaintiffs alleged only statements from uninvolved officials that were "remote in time and made in unrelated contexts," Defendants might have an argument. *See Regents of the Univ. of California*, 140 S. Ct. at 1916. But Plaintiffs' allegations are specific to the agency, office, and official that promulgated the Rollback Rule, and show that these actors expressed animus toward LGBTQ+ people and acted to strip their protections. That is sufficient at the pleading stage.

In any event, dismissal now would be premature. Defendants have not produced the administrative record, which, as they acknowledge, is relevant to the question whether an administrative action was based on unconstitutional animus. *See* Mot. at 33; *see also Arlington*,

429 U.S. at 266, 268 (explaining that the "administrative history may be highly relevant"); *District Hosp. Partners, L.P. v. Sebelius*, 794 F. Supp. 2d 162, 171–173 (D.D.C. 2011).

B. The Amended Complaint States A Final, Reviewable Agency Action.

Plaintiffs alleged that the Rollback Rule adopted a final, reviewable enforcement policy. To be final, an action must (1) "mark the consummation of the agency's decisionmaking process" and (2) "be one by which rights or obligations have been determined, or from which legal consequences will flow." *Bennett*, 520 U.S. at 177–178 (internal quotation marks omitted).

Those requirements are met here. HHS stated that it would "return[] to" a policy of enforcing Section 1557 based on a "biological binary meaning of sex," which in its view means that Section 1557 does not cover anti-LGBTQ+ discrimination. Am. Compl. ¶ 425(a) (quoting 85 Fed. Reg. at 37,180). It "disavow[ed]" any prior interpretations of Section 1557 that were inconsistent with that new policy. *See supra* at 5; 85 Fed. Reg. at 37,191. It did so not to *avoid* taking a position on what Section 1557 means but because it had *rejected* its prior interpretations. *See* 85 Fed. Reg. at 37,191 (HHS "has concluded that the position stated in the 2012 OCR letter reflected an incorrect understanding of Title IX."); *id.* ("Having considered the matters raised fully, [HHS] disavows the views expressed in the 2012 letter that concern the coverage of gender identity and sex discrimination under Section 1557."). Indeed, HHS made clear that "some covered entities may no longer incur costs associated with processing grievances related to gender identity discrimination under Title IX, because such claims *will not be cognizable under this final rule*." *Id.* at 37,225 (emphasis added). HHS's policy decision that such claims "will not be cognizable" is not a "tentative or interlocutory" position—it is the "consummation of the agency's decisionmaking process." *Bennett*, 520 U.S. at 178.

This policy has legal effect. It means that OCR will not take administrative enforcement action on complaints of discrimination based on gender identity. *See* 85 Fed. Reg. 37,180

("returning to" enforcing Section 1557 using "the biological binary meaning of sex" irrespective of discrimination on the basis of sexual orientation or transgender status). That removes a key route for those who experience discrimination to seek relief. *See* Am. Compl. ¶¶ 10, 210, 216. Indeed, HHS itself explained that its interpretation means that a claim based on LGBTQ+ discrimination "will not be cognizable" under its regulations and relief lies, if at all, in a private right of action. 85 Fed. Reg at 37,225; *see also id.* at 37,203 ("To the extent that Section 1557 permits private rights of action, plaintiffs can assert claims under Section 1557 itself . . . .").

Defendants' contrary argument hinges on a single sentence in the rule's preamble: "[T]o the extent that a Supreme Court decision is applicable in interpreting the meaning of a statutory term, the elimination of a regulatory definition of such term would not preclude application of the Court's construction." *Id.* at 37,168. This statement cannot bear the weight Defendants pile atop it. It simply restates the truism that eliminating the definition of discrimination on the basis of sex would not *prohibit* interpreting Section 1557 in line with Supreme Court precedent. But HHS published its rule, and this sentence, *after Bostock*. The only reading of HHS's actions is that—as of the time of the Rollback Rule—it did not see *Bostock* as relevant to its decision to enforce Section 1557 in line with a "biological binary meaning of sex" that excludes anti-LGBTQ+ discrimination. 85 Fed. Reg. at 37,180. Just as a severability clause cannot save a regulation thoroughly infected with legal error, *see Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2319 (2016), this sentence cannot save the Rollback Rule's enforcement policy where that policy relies entirely on an interpretation of sex-based discrimination that *Bostock* rejected.

Defendants' cursory argument that this enforcement policy is unreviewable is also wrong. A "statement of a general enforcement policy" is reviewable. *Crowley Caribbean Transp., Inc. v. Pena*, 37 F.3d 671, 676–677 (D.C. Cir. 1994); *OSG Bulk Ships, Inc. v. United States*, 132 F.3d

808, 812 (D.C. Cir. 1998). Such a policy does not involve the case-by-case exercise of discretion that is presumptively shielded from review. *See Edison Elec. Inst. v. EPA*, 996 F.2d 326, 333 (D.C. Cir. 1993) (reviewing a general enforcement policy based on an interpretation of the statute and implementing regulations); *Crowley*, 37 F.3d at 676 (holding that "an agency's statement of a general enforcement policy may be reviewable" if set out "in some form of universal policy statement"). HHS's statement of a new general policy that a claim based on LGBTQ+ discrimination "will not be cognizable" is thus reviewable. 85 Fed. Reg at 37,225.

CONCLUSION

The Court should deny Defendants' motion to dismiss the Plaintiffs' Complaint.

Dated: November 18, 2020

Respectfully submitted,

/s/ William H. Kettlewell

William H. Kettlewell (BBO No. 270320)
HOGAN LOVELLS US LLP
125 High Street
Suite 2010
Boston, MA 02110
Phone: 617.371.1000
bill.kettlewell@hoganlovells.com

Jessica L. Ellsworth (admitted pro hac vice)
Kirti Datla (admitted pro hac vice)
Jo-Ann Tamila Sagar (admitted pro hac vice)
Erin R. Chapman (admitted pro hac vice)
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
Phone: 202.637.5600
jessica.ellsworth@hoganlovells.com
kirti.datla @hoganlovells.com
jo-ann.sagar@hoganlovells.com
erin.chapman@hoganlovells.com

Kristina Alekseyeva (admitted pro hac vice)
Peter W. Bautz (admitted pro hac vice)
HOGAN LOVELLS US LLP
390 Madison Avenue
New York, NY 10017
Phone: 212.918.3000
kristina.alekseyeva@hoganlovells.com
peter.bautz@hoganlovells.com

Lynly Egyes (admitted pro hac vice)
Dale Melchert (admitted pro hac vice)
TRANSGENDER LAW CENTER
P.O. Box 70976
Oakland, CA 94612
Phone: 510.587.9696
lynly@transgenderlawcenter.org
dale@transgenderlawcenter.org

Kevin Costello (BBO No. 669100)
Maryanne Tomazic (admitted pro hac vice)
Alexander Chen (admitted pro hac vice)
CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School
1585 Massachusetts Avenue
Cambridge, MA 02138
Phone: 617.496.0901
kcostello@law.harvard.edu

Sunu Chandy (admitted pro hac vice)
Michelle Banker (admitted pro hac vice)
Lauren Gorodetsky (admitted pro hac vice)
Dorianne Mason (admitted pro hac vice)
NATIONAL WOMEN'S LAW CENTER
11 Dupont Circle NW Suite 800
Washington, DC 20036
Phone: 202.588.5180
schandy@nwlc.org
mbanker@nwlc.org
lgorodetsky@nwlc.org
dmason@nwlc.org

David Brown (admitted pro hac vice)
Noah E. Lewis (admitted pro hac vice)
Alejandra Caraballo (admitted pro hac vice)
TRANSGENDER LEGAL DEFENSE AND EDUCATION FUND, INC.
520 8th Ave. Ste. 2204
New York, NY 10018
Phone: 646.862.9396
dbrown@transgenderlegal.org
nlewis@transgenderlegal.org
acaraballo@transgenderlegal.org

Counsel for Plaintiffs

EXHIBITS

- **Exhibit A**: Declaration of Jasmine Beach-Ferrara, Executive Director of Campaign for Southern Equality
- **Exhibit B**: Declaration of Chastity Bowick, Director of the Transgender Emergency Fund of Massachusetts
- **Exhibit C**: Declaration of Ivy Hill, Community Health Program Director of Campaign for Southern Equality
- **Exhibit D**: Declaration of Ellen LaPointe, Chief Executive Office of Fenway Health
- **Exhibit E**: Declaration of Darren Lazor, Member of Equality California
- **Exhibit F**: Declaration of Rachael Lorenzo, Co-founder of Indigenous Women Rising
- **Exhibit G**: Declaration of Alice Riener, Chief of Staff of NO/AIDS Task Force, d/b/a CrescentCare
- **Exhibit H**: Declaration of Galina Mae Smith, Health Programs Manager at the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth
- **Exhibit I**: Declaration of Wendy Stark, Executive Director of Callen-Lorde Community Health Center
- **Exhibit J**: Declaration of Grace Sterling Stowell, Executive Director of the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth
- **Exhibit K**: Declaration of Stephe Thayer Koontz, Member of Campaign for Southern Equality
- **Exhibit L**: Declaration of Noel Twilbeck, Chief Executive Officer of NO/AIDS Task Force, d/b/a CrescentCare
- **Exhibit M**: Declaration of Rick Zbur, Executive Director of Equality California

Exhibit A

Declaration of Jasmine Beach-Ferrara,

Executive Director of Campaign for Southern Equality

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts, Plaintiffs, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-11297

Affidavit of Jasmine Beach-Ferrara

1. I, Jasmine Beach-Ferrara, swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:
2. I am the Executive Director of Campaign for Southern Equality, a nonprofit organization based in Asheville, North Carolina, dedicated to advancing LGBTQ civil rights across the South, both legally and in the lived experiences of Southerners. I am an ordained minister in the United Church of Christ and also serve in local elected office as a County Commissioner in Buncombe County, NC.

3. As the founding Executive Director of the Campaign for Southern Equality, I have served in this role since the organization launched in 2011. My role includes developing and implementing programs, managing all staff, reporting back to our Board of Directors, fundraising, and overseeing the organization's budget. As such, I have detailed knowledge of all of the Campaign for Southern Equality's programs, staffing and finances.
4. The Campaign for Southern Equality advocates for LGBTQ people to survive and thrive throughout the South. Our mission is to promote full equality for LGBTQ Southerners in all spheres of life and across race, class and gender.
5. We use a range of strategies to achieve these goals. These include direct services, direct action, litigation, grant-making, long-term organizing strategies to respond to immediate – and often urgent - community needs that support a new generation of LGBTQ leaders and build political voice and power over the long term. One of the most critical needs identified by our members is access to safe and supportive health care, and as such it is one of the main areas our work focuses on.
6. The Campaign for Southern Equality has about 8,000 members throughout the nation, particularly in the South, the majority of whom live in North Carolina, South Carolina, Tennessee, Alabama, and Mississippi. Our members help shape the organization's long-range goals and priorities and direct the organization's mission and direction. Many members contribute financially to support the Campaign for Southern Equality's work, but members who have limited financial resources may contribute through participating in the organization's programs.

7. About 40% of our work focuses on LGBTQ people's access to healthcare because it is such a critical and ever-present need in the lives of our members. For the past nine years I have had the honor of sitting with hundreds of our members as they have shared stories about their lives, including their experiences with health and health care. Family and health are the two issues that come up perhaps more than any other when people begin to speak honestly about their fabric of their lives and what it is like to be a LGBTQ person living on the coast of Alabama, or a small town in Mississippi, or the mountains of North Carolina. Beyond the individuals I have spoken with personally over the years, this trend is also reflected when we conduct community surveys, facilitate town halls, and hear community feedback at direct service clinics.
8. Specifically, people share stories of the challenges of finding transgender-friendly primary care, specialty care, and mental health services in their local community. This includes families seeking care for transgender youth who need trans-affirming pediatric care to people navigating the challenges of insurance denials and coverage. I have heard stories of people being denied care by longtime providers when they come out, being mocked or treated insensitively in the doctor's office, and not receiving adequate screening or treatment for mental health issues because clinicians are not well-informed about LGBTQ experience and medical needs.
9. In response to this need we have developed a slate of resources and programs to support our members to access safe and affirming health care with dignity and respect. We address the problem of health care access from many angles by educating health care providers about best practices, educating our members about their rights, and creating user friendly tools and resources accessible online to maximize our reach to our

membership. It should not be hard for people to access quality health care but unfortunately due to animus and discrimination, it often is; so our goal is to make it easier for LGBTQ Southerners to access the care they need and deserve.

10. One such project that we have launched to assist our membership is creating the *Trans in the South: A Guide to Resources and Services*,[1] a regularly updated, bilingual (Spanish and English) directory of more than 400 Southern health service providers—including mental health providers, primary care physicians, HIV care specialists, and endocrinologists—whom Campaign for Southern Equality staff has confirmed to be willing to provide, and to be competent in the provision of, gender affirming care. In *Trans in the South*, we collect and compile the gender-affirming services the provider offers, what pre-requisites a patient must meet in order to receive gender-affirming services, whether the provider serves Spanish-speaking populations, where the provider is located, and whether the provider is likely to be able to take on new patients within the next six months. We also include resources to assist with funding medical transition, including information about health insurance coverage, namely information about insurance codes and corresponding diagnoses and treatments the codes refer to. We intentionally included this because we know from our membership and from the data we have collected, health insurance coverage is often a prohibitive barrier to gender affirming care for many transgender people in the South, particularly those who are low income. Insurers often refuse to cover medical transition or make the process of getting coverage very difficult.

---

[1] Ivy Gibson-Hill et al., *Trans in the South: A Guide to Resources and Services*, CAMPAIGN FOR SOUTHERN EQUALITY, (3d ed., 2019), https://southernequality.org/resources/transinthesouth/ ("*Trans in the South*").

11. This project originated in responding to a need: transgender people described the difficulties they faced in finding providers who would care for them and the painful experience of spending hours cold-calling one doctor's office after another to ask – "can I get the care I need here." Too often, the answer was "no" and the calls would continue until they either found someone (often many miles away from their hometown) or made the difficult decision to delay or forgo getting care. We saw an opportunity to create a resource so that people could avoid this difficult cycle and instead simply find an affirming doctor and get the care they needed. For LGBTQ Southerners, many things that should be easy – like finding a caring competent doctor – are made hard due to animus and discrimination; one of our goals is to make these aspects of life easier so that people can focus their energies and resources on the matters they choose to.
12. When members contact our staff about health insurance denials for gender-affirming care, we frequently provide advocacy and healthcare navigation and/or information about attorneys who specialize in health insurance appeals.
13. We also operate the Southern LGBTQ Health Initiative, in partnership with Western NC Community Health Services. As part of the Southern LGBTQ Health Initiative we produced a comprehensive health survey of LGBTQ+ people living in the South.[2] This survey, revealed several disparities that LGBTQ+ Southerners face in health care settings, particularly for transgender respondents and respondents living in rural areas.

[2] Chase Harless, et al., *The Report of the 2019 Southern LGBTQ Health Survey*, CAMPAIGN FOR SOUTHERN EQUALITY, (2019), https://southernequality.org/wp-content/uploads/2019/03/TransIntheSouth2019Guide.pdf?pdf=TISEng&source=LandingPageThumbnail.

14. We also conducted focus groups allowing diverse transgender Southerners across six states to share in-depth accounts of their experiences related to accessing health care,[3] which also found that many have experienced barriers in accessing basic services and that factors including race, age, and living in a rural community significantly increase that likelihood.

15. The most prevalent barriers I hear people describe include: struggling to find a primary care providers who will prescribe Hormone Replacement Therapy – even providers who may be transgender-affirming in principle will often say they do not feel qualified to provide HRT to other transition-related care because they have not received specific training to do so; experiencing outright hostility, mockery, or insensitivity in a clinical setting that makes it very difficult to be share honest health history information with providers, especially related to mental health issues and sexual health issues; and being treated by clinicians who are not responsive to their particular wishes related to transition, but instead prescribe a formulaic approach.

16. In 2019, we awarded grassroots grants to organizations that provide primary care focused on ensuring that LGBTQ+ people are treated with dignity and respect and on reproductive healthcare in Southern healthcare settings.

17. At the Campaign for Southern Equality, we also facilitate access to healthcare for LGBTQ people through cultural competency trainings for healthcare service providers. In a number of these trainings, our staff have used materials prepared by the Department of Health and Human Services ("HHS"), explaining how the agency interprets section 1557

[3] Johnson, A.H, I. Gibson-Hill, and J. Beach-Ferrara, Austin H. Johnson, et al., *The Report of the 2018 Southern Trans Health Focus Group Project*, SOUTHERN LGBTQ INITIATIVE (2018), https://southernequality.org/wp-content/uploads/2018/12/2018SouthernTransHealthFocusGroupExecutiveReport.pdf?pdf=Exec-Report&source=LandingPageButton.

of the Affordable Care Act. Addressing section 1557 and the 2016 regulations was an important part of the content of these trainings, as they are generally the only protections in place for transgender people in these states.

18. We also provide know your rights Pop-Up Resource Clinics that educate LGBTQ people about their rights on a variety of topics including healthcare. The goal of these clinics is to provide services that improve people's legal protections and their readiness to be self-advocates in legal and medical settings.

19. The Rollback Rule will harm the Campaign for Southern Equality's work supporting the healthcare needs of the LGBTQ community in several significant ways, and also has already harmed our members as described below.

20. I expect the rule will negatively impact our finances because we likely will have to expend additional resources producing our current update of *Trans in the South*, and providing information about providers who serve transgender patients. In recent years, the number of providers willing to provide transgender-inclusive healthcare in the South has significantly grown. As someone who has participated in this project from its inception, and has worked to increase healthcare access to transgender people living in the South for the past six years, I believe that this is due in part to Section 1557's prohibition of discrimination on the basis of sex because this policy established a new standard and guideline for care. Health care providers and health care systems are, by design, responsive to regulatory changes and changes in standards of care – therein rests of the power of federal health care policy.

21. If the Rollback Rule is allowed to fully go into effect, we will need to expend additional staff and financial resources producing a new update to *Trans in the South: A Guide to*

Resources and Services and helping its members locate providers who are willing to care for transgender patients with dignity and respect. Producing *Trans in the South: A Guide to Resources and Services* is a resource intensive task because the Campaign for Southern Equality must vet each provider. That task is made particularly time-consuming because the guide focuses on rural areas and states that lack protections for LGBTQ people in the healthcare context, meaning that providers who offer gender-affirming care are few and far between and staff members must devote a significant amount of time attempting to locate and vet those providers.

22. We have already received almost double the requests to vet providers to be included in our upcoming edition compared with the number of requests we had received during the same time frame for our last update. Our currently published edition includes 425 providers. It took approximately five years to find and vet those providers and compile the current edition. Currently, we have already received over 300 requests to vet additional providers since we published the last update in January of 2019. We had planned to have a team of three staff members and one intern complete our 2020/2021 update. However, with this new rule in effect, we would hire a team of six to eight additional seasonal staff and assign five permanent staff to enable us to expedite the timeline for publishing the next update to this guide as quickly as possible. Seasonal and permanent staff would conduct another full round of vetting of listed and nominated providers to ensure their capacity to provide trans-affirming care. (The guide is consistently the most accessed page on our website. I believe that this is due to the many challenges transgender Southerners face finding a friendly and competent care provider

in the South and because of the increased fear of discrimination since the announcement of the Rollback Rule.)

23. Campaign for Southern Equality's staff is currently made up of nine full time, permanent employees and approximately ten seasonal consultants and temporary employees. Our total annual budget is currently $850,000. As such we are a small but effective organization and these anticipated changes to updating *Trans in the South* will have a significant impact on our organization for that reason. The Campaign for Southern Equality hires seasonal staff to identify and to collect information about providers who should be included in the guide. It will likely have to train and hire additional seasonal staff, and devote more permanent staff time, to this work should the Rollback Rule take effect.

24. The Rollback Rule will also harm the Campaign for Southern Equality's grassroots grant program (the Southern Equality Fund), which annually distributes grants ranging in size from $500 to $10,000 to grassroots groups and direct service providers across the South, with an emphasis on groups that promote health equity for LGBTQ Southerners. Because the Campaign for Southern Equality expects that the Rollback Rule will decrease access to LGBTQ-friendly primary care by making clear that the HHS does not consider discrimination against transgender people to constitute discrimination on the basis of sex under the ACA greenlighting such discrimination and deterring LGBTQ Southerners from seeking care, the Campaign for Southern Equality projects that the Rollback Rule will exacerbate the need for this type of funding.

25. For similar reasons the Rollback Rule will also strain the Campaign for Southern Equality's capacity to train healthcare providers on best practices working with LGBTQ

patients including using their correct names and pronouns. Anyone can request a provider training, including patients. The Rollback Rule will encourage more healthcare providers to discriminate against LGBTQ Southerners. The Rollback Rule's lack of guidance to providers and patients alike about what constitutes unlawful discrimination on the basis of sex, will embolden hostile providers and deter LGBTQ Southerners from seeking care, increasing the urgency that friendly providers receive training to counteract the harmful effects of this on our communities. Not only is this harmful to our members, who we know forgo needed care due to fear of discrimination, but also Campaign for Southern Equality is a small organization, as stated, previously, and increased demand for training will require us to divert more resources to this important need in order for us to fulfill our mission of lived equality. The Campaign for Southern Equality currently devotes 60% of one staff member's time and 25% of another's to trainings. I anticipate having to divert additional staffing and funding resources towards training endeavors and hiring a consultant for about ten additional hours each month.

26. I also anticipate that the Rollback Rule will be detrimental for the Campaign for Southern Equality's legal and healthcare navigation services. The Rollback Rule's exemption of many insurers from Section 1557 will likely increase the number of health insurance denials of transgender-affirming care, overwhelming the organization's ability to provide referrals. Currently, we receive an average of between three to five requests from LGBTQ Southerners for navigation support and crisis support monthly and are at capacity to field those requests; any increase in these requests would require assigning additional staff to responding to these requests, who we would have to train.

27. The Rollback Rule will undoubtedly harm our members. My understanding of the Rollback Rule is that, among other things, it has changed HHS's view of the scope of entities that are subject to the protections of 1557. Namely, HHS now exempts many insurers from complying with them. Numerous members of Campaign for Southern Equality have health insurance and seek gender-affirming care and live in states that have no state anti-discrimination laws on the basis of gender identity. Many rely on health insurance coverage to access medically necessary, gender-affirming care because without it the cost would be prohibitive. Insurers frequently maintain policies and practices that are discriminatory against transgender people, such as including blanket bans on any transition related care irrespective of medical necessity or deny coverage of biologically specific care because of the transgender patients' gender marker, which would otherwise be covered if the patient was cisgender. (For example, many insurers refuse coverage for pap smears for transgender men but provide coverage for the same procedure for cisgender women.) While increasing insurance companies have begun to come into compliance with the mandates of 1557 in recent years, many still maintain such policies.
28. HHS makes clear in the Rollback Rule that its interpretation of discrimination on the basis of sex does not encompass discrimination against people because they are transgender stating: " 'Sex' according to its original and ordinary public meaning refers to the biological binary of male and female that human beings share with other mammals." 85 Fed Reg. at 37,178. Such a dangerous and incorrect interpretation of sex (legally and medically) sends a very clear message to transgender patients and insurers alike: seeking legal recourse for discrimination of such claims provided by the Rollback Rule will be futile.

29. Most of the people Campaign for Southern Equality works with are not easily able to sue in federal court to assert their rights. Even for those who want to sue, there are major barriers. Many lack the financial resources or know-how to navigate the judicial system, let alone find an attorney to bring such claims *pro bono* by getting on the radar of a national impact litigation organization or otherwise; all of it is prohibitively hard. Instead, we usually see people focus on the functional goal of getting the health care they need, by seeking alternate care options, putting up with inferior care because at least it is something or forgoing care altogether.

30. Policies and laws have a teaching effect and from the time the Rollback Rule was announced, I have already seen the chilling effect it is having on the lives of LGBTQ people, especially transgender people in the South. The Rollback Rule has already caused panic and confusion amongst our members. The Campaign for Southern Equality has received many inquiries from our membership about what the Rollback Rule would mean for them and—inquiries about its inconsistency with Section 1557, unlawful definition of "covered entities," and enforcement mechanisms. Because healthcare discrimination is so rampant for the Campaign for Southern Equality's transgender and gender non-binary members, many reasonably fear it will recur. It strikes me as particularly cruel to implement this policy during a global pandemic, when it is critical that people can access health care when they need it and when so many in our community are grappling with job losses, the fear of eviction, and an uncertain future.

Dated: November 17, 2020
Asheville, North Carolina

/S/ Jasmine Beach-Ferrara
Jasmine Beach-Ferrara

Exhibit B

Declaration of Chastity Bowick,

Director of the Transgender Emergency Fund of Massachusetts

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts, Plaintiffs, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services,* Defendants.	Civil Action No. 1:20-cv-11297

DECLARATION OF CHASTITY BOWICK

I, Chastity Bowick, declare as follows:

1. I am the Director of the Transgender Emergency Fund of Massachusetts ("TEF"), a nonprofit organization dedicated to providing critical financial support and other assistance to low-income and homeless transgender people in Massachusetts. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. Founded in 2008, TEF seeks to promote the health and equality of transgender individuals in Massachusetts by providing critical financial and other support. TEF serves the healthcare needs of transgender people in multiple ways, including providing financial assistance for co-payments for hormone replacement therapy and providing referrals for medical care and transportation and escort to medical appointments. Approximately 15% of the Transgender Emergency Fund's budget is currently spent on providing transportation to medical appointments and money for co-payments at medical appointments. We also support our clients' healthcare needs by assisting clients who have been denied insurance coverage for needed care in navigating those denials with their health plans. My colleagues and I have conferred directly with insurance plans, including both private and public insurers, on behalf of our clients to assist with resolving coverage issues. TEF also provides financial assistance for basic necessities, including shelter assistance; nutrition assistance; personal supplies such as soap, toothpaste, and deodorant; clothing for winter months; money for laundromat services; replacement identification with corrected gender markers; home rental startup costs like the first and last months' rent for an apartment; and assistance with relocating due to harassment. TEF has limited financial resources and is funded entirely from private grants, donations, and fundraising.

3. The recipients of TEF's services are entirely transgender identified. In particular, about 85% of the recipients of TEF's services are transgender, and about 15% are non-binary. The recipients of TEF's services have limited financial resources. In particular, about 60% of the recipients of TEF's services are homeless, about 20% are at or near the federal poverty line, and about 20% are low income. About 15% of the recipients of TEF's services are uninsured. Among those clients with insurance, 83% have Medicaid, MassHealth, or other public insurance, and 17% have private insurance. The people that TEF serves face additional barriers to advocating on

their own behalf. For example, about 6% of the recipients of TEF's services have limited English proficiency.

4. I am familiar with the rule "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 85 Fed. Reg. 37,160 (June 19, 2020) (the "Rollback Rule"), as well as the 2016 rule "Nondiscrimination in Health Programs and Activities," 81 Fed. Reg. 31,376 (May 18, 2016) (codified at 45 C.F.R. § 92 (2019)) (the "2016 Rule"). I have observed a marked spike in clients' ability to access medical services, and a corresponding decrease in the number of clients coming to TEF for assistance obtaining medical care, since mid-2016, which I attribute to the 2016 Rule. I anticipate that TEF will need to reallocate funds and devote more resources to financing clients' copayments for hormone replacement therapy, providing referrals for medical care and transportation to medical appointments, navigating insurance denials on behalf of our clients, and providing other financial assistance necessary for our clients' health and well-being as a result of the Rollback Rule, at a time when our funds are already strained due to the COVID-19 pandemic. I also anticipate that TEF will need to divert resources to vet additional health care providers to whom we can refer clients, as the already-known gender affirming providers will likely be strained in their ability to meet the increased demand for services.

5. From 2008 until 2016, TEF paid approximately $100-$500 per year towards copayments for hormone replacement therapy for our clients. In recent years, the amount TEF has spent on copayments for hormone replacement therapy has begun to decrease and was approximately $25 in 2018, and $0 in 2019. I attribute this decrease in expenditures to improved insurance coverage of gender affirming care following the issuance of the 2016 Rule. Based on

these past trends I anticipate that the Rollback Rule will increase the amount TEF must spend to ensure that our clients are able to obtain the hormone replacement therapy they need.

6. TEF refers and transports many patients to medical facilities that provide quality, culturally competent and sensitive care, including gender affirming care. We direct the vast majority of clients for whom we provide referral and transportation services to Fenway Health and Boston Health Care for the Homeless. Separately, when we are unsuccessful at resolving a coverage issue with a client's insurance plan, we refer the client to Fenway Health for assistance. After the 2016 Rule was issued, our referral and transportation-related costs decreased, as we received fewer requests for assistance in obtaining medical care or coverage, fewer requests for transportation services, and had fewer clients requiring long-distance travel to obtain needed medical care.

7. Since the Rollback Rule was first released on June 12, 2020, TEF has observed an increase in patients contacting TEF, the majority of whom have mentioned the Rule or expressed concern and anxiety that the Rule will lead to increased discrimination and denials of healthcare and coverage. This increase strongly suggests widespread concerns in the trans community about how the Rule will affect access to healthcare. Where appropriate, we have referred clients to Fenway Health and Boston Health Care for the Homeless. Many of these clients lack health insurance and lack the means to pay for their care out of pocket. I anticipate that if the Rollback Rule is permitted to take effect, this spike in requests for both TEF's and Fenway's services will magnify.

8. Since 2008, TEF has paid for personal supplies and other basic necessities to support the health and welfare of our clients. From 2008 to 2016, TEF paid approximately $2,000-$5,000 (depending on budget size) per year for personal supplies and other financial

support. Beginning in 2017, the amount TEF spent on such financial assistance decreased to approximately $1,000 in 2017, $1,000 in 2018, and $500 in 2019. Similarly, since 2016, TEF has received fewer requests for assistance in obtaining medical care or coverage, fewer requests for transportation services to medical facilities, and has had fewer clients requiring long-distance travel to obtain needed medical care, resulting in a decrease in TEF's expenditures. I attribute this decrease in expenditures in part to improved health of our community following the 2016 Rule. This is because when individuals are denied access to preventive and other health care, conditions worsen and become more expensive to treat. Moreover, financial difficulties are compounded if people are unable to work while ill. In such circumstances, TEF must allocate increased financial resources to helping individuals obtain basic necessities, including shelter and nutrition assistance, clothing, and personal supplies.

9. The Rule will harm the clients TEF serves in a multitude of ways. The Rollback Rule's deletion of the 2016 Rule's explicit regulatory prohibitions against discrimination on the basis of sex, the incorporation of new exemptions, and the attempt to limit insurance plans subject to the Rule will encourage discrimination against our clients for being transgender or gender non-conforming and will invite denials of gender affirming care and coverage. The Rule also will embolden discrimination against our clients who have obtained or who are seeking reproductive health care.

10. The Rollback Rule will also harm the clients we serve by weakening the 2016 Rule's protections for language access for LEP individuals. Many of the clients we serve are immigrants and people for whom English is not their first or preferred language. Our clients report that they are more likely to seek and obtain needed healthcare when they are able to communicate with providers and are aware of their rights. The removal of language access

protections in healthcare facilities and in health insurance communications will make it much more difficult for our LEP clients to obtain quality and competent care; to be aware of their rights; to know which language services are available, if any; to learn how to access such services; to understand their medical bills and challenge coverage denials; and to handle discrimination and other complaints.

11. The Rollback Rule will also make it more difficult for our clients experiencing multiple and intersecting forms of discrimination to seek redress. Rather than being able to assert claims under a single legal standard, intersectional discrimination claims will be subject to different standards, enforcement mechanisms, and remedies based on which characteristics are at issue. But many of our clients suffer discrimination because of a combination of characteristics and will have little clarity on how to seek redress under the Rollback Rule.

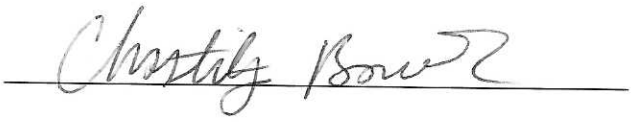
12. Since the Rollback Rule was issued, TEF has observed an increase in patients contacting us, the majority of whom have mentioned the rule or expressed concern and anxiety that the rule will lead to increased discrimination and denials of healthcare and coverage. Where appropriate, we have referred clients to healthcare facilities, including Fenway Health. Based on this influx of intakes, and based on past trends regarding the TEF's healthcare expenditures following the 2016 Rule, I anticipate that TEF will need to reallocate funds and devote more resources to financing clients' copayments for hormone replacement therapy, providing referrals for medical care and transportation to medical appointments, navigating insurance denials on behalf of their clients, and providing other financial assistance necessary for their clients' health and well-being as a result of the Rollback Rule, at a time when their funds are already strained due to the COVID-19 pandemic.

13. TEF also will need to divert resources to vet additional healthcare providers to whom it can refer clients, as already-known gender-affirming providers such as Fenway Health will be strained in their ability to meet the increased demand for services. As TEF is forced to divert more and more resources to counteract the harms the Rollback Rule will cause to our clients' health and economic security, we will risk depleting our already limited funding and may be forced to forgo providing other services critical to accomplishing its mission of supporting low-income and homeless transgender people in Massachusetts.

14. As TEF is forced to divert more and more resources to counteract the harm the Rollback Rule will cause to our clients' health and economic security, we will risk depleting our already limited funding. As a result, we may be forced to forgo providing other services critical to accomplishing our mission of supporting low-income and homeless transgender individuals in Massachusetts.

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 17, 2020



Chastity Bowick

Exhibit C

Declaration of Ivy Hill,

Community Health Program Director of Campaign for Southern Equality

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts, Plaintiffs, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-11297

Affidavit of Ivy Hill

I, Ivy Hill, swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:

1. I am the Community Health Program Director of Campaign for Southern Equality where I have served as a full time staff member since 2015. I am also the founder and executive Director of Gender Benders, an organization that runs a summer camp for transgender and non-binary Southerners where we connect our campers with medical care including Hormone Replacement Therapy, HIV testing, and mental health services. As a non-

binary and intersex person, my work to facilitate access to health care for LGBTQ Southerners is more than a job or even a passion; it is my lifeline.

2. In my role at Campaign for Southern Equality, I manage the update of *Trans in the South: A Guide to Resources and Services*, ("*Trans in the South*")[1] our training program for healthcare providers, our pop up clinics and our health related research, including the 2019 Southern LGBTQ Health Survey and *The Report of the 2018 Southern Trans Health Focus Group Project*. As such, I am very familiar with all of Campaign For Southern Equality's healthcare related work.
3. All of Campaign for Southern Equality's projects are developed directly to meet the needs expressed by our membership. Our transgender and gender non-binary members consistently raise access to affirming health care as a primary concern and obstacle to living healthy, authentic lives, particularly for those who live in rural areas where there are fewer providers.
4. Because of this, Campaign for Southern Equality launched several health-related programs and resources that dovetail with each other to increase their effectiveness. Not only do we provide a resource list of trans-affirming health care providers in the South, but we also offer free trainings to health care providers about best practices for serving transgender and non-binary patients because one of the most frequently mentioned barriers to accessing health care for our transgender members is that the vast majority of providers do not possess the basic competency to treat them with respect. Frequently, our members share experiences of harassment and embarrassment with health care providers,

[1] Ivy Gibson-Hill et al., *Trans in the South: A Guide to Resources and Services*, Third Ed., CAMPAIGN FOR SOUTHERN EQUALITY, (2019), https://southernequality.org/resources/transinthesouth/

or, having to teach their provider about trans-affirming care. In order to best meet the needs of our transgender members, we conducted our own qualitative and quantitative research on their experiences with health care, and use the results to inform our programs.

5. Since I began at Campaign for Southern Equality, I have trained over 2,000 health care providers. During my tenure I have noticed an increased request for such trainings. Patients can request training for their health care providers, or the providers can request them directly. Our training materials included, among other resources, fact sheets by the Department of Health and Human Services ("HHS") about its interpretation of 1557.I believe that this increase is due in part to the increased confusion caused by the Rollback Rule of community members and health care providers alike.
6. We began *Trans in The South* because of the apparent need of our transgender members to access affirming health care, who frequently raise the challenges of finding providers in their local hometowns. I witnessed how helpful it was when our transgender members came together and shared their experiences about different providers, positive and negative, with each other.
7. Our members nominate health care providers, including mental health clinicians, endocrinologists, and those that offer primary care and HIV care across thirteen states in the South. We in turn, vet the providers for their LGBTQ competence and gather information our members have identified as helpful including the services the provider offers, whether they provide sliding scale services, whether or not the provider provides letters in support of gender affirming care and whether they are likely to accept new patients.

8. Based upon my understanding of the Rollback Rule, including HHS's interpretation that discrimination on the basis of sex "refers to the biological binary of male and female that human beings share with other mammals," 85 Fed Reg. at 37,178, the Rollback rule will embolden health care providers to discriminate against LGBTQ patients and discourage our transgender members from seeking needed medical care. Since the Rollback Rule was announced we have received many inquiries from our members about what it means for them, many of whom have expressed fear and panic that it will greenlight discrimination by providers.

9. We know from our research that transgender people in the South already forgo needed medical care for fear of facing discriminatory treatment and harassment by providers. 25.8% of transgender respondents in our survey of LGBTQ adults in the South reported that they delay needed health care because of their transgender identity.[2] Similarly, a national survey of transgender adults found that nearly one-quarter (23%) of respondents reported that at some point in the past year they needed health care but did not seek it due to fear of being disrespected or mistreated as a transgender person. Sandy E. James, *et al*., *The Report of the 2015 U.S. Transgender Survey*, NAT'L CTR. FOR TRANSGENDER EQUALITY, 98 (Dec. 2016) ("2015 U.S. Transgender Survey").

10. Undoubtedly, the Rollback Rule will further deter transgender people from seeking care as they fear discriminatory treatment and are uncertain what protections or lack thereof it affords.

11. Such fear is well founded because we know that transgender people face rampant discrimination when trying to access health care. Participants in our focus groups for *The*

[2] Chase Harless, et al., *The Report of the 2019 Southern LGBTQ Health Survey*, 23 (2019), https://southernequality.org/wp-content/uploads/2019/11/SouthernLGBTQHealthSurvey-ExecutiveSummary.pdf.

Report of the 2018 Southern Trans Health Focus Group Project reported frequent denial of care due to religious beliefs or personal disapproval for gender diverse experience. Austin H. Johnson, et al., *The Report of the 2018 Southern Trans Health Focus Group Project*, SOUTHERN LGBTQ INITIATIVE, 6 (2018). The 2015 U.S. Transgender Survey found that one third of respondents who had seen a doctor during the previous year reported having a negative experience related to being transgender. *The 2015 U.S. Transgender Survey*, at 96.

12. Furthermore, many states in the areas we serve have introduced anti-transgender legislation, which sends the message to their transgender population that their state and local governments not only refuse to protect them but also are going out of their way to actively take steps to make healthcare even less accessible. For example, after H4716, a bill that criminalized doctors for providing medically necessary care to transgender people under the age of 18, was introduced in the South Carolina legislature earlier this year panic from transgender people and their families living in the state ensued. I witnessed this personally when I presented at conferences in the state shortly after it was introduced. HHS has made it clear that it does not consider discrimination against transgender people to be included in definition of discrimination on the basis of sex under section 1557, exacerbating our transgender members fear for their ability to access medically necessary health care without facing abuse or discriminatory treatment.
13. Unchecked discrimination has dire health outcomes for transgender Southerners. The 2015 U.S. Transgender Survey found that Twenty-two percent (22%) of respondents rated their health as “fair” or “poor,” compared with 18% of the U.S. population and thirty-nine percent (39%) of respondents were currently experiencing serious

psychological distress, nearly eight times the rate in the U.S. population (5%). *The 2015 U.S. Transgender Survey*, at 103.

14. Fear of discrimination is particularly problematic during the COVID-19 pandemic when members are much more likely to interact with healthcare providers in the event that they contract the virus or need emergency care. This is especially salient for members who live in rural areas with few health care providers and barriers to travelling longer distances because of the risks of traveling during the pandemic. If the few local providers available deny them care, members in rural areas will likely have dangerously few, to no other options.

15. Because our mission is to achieve both the legal and lived equality of LGBTQ Southerners, what affects our members, affects Campaign for Southern Equality's work. Based upon my experience updating *Trans in the South*, I anticipate that because of announcement of the Rollback Rule Campaign For Southern Equality will have to spend additional funds for our next update of it. This is because the Rollback Rule encourages health care providers to discriminate against LGBTQ patients especially in states and localities where there are no state or local protections on the basis of gender identity, as is the case with all thirteen of the states that the guide includes with the exception of Virginia. We are currently working on our fifth update of *Trans in the South* and have already received almost double the requests to vet providers to be included in our upcoming edition than the number of requests we received during the last update for the same amount of time. It is important to point out that both providers and members can request vetting. Our currently published edition provides information about 425 health care providers we screened for LGBTQ competent care. It took approximately five years

to find and vet those providers and compile the current edition. Currently, we have already received over 300 requests to vet additional providers since we published it in January of 2019, a significant increase. I believe that this increase in screening requests for providers is due in part to our transgender members' fear of discrimination in light of the Rollback Rule.

16. In response to this increase in requests, our team must screen more providers, and more thoroughly vet them, as well as re-vet those who had formerly been included in past editions. For our current update of the guide, we are adding additional questions about how providers are responding to the Rollback Rule as an additional measure to ensure the providers maintain their accessibility to transgender patients: the purpose of the guide. Campaign for Southern Equality expects we will be required to increase the budget and staffing to complete this update of the guide to meet the increased requests in fulfillment of our mission.

17. In my position I coordinate and manage Campaign for Southern Equality's pop-up clinics where we provide information to our members about different varieties of topics such as how to complete a name change, and power of attorney documents. The purpose of these clinics is to equip community members with the knowledge and resources to navigate situations that uniquely effect LGBTQ Southerners. During these clinics I speak with many members who frequently share their experiences of the challenges they face when seeking health care. Regrettably challenging experiences accessing healthcare are commonplace.

18. Transgender members often approach me at different Campaign For Southern Equality events and request help navigating health insurance denials and finding affirming

providers. I, and another staff member, frequently provide health care navigation services to our members as a result. During the past year alone, I have assisted approximately 100 transgender members total and approximately 60 met at pop-up clinics. Sometimes our assistance is limited to helping the person navigate our *Trans in the South* guide. At others, our advocacy entails referring members to our network of *pro bono* attorneys who have expertise challenging insurance denials.

19. The Rollback Rule will undoubtedly harm our members. My understanding of the Rollback Rule is that, among other things, it has changed the scope of entities that HHS says are subject to the protections of 1557. Specifically, HHS now exempts many insurers from complying with them. Numerous members of Campaign for Southern Equality have health insurance and seek gender-affirming care and live in states that have no state anti-discrimination laws on the basis of gender identity. Many rely on health insurance coverage to access medically necessary, gender-affirming care because without it the cost would be prohibitive. I know personally from assisting members to navigate health insurance coverage that insurers frequently maintain policies and practices that are discriminatory against transgender people. For example, many insurance policies contain blanket bans on any transition related care irrespective of medical necessity. Many policies deny coverage of biologically specific care because of the transgender patients' gender marker, which would otherwise be covered if the patient was cisgender. (For example, many insurers refuse coverage prostate exams for transgender women but provide coverage for the same procedure for cisgender men.) While increasing insurance companies have come begun to come into compliance with the mandates of 1557 in recent years, many still maintain such policies.

20. The Rollback Rule's exemption of many insurers is a dangerous step backwards and will prove devastating for our transgender membership. I expect it will result in an increase in insurance denials of coverage for gender affirming care and an increase in need for our advocacy. Campaign for Southern Equality is a small organization with nine full time staff members. We are currently at capacity to field such requests. In order to continue to meet the needs of our members I expect we will need to dedicate more staff and funding to this work.
21. The harm that Rollback Rule has and will continue to inflict on Campaign for Southern Equality's membership and our organization, are far from hypothetical. I know from my own experiences and from the experiences of our members the pervasive discrimination and abuse transgender people face when seeking health care and the dire consequences of it. The Rollback Rule is a direct threat to my life and well-being, my community's and to organizations like Campaign for Southern Equality we have created to fight for a chance at survival.

Dated: November 17, 2020
Asheville, North Carolina

/S/ Ivy Hill
Ivy Hill

Exhibit D

Declaration of Ellen LaPointe,

Chief Executive Office of Fenway Health

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH, TRANSGENDER EMERGENCY FUND OF MASSACHUSETTS, CALLEN-LORDE COMMUNITY HEALTH CENTER, CAMPAIGN FOR SOUTHERN EQUALITY, CRESCENTCARE, DARREN LAZOR, EQUALITY CALIFORNIA, FENWAY HEALTH, and INDIGENOUS WOMEN RISING

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services, ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services, SEEMA VERMA, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF ELLEN LAPOINTE, CEO OF FENWAY HEALTH

I, Ellen LaPointe, declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

A. Introduction

1. I am the Chief Executive Officer of Plaintiff Fenway Health. In this capacity, I am responsible for the leadership, direction and overall management of the organization. I oversee the acquisition and utilization Fenway Health's resources, including the recruitment, retention, and

motivation of a diverse, high-performing leadership team and staff. I cultivate and support collaboration, serving as Fenway's primary voice in local, regional, national and international forums. Serving as an ambassador and influencer, I work closely with external constituents and partners to advance Fenway's impact. I am responsible for cultivating and supporting collaboration across all of Fenway Health's parts, which are its federally qualified health center, The Fenway Institute, and AIDS Action.

2. Fenway Health is a federally qualified health center whose mission is to provide healthcare to the LGBTQ+ community and to all people through access to the highest quality healthcare, education, research, and advocacy. I use the term LGBTQ+ to refer to lesbian, gay, bisexual, transgender, queer, intersex, or gender-non-binary people. Fenway Health aims to increase access to care for existing and new patients and to work towards greater racial and ethnic health equity within its community.

3. A significant part of Fenway Health's patient population is LGBTQ+. About 42% of Fenway Health's patient population has a sexual orientation other than heterosexual; and about 12% of Fenway Health's patient population is transgender. Fenway Health's patient population also has limited financial resources. About 36% of Fenway Health's patient population lives at or below the federal poverty line. And, in 2019, Fenway Health served 348 patients who were homeless. Fenway Health's patient population also faces other barriers to advocating on their own behalf. For example, in 2019, Fenway Health saw 1,212 patients who were best served in a language other than English, 718 of whom made use of a translation service to communicate with staff.

4. Fenway Health serves more than 33,000 patients annually at its three locations in Boston. Patients come from all over New England and neighboring states, many travelling significant distances for care.

5. Through its telehealth program, Fenway Health also provides healthcare services to people who live outside of the New England region. In 2020 alone, Fenway Health has already served more than 12,000 patients through its telehealth program. In this manner, Fenway Health has served patients in 49 states, the District of Columbia, Puerto Rico, and various foreign countries within the past three years.

6. Fenway Health has a specific emphasis on providing healthcare services to LGBTQ+ people. Fenway Health's Transgender Health Program provides hormone therapy; mental health services; drop-in social group activities for transgender and gender non-binary people; and transgender suicide prevention programs, including a help line, a peer listening line, and anonymous referrals to therapy. Fenway Health also operates a Transgender Youth Clinic that provides gender affirming treatment for transgender and gender diverse youth under age 18, working with them to develop a treatment plan that considers both the goals of treatment and any care needs based on age, development, medical and mental health conditions; a Transgender Health Research Program that conducts ground-breaking research to improve the health and well-being of transgender people everywhere; a support group for transgender and gender non-binary people; and drop-in consultations for parents and guardians of transgender and non-binary young people.

7. Fenway Health also works closely with Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY). In partnership with Fenway Health, BAGLY operates The Clinic @ BAGLY, which provides screening for sexually transmitted infections; sexual healthcare

through peer health education and a nurse; and referrals for primary healthcare, mental healthcare, and health insurance enrollment. The Clinic @ BAGLY provides this important array of clinical services free of cost for LGBTQ+ people ages 29 and younger and does not require proof of insurance or identification.

8. Fenway Health also operates a number of programs focusing on research, training, education, and policy development. These programs develop clinical techniques, training materials, and model policies, as well as providing training and technical assistance to health centers and HIV care providers across the nation in order to optimize access to quality healthcare for LGBTQ+ populations and people living with HIV.

B. HHS Rulemaking

9. I am aware that the United States Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act on June 14, 2019. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule"). In response to the 2019 Proposed Rule, Fenway Health, via the Fenway Institute, submitted a Comment Letter to HHS. *See* The Fenway Institute, Comment Letter on 2019 Proposed Rule (Aug. 13, 2019), https://bit.ly/3dWDa6t. The Comment Letter was written on behalf of a group of health care providers, policy advocates and elected officials, and expressed well-founded opposition to the 2019 Proposed Rule. For example, the Comment Letter noted that "[t]he proposed removal of [sexual orientation and gender identity] nondiscrimination provisions from [] regulations governing Medicaid enrollment and services, state and federal health insurance exchanges, insurance coverage, Qualified Health Plans, and PACE Program would hurt LGBT people who have disproportionately benefited from many of these programs."

10. It is my understanding that on June 19, 2020, HHS published a final rule that adopts, with only minor or technical alterations, the entirety of the 2019 Proposed Rule. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that Fenway Health and thousands of other commenters raised.

C. The Rollback Rule Will Embolden an Atmosphere of Discrimination Against our Patients

11. The Rollback Rule will embolden an atmosphere of discrimination against our patients. The Rollback Rule will also cause fear among Fenway Health's patient population that the historical discrimination in access to healthcare services and health insurance coverage will be exacerbated.

12. Many LGBTQ+ patients at Fenway Health have historically been refused medical care by other providers, including routine care unrelated to gender dysphoria, simply because they are LGBTQ+. Such discrimination has been reported to Fenway providers and staff members on countless occasions over the last 4 years. These experiences are consistent with the results of Project VOICE, a survey published in 2013 by the Fenway Institute at Fenway Health and the Massachusetts Transgender Political Coalition, exploring the health and wellbeing of transgender people in Massachusetts. *See* Reiner, S.J., et al., Discrimination and Health in Massachusetts: A Statewide Survey of Transgender and Gender Nonconforming Adults (July 2014), https://bit.ly/2O5Bb55. The Project VOICE study found that 24% of 452 transgender Massachusetts residents surveyed reported discrimination in healthcare settings. Of those reporting discrimination in health care, 19% did not seek care when they were sick or injured after that experience of discrimination, and 24% did not seek subsequent preventive or routine care. Those

who reported experiencing public-accommodations discrimination were nearly twice as likely as those who did not report experiencing such discrimination to report negative emotional and physical symptoms, such as headache, pounding heart, feeling sad and feeling frustrated.

13. I am aware that many Fenway Health patients have encountered health care providers hostile to or unaccepting of LGBTQ+ patients and people seeking reproductive health care. For example, many patients have come to Fenway Health for alternative insemination (AI) services due to being discriminated against in other AI settings. Such discrimination and fear of discrimination has led some Fenway patients to seek out non-discriminatory care with us despite living outside of Massachusetts.

14. Additionally, I am aware that many Fenway Health patients have been denied translation services in other health care settings, despite the patient's right to access health care in their preferred language.

15. Health care providers who have practiced discrimination in the past will be emboldened by the Rollback Rule. By repealing HHS's prior interpretation of "on the basis of sex," the Rollback Rule lends support to health care providers, insurers and institutional actors who are fundamentally opposed to serving Fenway's patients in a non-discriminatory manner. Such individuals and entities will use the Rollback Rule to discriminate against Fenway patients on the basis of their sexual orientation and gender identity, on the basis of who our patients associate with, and on the basis of having previously sought pregnancy-related services. For example, Franciscan Alliance, a Catholic healthcare provider that operates in states where our patients live, declared that their organization "employs physicians who offer endocrinology hormone services, hysterectomies, mastectomies, and psychiatric support. The [2016] Rule would force Franciscan to offer these services as part of a medical transition, which would violate both

Franciscan's best medical judgment and its religious beliefs." Appendix to Plaintiffs' Brief in Support of Their Motion for Partial Summary Judgment or, in the Alternative, Preliminary Injunction at App.9, Franciscan Alliance, Inc. v. Price, No. 7:16-cv-00108-O, 2017 WL 3616652, (N.D. Tex. Aug 23, 2016). My interpretation of this statement is that Franciscan Alliance providers feel free to deny gender affirming care in the absence of the definitional protections of the 2016 Rule, forcing their patients to seek out more accommodating providers, such as Fenway Health. In my view, other healthcare providers are likely to behave in a similar manner to Franciscan Alliance. In order to make itself accessible to such patients in distantly located places, Fenway Health operates a telehealth practice.

16. The discrimination occasioned by the Rollback Rule will also limit access to care for Fenway's patients. More than one in seven people in the U.S. receive their healthcare from Catholic hospitals, which are governed by the Ethical and Religious Directives for Catholic Healthcare Services ("directives"). American Hospital Association, Annual Survey (2018). These directives are known to discriminate against people for seeking pregnancy-related care, including but not limited to miscarriage management and pregnancy termination, as well as sterilization procedures to treat gender dysphoria. It is the belief of our patients and staff that Catholic-affiliated providers continue to discriminate against transgender people, despite Massachusetts antidiscrimination law. In the greater Boston area, there are nearly 70 Catholic hospitals or medical centers. Archdiocese of Boston, 2020 Hospital Directory, https://bit.ly/3o4ixM0. St. Joseph Health, a Catholic healthcare affiliate with locations across the country, including in states where our telehealth patients live, generally provides sterilization services, but cancelled the scheduled sterilization of a transgender patient minutes before it was to occur, based on an "ethics assessment" conducted by a reverend with no medical training. Knight v. St. Joseph, Case No.

DR190259 (Mar. 21, 2019). Our patients that encounter such providers in their home state may receive care that worsens existing conditions, including trauma related to gender dysphoria, may be denied care, or may avoid seeking necessary care until they are able to access a provider that does not discriminate.

17. It is likely that some of our patient's health insurers will understand the Rollback Rule to mean that they are no longer constrained from offering plans that categorically exclude gender-affirming care or other sex-based treatments that HHS incorrectly asserts to be exempt from Section 1557's scope. This will exacerbate the existing issue that, nationally, one-quarter of transgender people report having issues with their insurance in the past year related to being transgender. 2015 Transgender Survey, National Center for Transgender Equality, https://bit.ly/2T8jYe6. I am familiar with the case of Boyden v. Conlin, which illustrates the impact of the Rollback Rule on insurance coverage. Officials in charge of a Wisconsin state health insurance plan voted to cover gender confirming surgery because they believed that the 2016 Rule compelled it. However, once they heard this Rule would be challenged in the Franciscan Alliance case, they prepared to reinstate the exclusion, based on "the belief that the Texas court's entry of an injunction absolved defendants of any legal obligation to provide coverage." Boyden v. Conlin, 341 F. Supp. 3d 979, *1002 (W.D. Wis. 2018). It is the belief of our patients and staff that some insurers will react in a similar manner, and continue to discriminate against transgender people, putting our patients' health at risk.

18. Insufficient insurance coverage and fear of discrimination due to the Rollback Rule will worsen health outcomes in our patient population, which is already disproportionately bearing the burden of health disparities. *See* 2015 Transgender Survey, *supra*. Fenway Health providers believe that delaying or forgoing necessary medical care has been shown to inhibit the return to

excellent or very good health, and to lower quality-of-life scores. There is evidence that this already happens: "In the past year, 23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 33% did not see a doctor because of cost." 2015 Transgender Survey, *supra*. Our patients' near-term and long-term health will suffer as a result of the Rollback Rule.

19. The Rollback Rule creates confusion for insured patients around what services and protections they are entitled to under their health insurance plan. For example, patients are not likely to adequately understand the nondiscrimination protections available to them regarding their insurance coverage. Since the Rollback Rule was published in the Federal Register, some Fenway Health patients have expressed concerns and confusion over whether their insurance providers must still comply with federal nondiscrimination protections or not. The regulatory changes around covered entities and notice requirements will harm our patients by leading them to believe they do not have the protections guaranteed by the law.

20. Limited-English proficient (LEP) patients in particular stand to have difficulty understanding the language access resources available to them regarding their insurance coverage. Some of our patients request such interpretation after reading signs posted at the entrances to and at other locations throughout our facilities. Knowledge of the availability of these services is an important part of ensuring limited English proficient patients can make informed decisions about their care and exercise their rights within our facilities. The regulatory changes eliminating tagline requirements on significant communications with third-party payors will harm our patients by decreasing knowledge of interpretation services for information directly related to their health care coverage and to the nondiscrimination protections that their third-party payor is required to provide.

C. The Rollback Rule Will Cause Fenway Health to Divert Crucial Resources

1. *The Rollback Rule will require Fenway Health to expend resources to meet an increased demand for services*

21. The Rollback Rule will cause both more discrimination against patients and increase patient fears of being discriminated against. As a result, and because of our longstanding reputation as leading providers of health care services to the LGBTQ+ community, Fenway Health expects to experience increased strain on our resources and capacity, caused by affected individuals seeking out a health care setting that is self-determined to be free from discrimination.

22. Access to care obstacles, underinsurance, and fear of discrimination will push patients to delay access to medical care, leading to a patient population at Fenway Health with more acute conditions. As noted above, patients who experience discriminatory healthcare are more likely to delay or forgo care for both minor and serious conditions. Acute conditions are less responsive to treatment and sometimes are no longer treatable; it is also costlier to provide health care at advanced stages of illness, as opposed to preventive care. This increase in acute conditions will strain Fenway Health's resources and increase the costs of care provision. Additionally, this delay stands to worsen community health outcomes in the populations we serve, which conflicts with a central goal of the Fenway Health mission.

23. In addition to discrimination from providers, the Rollback Rule will also negatively affect the ability of patients of Fenway Health to pay for healthcare services. In particular, the Rollback Rule's provisions regarding health insurance plans will cause those patients to experience significantly less advantageous third-party reimbursement for the health care services that they need. Likewise, some third-party payors with whom Fenway Health interacts will understand the Rollback Rule to allow them to offer plans that discriminate in their benefit design. These regulatory changes directly harm Fenway Health's patients, and the pool of potential patients that

Fenway Health draws from, by diminishing the scope of third-party reimbursement available to us for necessary health care.

24. The Rollback Rule will also cause Fenway Health to lose revenue. Fenway Health provides healthcare, including gender affirming care, regardless of insurance status and regardless of ability to pay. As an FQHC that receives funding from the Health Resources & Services Administration ("HRSA"), Fenway is beholden to federally defined obligations to remain eligible for such funding. One of these obligations is that Fenway Health is required to reduce or waive fees for patients who are unable to pay. Fenway Health will continue to provide services to patients regardless of ability to pay; increased patient demand for our services, or limitations on the reimbursement available to us will therefore injure Fenway Health.

25. Fenway Health currently generates about 73% of its operating revenue from insurer reimbursement for patient services. Of that insurer reimbursement, 78% comes from commercial insurers, some of which are subject to limited or no state regulation. Because some of the patients seeking out Fenway Health to avoid discrimination from other providers will be uninsured or underinsured, Fenway Health will be obligated to provide an increased quantity of uncompensated or undercompensated care. This problem will be exacerbated when insurance providers interpret the Rollback Rule to permit exclusions for gender affirming care, which Fenway Health is known to provide.

26. Where insurance plans impose categorical exclusions on gender-affirming care or other sex-based treatment that HHS incorrectly asserts to be exempt from Section 1557's scope, Fenway Health will be faced with significantly less advantageous third-party reimbursement for the medically necessary healthcare services that it provides. Not only does this decrease the amount of revenue reimbursed for services, but Fenway Health will also need to expend resources and

administrative time to understand, apply, and appeal associated coverage decisions. In the wake of the new Rule, Fenway Health will expend more resources and staff time to understand confusing new coverage policies, apply for coverage and make coverage appeals.

27. The Rollback Rule will also likely cause Fenway Health financial harm through an increase in non-reimbursable costs. Fenway Health provides patient navigation services to its patients, including insurance verification, financial assistance, and Medicaid enrollment assistance. An increase in patient volume, whether insured or uninsured, will lead to an increased demand in non-medical services, including patient navigation. Such services cannot be billed to insurance. An increased demand for these services will lead to an increase in non-reimbursable costs.

28. The Rollback Rule will require Fenway Health to dedicate additional resources to helping patients with limited English proficiency understand significant communications from third-party payors. For example, many third-party payors will stop including taglines in significant communications to members, because they no longer believe themselves to be subject to Section 1557 enforcement and because of the elimination of tagline requirements for covered entities. For instance, Harvard Pilgrim, which provides insurance plans and services to more than 3 million people in New England and beyond, commented on the proposed Rollback Rule that they supported the elimination of the taglines requirement and understood this exemption to apply to health benefit plans. The Rollback Rule followed through on this recommendation and codified the elimination of the tagline requirement. Harvard Pilgrim and other third-party payors are now exempted from providing this resource to LEP patients. Some of our patients bring in insurance documents to our facilities to better understand the implication of such documents and for questions related to their benefits and health care rights. The regulatory changes eliminating tagline

requirements on significant communications with third-party payors will harm Fenway Health by straining the resources we dedicate to providing interpretative services.

29. Furthermore, the COVID-19 pandemic has strained the resources and structure of Fenway Health, as our staff have restructured our service delivery and been forced to quickly expand our telehealth offerings. Expanding services to meet the need of patients who are discriminated against or fear discrimination is exceptionally difficult in this moment because of COVID-19's stress on our operations.

2. *The Rollback Rule forces Fenway Health to expend resources to make operational changes*

30. The Rollback Rule will also put a strain on Fenway Health's training and education programs. Fenway Health will revise its training curricula to address the confusion about the requirements of federal law under the Rollback Rule. The Rollback Rule will cause Fenway Health to expend resources associated with revising staff training curricula to address the confusion about the requirements of federal law.

31. The Rollback Rule will cause Fenway Health to expend resources associated with our responsibility to our patient community. For example, shortly after the Proposed Rollback Rule was issued, the Fenway Institute invested time and resources necessary to publish a report describing the impact of the proposal on our patient population and the broader community. It is available here:

https://fenwayhealth.org/wp-content/uploads/TFIP_31_Section1557_brief_final_web.pdf.

32. Fenway staff have invested time and resources researching the impact of the Rollback Rule. On August 7, 2019, we held a community education forum to help our patients understand the impact of the Rollback Rule, which roughly two-dozen people attended. A video from the community forum is available here: https://www.youtube.com/watch?v=bey9ojtnzrE.

33. The Rollback Rule will put a strain on Fenway Health's resources and operations dedicated to helping patients navigate and understand health insurance coverage. For example, many of Fenway Health patients' third-party payors will stop sending nondiscrimination notices to members in significant communications, because the payors no longer believe themselves to be subject to Section 1557 enforcement and because of the elimination of notice requirements for covered entities. Many of Fenway Health's patients have experienced discrimination when seeking coverage of medically necessary health care services and when interacting with third-party payors on other issues. Some of our patients work with Fenway Health patient navigators to facilitate or lead these sensitive conversations, particularly where patients can expect discriminatory treatment. The regulatory changes around covered entities and notice requirements will thus add strain to Fenway Health's resources dedicated to patient navigation.

34. Based on the atmosphere of emboldened discrimination described above, the Rollback Rule will impair Fenway Health's ability to provide appropriate referrals to our LGBTQ+ patients. Without the protections of the 2016 Rule, we won't be able to assure patients that they will receive non-discriminatory care without deep investigation into the practices of any given provider or health system. This is especially problematic for our patients who require care from a specialist and live out-of-state and may be subject to discrimination and denial of care.

3. *There are no supplemental resources available to alleviate Fenway Health's injury.*

35. Fenway Health has finite financial resources to dedicate to its healthcare services, and it does not anticipate an increase in funding that will match the increase in need for services. Our funding streams do not rapidly account for increases in uncompensated services and will not offset expected cost increases in a timely manner. For example, federal funding from HRSA will very likely not offset the costs associated with a rapid increase in demand and a decrease in covered

services. Fenway Health's annual HRSA grants are not immediately increased based on an increased patient population. As an FQHC, Fenway Health is also eligible for the Community Health Center Fund ("CHCF"), which provides supplemental federal grants to respond to emerging priorities. While the amount of CHCF funding Fenway Health receives generally depends on patient volume, the funding calculation is not based on current patient volume. For example, COVID-19 supplemental funding provided in the Spring of 2020 was calculated using Fenway Health's 2018 patient volume. A rapid increase in patient volume will not be accounted for immediately through federal funding, and thus will not offset Fenway Health's expected cost increase.

Dated: November 17, 2020 at Boston, Massachusetts.

/s/ Ellen LaPointe
Ellen LaPointe
Chief Executive Officer
Fenway Health

Exhibit E

Declaration of Darren Lazor,

Member of Equality California

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF DARREN LAZOR

I, Darren Lazor, declare as follows:

1. I am 35 years old. I live at 1108 Glencove Commons, Brunswick, Ohio 44212.

And I am a transgender man.

Past Experience of Discrimination in Healthcare

2. I have experienced sex discrimination—specifically discrimination based on my gender identity—in healthcare. I first experienced discrimination in healthcare as a child. I remember one experience where a physician commented on the fact that I was wearing boys' underwear even though my medical chart said that I was a girl. That experience made me feel uncomfortable visiting the doctor's office.

3. As an adult, I have experienced a similar type—but a more severe form—of sex discrimination related to my gender identity. For example, I experienced discrimination when I sought treatment for issues I was having with my reproductive organs. Starting in 2012, I sought treatment for heavy, frequent, and severely painful menstruation. I did not have a primary care physician at that time, so I visited my mother's primary care physician who conducted blood tests and an ultrasound, discovered that I was borderline anemic, and provided me with a referral to see an obstetrician-gynegologist (OG-GYN) at the same hospital. But I was subsequently denied treatment on three successive occasions when I tried to address my symptoms.

4. First, I made an appointment with the OB-GYN referred by mother's doctor. But when I saw the doctor, he refused to examine me or review my symptoms. He told me that although a hysterectomy can be a treatment option for a person with my symptoms, "I will never perform a hysterectomy on a young woman." That statement both misgendered me and declared that a treatment option was not available to me simply because of my physician's biases about my gender identity. I did not accept treatment

from that first OB-GYN and continued to search for care.

5. I made an appointment with a second OB-GYN at a new hospital. About a week to ten days before this appointment, a receptionist at the hospital called me and said that this doctor did not want to see me and thought it best if I found another OB-GYN.

6. I then made an appointment with a third OB-GYN at the the same hospital as the previous one. Before the appointment, I received a message asking me to call the doctor's office. When I did, that doctor told me that the second OB-GYN, the one who had previously canceled the appointment with me, was a "close friend." The third OB-GYN also mentioned that she knew I had been treated for gender dysphoria. However, I had never told either doctor that I had been treated for gender dysphoria. Nor had either doctor diagnosed me with that condition. This leads me to believe that both doctors had made assumptions about me, my symptoms, and my treatment that were not based on discussions that they had actually had with me. Finally, the third OB-GYN also told me that, although she was willing to treat me, she would not be willing to perform a hysterectomy to resolve my symptoms. I felt that, in saying that she would not be willing to perform a hysterectomy without having met me, examined me, or heard me describe my symptoms, she was indicating that she would not treat me as she would treat any other patient. I cancelled my appointment with that third OB-GYN.

7. Finally, the fourth OB-GYN I visited was willing to treat me without discrimination and took my symptoms seriously. But in order to find this physician, I needed to seek care at a medical facility that is further away from my home than the hospitals where I had initially sought care. That fourth OB-GYN diagnosed me with

endometriosis and suggested a hysterectomy as a treatment option. I agreed to that treatment plan. During the hysterectomy surgery, the fourth OB-GYN also discovered a large cyst on one of my ovaries. The ovarian cyst contained a liter of fluid and caused me problems with my urinary tract, leading me to occasionally lose control of my bladder. That cyst should have been identified in the first ultrasound that I received with my first physician—my mother's primary care doctor—but it was not. The fourth OB-GYN's diagnosis of endometriosis and discovery of a large ovarian cyst further confirmed my view that the previous physicians had discriminated against me based on my gender identity and denied me medically appropriate care based on my gender identity.

8. I know that the hospital where I experienced discrimination from the second and third OB-GYNs has a policy against discrimination on the basis of gender identity. However, it is clear to me that the hospital has failed to provide the requisite training and culture to ensure that transgender individuals receive nondiscriminatory care. I believe that discrimination at that hospital will only worsen if federal law no longer unambiguously requires the hospital to maintain its nondiscrimination policy.

9. I also experienced discrimination related to my gender identity when I sought treatment for a recurring health problem that causes shortness of breath and that has required me to seek emergency, life-saving care. When I first experienced this problem in 2006 or 2007, I did receive adequate treatment for it. The physician who treated me at that time believed that my symptoms were caused by an autoimmune issue. The physician treated me with antibiotics, and my symptoms resolved.

10. However, when I experienced a recurrence of these symptoms in December 2017,

I did not received adequate care because hospital staff discriminated against me on the basis of my gender identity. When I began experiencing shortness of breath, I went to the emergency room closest to my home. While I was there, the hospital staff discriminated against me in several ways. First, the doctor asked me when my last menstrual period was and if there was a possibility that I might be pregnant even though my transition was complete at that point and my driver's license identified me as a man. Second, the hospital staff misgendered me on the hospital bracelet as a female. Third, the physician's assistant expressed disgust when preparing me to take an EKG; his facial expressions spoke volumes as it appeared he was disgusted by my mastectomy scars. The physician's assistant also refused to remove the EKG stickers from my chest after the EKG. It appeared that the physician's assistant would not remove the stickers because the physician's assistant did not want to touch me. Fourth, the hospital staff left me unmonitored and waiting for assistance for a significant period of time. My repeated attempts to call a nurse by pressing the call button went unanswered. And finally, the physician told me "we don't know how to treat you," then sent me away without any diagnosis or treatment plan. I was forced to deal with my symptoms on my own. During that time, I suffered from both physical and mental distress. But, fortunately, my symptoms resolved after several weeks.

11. In December of 2017 or January of 2018, I filed a complaint about this discrimination through the hospital's internal grievance process. In that complaint, I described the December 2017 experience, and how the hospital staff had discriminated against me on the basis of my gender identity and had ultimately denied me care. I

received a letter from the hospital in response acknowledging the existence of my complaint. But the letter did not indicate that the hospital had taken any action to reprimand the medical staff that discriminated against me, or to educate them about discrimination.

12. I have forgone health care for shortness of breath due to fear of further discrimination. For example, in 2019, I experienced another episode of extreme shortness of breath. I refused to call (and refused to permit others to call) an ambulance when I needed emergency treatment. I knew that the closest emergency room was associated with a hospital where I had previously experienced discrimination in December 2017. And I had no family members or friends available to drive me to a hospital further away. Instead of calling an ambulance, I decided to attempt to treat myself. I knew that this self-treatment would be less effective than medical treatment, but I also believed that I would not receive adequate medical treatment if I returned to the hospital where I had previously been denied treatment and faced discrimination.

Fear of Future Discrimination Due to the Rule

13. I understand that the Department of Health and Human Services has published a new rule that attempts to rescind critical protections against discrimination for the LGBTQ community, in the health care setting. I believe that this Rule's rescission threatens my health, my safety, and my life, as well as the health and safety of others.

14. Like all people, I may experience a medical emergency. Unfortunately, the hospital at which I have previously been discriminated against and at which I have been denied treatment is the hospital that has an emergency room closest to my home. For that

reason, if I ever experience an emergency, I would not call an ambulance. An ambulance would take me to the closet emergency room, and because I was discriminated against and denied care the last time I was there, I believe that I would not receive appropriate treatment if I were to return to that hospital. I have refused to call an ambulance on this basis in the past, and I would do so again. Instead, I would ask a friend or family member to drive me to an emergency room that is further way and that is associated with a hospital where I have not experienced discrimination. I do fear, though, that traveling this longer distance may be the difference between life and death in an emergency situation.

15. I also have health insurance needs related to my transgender identity, which the Rule also puts at risk. I have had many different types of insurance plans, including employer-sponsored plans and plans that I have found on the online exchange. I need bi-yearly doctor's visits and yearly bloodwork to keep receiving the hormone treatments that are part of my gender-affirming care. I have always used insurance to pay for those doctor's visits and that bloodwork. Because the Rule has created a lack of clarity around discrimination protections, I am also afraid that my health care insurer may deny me access to the care that I need.

16. The Rule has also amplified my fear and anxiety about contracting COVID-19. I have recurring health issues with shortness of breath. I believe those recurring issues put me at further risk for contracting COVID-19. Because of the Rule, I am afraid that health care providers may either refuse to treat me or provide me with incomplete care on account of my being transgender, which could ultimately lead to severe health

consequences or even my death. This denial of care would also put others at risk, since if undiagnosed, a respiratory illness or highly infectious disease poses a danger to the population as a whole.

17. The Rule further harms me by eliminating my previous ability to seek recourse for any discrimination or mistreatment I receive from health care providers or insurers on account of my gender identity. I have filed a complaint about mistreatment in the past, and I would do so again in the future if I thought that it would help me or others receive better care in the future.

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 17, 2020

Darren Lazor

Exhibit F

Declaration of Rachael Lorenzo,

Co-founder of Indigenous Women Rising

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts, Plaintiffs, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-11297

DECLARATION OF RACHAEL LORENZO,
CO-FOUNDER AND ABORTION ACCESS LEAD, INDIGENOUS WOMEN RISING

I, Rachael Lorenzo, declare as follows:

1. I am a co-founder of Indigenous Women Rising (IWR), a Native-led and Native-centered reproductive justice collective that uplifts Indigenous-led community organizing and ensures reproductive justice movements are inclusive of Indigenous people and families. Our

mission is to honor Native & Indigenous People's inherent right to equitable and culturally safe health options through accessible health education, resources, and advocacy.

2. I am Mescalero Apache/Laguna Pueblo/Xicana, born in Las Cruces, New Mexico, and raised on my father's ancestral land in Laguna, New Mexico. I attended the University of New Mexico, where I graduated with a bachelor's degree in political science and a master's degree in public administration, focusing on public health. Currently, I serve as Assistant Commissioner of Engagement and Tribal Liaison at the New Mexico State Land Office and Chair of the Board of Directors for the YWCA-New Mexico in addition to my role as Co-Founder and Abortion Access Lead of IWR. I am a queer parent of two and live in Albuquerque, New Mexico.

3. I helped start IWR in 2014 as a campaign to bring attention to the fact that Indigenous people who can become pregnant and who rely on the United States Indian Health Service (IHS) for health care were being denied access to emergency contraception. Now, IWR has expanded to provide broader support for Indigenous people in accessing health care, focusing in particular on abortion care, midwifery care, and sex education. IWR also provides education for Indigenous people, including information about abortion, access to reproductive health care and lactation support, and most recently the COVID-19 care packages.

4. IWR's Abortion Fund is open to all Indigenous people in the United States and Canada who have the capacity to become pregnant and are seeking an abortion in the United States. IWR's Abortion Fund helps Indigenous people pay for abortion care by paying clinics for a portion of the procedure and by providing our clients the necessary funds to cover lodging, gas, food, childcare, and other related travel expenses. The Abortion Fund also provides critical information about pregnancy options and abortion care to clients that often is not provided by either IHS or

other health care providers and hospitals upon which IWR's clients rely. To date, the Abortion Fund has served 172 clients (including repeated clients).

5. The Abortion Fund's work is critical because health insurance in the United States often fails to include coverage for abortion, making abortion care unaffordable and inaccessible for many. This is particularly true for Native people, the vast majority of whom rely upon IHS for their health care. IHS is subject to the Hyde Amendment, which prohibits certain federal funds, including funding for IHS, from being used to pay for an abortion except in the case of incest, rape, or life endangerment. Historically, however, most IHS facilities have failed to provide or refer for *any* abortion care, even in these limited permitted circumstances.[1] Notably, many Native people obtain insurance in addition to their IHS benefits, such as Medicaid or a qualified health plan offered through the Affordable Care Act marketplaces, because of the limitations on services available through IHS. However, because of the Hyde Amendment's application to other health coverage programs, state laws that prohibit insurance coverage of abortion in private and marketplace plans, and other barriers put in place for private issuers, coverage of abortion care is often non-existent. IWR's Abortion Fund clients often also look to us to explain their pregnancy options and what to expect when obtaining abortion care, as they generally do not receive this information from their own providers at IHS facilities. We have to provide basic education about abortion care to about three-quarters of our clients. Thus, Native pregnant people must turn to IWR both to be able to afford abortion care and to learn how to access abortion care.

6. While our Abortion Fund clients come from Indigenous communities or tribes all over the United States, about half of the clients we serve identify as Diné or Navajo. And while we provide funding at clinics across the country, most of the clients we serve receive care in clinics

[1] *See* Shaye Beverly Arnold, *Reproductive Rights Denied: The Hyde Amendment and Access to Abortion for Native American Women Using Indian Health Service Facilities*, 104 Am. J. Pub. Health 1892, 1892 (2014).

in Phoenix, Arizona; Fargo, North Dakota; and Albuquerque, New Mexico. Approximately one-fifth of our clients require abortion care towards the second half of their second trimester or in their third trimester, but there are very few providers who are able to provide abortion care later in pregnancy. In particular, our clients seeking abortion care at or after 24 weeks generally must travel to Colorado or New Mexico to obtain the care they need. Yet patients who require abortion care later in pregnancy are also those who are at greater risk of experiencing emergency pregnancy complications, rendering such travel a danger to their health and lives.

7. Most of the IWR Abortion Fund's clients have limited financial resources and are either uninsured or lack insurance coverage of abortion. Moreover, many of our clients come from traditional Native communities and live in rural Native lands. These clients are oftentimes represented by an elder for whom English is not their first language. In our communities, it is common for grandparents to raise grandchildren. In part, community elders and grandparents assume this responsibility because they are the keepers of our cultural knowledge, traditional language, and spiritual wisdom. But grandparents have also been forced into this role by federal policy and colonization causing generational trauma that manifests in parents as substance abuse, unemployment, incarceration, teen parenting, abandonment, and serious illnesses.[2] And yet Native elders face their own inequalities: Native grandparent caregivers are more likely to be female, live on a reservation, speak little or no English, not participate in the labor force, not have a college degree, and have many people living in the household.[3] As a result, we often have grandparents calling on behalf of their grandchildren, who are usually minors. Some of these families are so far

[2] *See* Lisa Byers, *Native American Grandmothers: Cultural Tradition and Contemporary Necessity*, 19 J. Ethic & Cultural Diversity in Social Work 305 309-10 (2010); Suzanne L. Cross, Mich. St. Univ. Sch. Social Work, American Indian Grandparents Parenting Their Grandchildren in Michigan: A Qualitative Study Report 1, 3 (March 2005).
[3] Byers, *supra*, at 310.

removed geographically that they may be six or seven hours from the nearest city and might not even have running water. About half of our Abortion Fund clients are driving distances from over 2 hours to about 10 hours to get to their appointment, especially our clients in North Dakota and South Dakota who must travel to Fargo for care. These geographic, linguistic, and financial limitations make it very difficult for our clients to access the care that they need.

8. Several of our Abortion Fund clients indicate that they will be alone when obtaining abortion care or do not have anyone at home or in their communities that will support them in accessing abortion care, which shows the stigma we are working against and how critical it is for us to provide support for our clients in a sensitive way. Moreover, many of our Abortion Fund clients indicate to us that it is not safe for us to leave a voicemail identifying who we are because of domestic violence or stalking. We routinely ask our clients whether they have access to mental health care and provide resources to assist them in accessing such care, because we know our clients may be experiencing post-traumatic stress disorder, abuse, or depression. We research mental health providers in their area, including whether the provider takes insurance, offers services on a sliding scale, or has ever seen Indigenous patients, and we provide that information to clients who need assistance. Some of our Abortion Fund clients are transgender or gender nonconforming and have specifically sought our help in obtaining mental health services that are sensitive to the needs of transgender and gender nonconforming people. It is very difficult for transgender or gender nonconforming Native people to find health care providers who are willing to listen to us and provide care that is gender affirming.

9. Not only do our clients face stigma in accessing abortion care, they also fear discrimination by health care providers at IHS facilities or at non-IHS hospitals. Abortion care is extraordinarily safe, but it is protocol for abortion providers to instruct patients to go to an

emergency room in the unlikely event they experience uncommon bleeding following a procedure. And in some circumstances, clients will seek follow up care to confirm termination of their pregnancies after obtaining a medication abortion. Clients have expressed fear that they will be discriminated against for having had an abortion if they visit a hospital or IHS facility. People ask: "if I need to go to the hospital, will they need to know that I have had an abortion?" This fear of discrimination may cause clients to either withhold information about their health or to forgo care altogether, with potentially devastating consequences.

10. IWR's Midwifery Fund was launched in May 2020 to help Indigenous people in New Mexico access quality, culturally competent pregnancy-related care by providing families with up to $10,000 to help pay for midwifery care, doula care, and related supplies. We also help to match families with a midwife that will best suit their needs, and we are currently in the process of compiling a referral network of midwives and doulas that will contain a host of information critical to our clients seeking care, including what kind of insurance they take, their fee, their experience working with Indigenous people, whether they travel, their policies around different spiritual beliefs, and other information that will be useful for Native people in obtaining nondiscriminatory, high quality, and culturally sensitive pregnancy-related care. We carefully screen the midwives and doulas in our network through a detailed intake form to ensure that they will provide nondiscriminatory, culturally competent care. Although the Midwifery Fund is a new program, we have also already raised enough funding to support three families, and we are currently providing one family with support.

11. The Midwifery Fund was established as a response to longstanding and pervasive discrimination against Indigenous people who can become pregnant seeking care related to pregnancy and reproductive health, as I will discuss more fully below. Birth attendants such as

midwives and doulas can function as a safeguard against discrimination based on both sex and race, such as the discrimination recently experienced by Native pregnant people in New Mexico who were racially profiled in the delivery room and had their newborns separated from them, discussed in greater detail below.[4] The Midwifery Fund was created out of an emergency need to help Indigenous people access quality pregnancy-related care.

12. Our sex education program, "NDN Sex Ed," engages with Native families, schools, agencies, and other entities to provide sexual education that is culturally competent and meets the State of New Mexico standards. We are also launching a texting hotline for our Native communities to ask questions about sex and bodies that they may not feel comfortable asking a family member or health care provider. Our sex education curriculum is inclusive of grandparents and any caretaker who might have trouble talking with the young person in their life about sex. Over the last two years, we have served approximately 3,000 people as we have traveled across New Mexico and the country to provide sexual health education and harm reduction products like condoms and dental dams.

13. Recently, we launched our COVID-19 care packages program. These packages contain masks, menstrual supplies, diapers, basic hygiene supplies, lactation support, sexual health items, education on bodily autonomy, and other necessities. So far, over 4,000 people from around the United States and Canada have applied for our care packages. We have been able to serve 443 to date and hope to complete these applications by the end of January 2021.

14. IWR is funded through individual donations and foundational grants. We do not receive funding from either the state of New Mexico or the federal government. Most of the

[4] Bryant Furlow, A Hospital's Secret Coronavirus Policy Separated Native American Mothers From Their Newborns, ProPublica (June 13, 2020), https://www.propublica.org/article/a-hospitals-secret-coronavirus-policy-separated-native-american-mothers-from-their-newborns.

funding we receive is unrestricted and may be reallocated to meet demand. For example, due to the COVID-19 pandemic, we have had to reallocate funding towards COVID relief efforts, including shipping COVID relief care packages. This has put a strain on our staff capacity.

15. We anticipate that we will need to deplete our already limited funding to address the increased strain on the Abortion Fund and Midwifery Fund that will occur as a result of increased discrimination and denials of reproductive health care and coverage under the Rule "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 85 Fed. Reg. 37,160 (June 19, 2020) (the "Rollback Rule"). Given IWR's limited budget and the existing strain on our resources, we may be forced to forgo providing other services critical to accomplishing our mission of supporting the health of Native communities in New Mexico and nationwide, such as our sexual and political education efforts.

Discrimination Against Native People Who Can Become Pregnant

16. Throughout the process of colonization, a period of 500 years and counting, Native people who can become pregnant have collectively experienced generational and individual trauma. These acts have come in many forms, including assault, rape, forced sterilization, poverty, assimilation, objectification, exploitation, murder, and everything in between.

17. This country has a long and dark history of relying on paternalistic, sexist, and racist beliefs to control Native populations. Reproductive justice is about the right to control your body, to have children or not have children, and to be able to parent the children you have in a way that makes sense economically, socially, politically, and culturally. But Native people have often been denied this fundamental right. In the late 1800s, the federal government forced thousands of

Native children to attend assimilation boarding schools, robbing families of the autonomy to raise their children within their own languages, religion, and culture.[5]

18. The abuse on Native people was especially acute in the 1960s and 1970s, when IHS, tasked with providing family planning services to Native Americans, instead performed forced sterilization on thousands of Native women. A federal report found that four IHS facilities sterilized 3,406 Native American women between 1973 and 1976.[6] That number included women under age 21, despite a court-ordered moratorium on sterilizations of women younger than 21.[7] In one case, two 15-year-old girls were sterilized during what they were told were tonsillectomy operations.[8] An independent study by Dr. Connie Pinkerton-Uri, Choctaw/Cherokee, found that 1 in 4 Native women had been sterilized without her consent.[9] Pinkerton-Uri's research indicated that IHS had "singled out full-blooded Indian women for sterilization procedures."[10]

19. Indigenous people who can become pregnant have also been coerced into taking long-acting reversible contraception ("LARCs"). Although LARCs are highly effective in preventing pregnancy and are an important option among contraceptive methods, when combined with coercive practices, they are a form of population control targeted toward Indigenous people. In the 1990s, at the height of the wars on poverty and drugs, states introduced measures that would require women to have LARCs inserted in order to receive public benefits or as a condition of

[5] Becky Little, *How Boarding Schools Tried to 'Kill the Indian' Through Assimilation*, History (Nov. 1, 2018), https://www.history.com/news/how-boarding-schools-tried-to-kill-the-indian-through-assimilation.
[6] U.S. Nat'l Library of Medicine, *1976: Government Admits Unauthorized Sterilization of Indian Women*, https://www.nlm.nih.gov/nativevoices/timeline/543.html.
[7] *Id.*
[8] Andrea Smith, Conquest: Sexual Violence and American Indian Genocide, Duke Univ. Press (Sept. 17, 2015).
[9] U.S. Nat'l Library of Medicine, *supra* note 6.
[10] *Id.* In 1977, the United Nations released a report prepared in conjunction with the Native American Solidarity Committee. It outlined the genocidal practices of the U.S. government, including the sterilization of Native American women. The report concluded that 24 percent of Native women had been sterilized and that 19 percent of the women were of child-bearing age. *See* The Systemic Genocide of Native Nations By the United States Government, Am. Indian Treaty Council Inform. Ctr. 3 (June 1977), available at https://tinyurl.com/yxtg8csj.

receiving a reduced sentence.[11] Even today, we hear stories of people not being given the full spectrum of reproductive health care options—including IHS offering only a limited selection of contraceptive methods, of providers pressuring Native people to have LARCs inserted regardless of the person's sexual or reproductive health needs, and of providers resisting Native people's requests to have LARCs removed.[12] Some state Medicaid plans also limit reimbursement for LARC removal.[13]

20. Hospitals have also played a role in separating Native families. Health care providers conduct drug tests on pregnant people—disproportionately people of color—and make reports to state authorities that result in arrests, civil commitment, and child separations.[14] My own relatives have reported doctors making unfounded insinuations about substance abuse during childbirth. Even now, in the middle of a global pandemic, it was reported that a hospital in Albuquerque, New Mexico instituted a secret policy that separated Native people from their newborn babies. The hospital staff racially profiled pregnant people who appeared to be Native, regardless of whether they were symptomatic or high-risk, and then compared their ZIP code against a hospital list of reservation ZIP codes. If the ZIP codes matched, the pregnant patient would be tested for COVID-19. But because the hospital does not use rapid testing, newborns would be taken away until the results came back, which could take up to three days.[15]

---

[11] Rachel Benson Gold, Guarding Against Coercion While Ensuring Access: A Delicate Balance, 17 Guttmacher Inst. 8, 10-11 (2014), https://www.guttmacher.org/sites/default/files/article_files/gpr170308.pdf.

[12] *See also* Jenny A. Higgins et al, Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Adult Women, 106 Am J. Pub. Health 1932–37 (2016).

[13] *See* Julia Strasser et al., Access to Removal of Long-acting Reversible Contraceptive Methods Is an Essential Component of High-Quality Contraceptive Care, 27 Women's Health Issues, 253, 254 (2017).

[14] *See, e.g.*, Lynn M. Paltrow & Jeanne Flavin, Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health, 38 J. Health Politics, Policy & L. 299, 300–01, 311–12 (2013).

[15] Bryant Furlow, A Hospital's Secret Coronavirus Policy Separated Native American Mothers From Their Newborns, ProPublica (June 13, 2020), https://www.propublica.org/article/a-hospitals-secret-coronavirus-policy-separated-native-american-mothers-from-their-newborns.

21. This American history is my own history. A close relative of mine was coerced into having her tubes tied shortly after giving birth to her youngest child. As she tells the story, the nurse and doctor came into the room together and insinuated that she did not need to have more children. They brought up insurance and the financial burden of pregnancy and childbirth and childrearing, and that pressure led her to give her "consent" to the procedure. And I have experienced coercion with contraception. I decided to have an IUD inserted, but after 10 months of uncommon bleeding, I decided that I wanted to have it removed. I went to see four different doctors, but none of them would remove it. They ignored my pain and limited my reproductive freedom.

United States Indian Health Service

22. IHS was founded in 1955 to fulfill U.S. treaty obligations to provide comprehensive health care for Indigenous people living in the United States. The agency serves approximate 2.56 million "Native Americans and Alaska Natives" who belong to 574 federally recognized Tribes in 37 states.[16] For many Indigenous communities, especially those in rural areas, IHS and tribal health care facilities are the only source of health care services.[17]

23. IHS has historically been underfunded and has never provided adequate care to Native people.[18] IHS facilities do not have enough doctors or nurses to provide quality care: in 2018, the overall vacancy rate for providers was 25%, ranging from 13% to 31% across areas.[19] Often, positions are filled with temporary contract providers who are unable to provide necessary

[16] Indian Health Servs., IHS Profile (August 2020), https://tinyurl.com/y4x37oll.
[17] Indian Health Servs., The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress 3 (2016), https://tinyurl.com/yxuxftw6.
[18] In 2017, IHS health care expenditures per person were only $3,332, compared to $9,207 for federal health care spending nationwide. U.S. Commission on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans 66-67 (Dec. 2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.
[19] U.S. Gov't Accountability Office, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies 9 (Aug. 2018), https://www.gao.gov/assets/700/693940.pdf.

continuity of care.[20] Funding is so poor that Native people are sometimes subjected to "life or limb" tests—that is, they are denied care unless their situation threatens life or limb.[21] But even in emergency situations, IHS is often unequipped to provide necessary care, as the emergency rooms at IHS facilities are frequently not open 24 hours per day and there is no guarantee that they will have someone on staff who is not an intern. In my experience, IHS providers also often are not members of the communities they serve and lack the cultural competency necessary to provide appropriate, high quality care for Native peoples.

24. Given these constraints in capacity and competency, it is not surprising that Native people have a lower life expectancy than the general population. Natives continue to die at higher rates from chronic liver disease and cirrhosis, diabetes, injuries, assault/homicide, intentional self-harm and suicide, and chronic lower respiratory diseases.[22] And Native people, like Black people, are experiencing a maternal mortality crisis in the United States. According to a CDC report, Native women were 2.5 times more likely than white women to die during pregnancy, labor, and within a year after childbirth.[23] The majority of these deaths are preventable, revealing the consequences of systemic and institutional racism.[24] Likewise, in 2013, the infant mortality rate was higher for Black infants (11.11 deaths per 1000 live births) and Native infants (7.61 deaths per 1000 live births) versus white infants (5.06 deaths per 1000 live births).[25] Disparities are also

---

[20] *Id.* at 32.

[21] Tribal Leader Letter, Department of Health and Human Services, Indian Health Service, (Jan. 15, 2013), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2013_Letters/01-15-2013_DTLL_FollowupCHSPreventionServices.pdf (providing update from Dr. Yvette Roubideaux on then-named Contract Health Services (CHS) program increases for referrals for prevention services as a follow-up to the Tribal Leader Letter dated August 2, 2012).

[22] Indian Health Servs., Disparities (Oct. 2019), https://www.ihs.gov/newsroom/factsheets/disparities.

[23] Ctrs. for Disease Control & Prevention, Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017 (May 7, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6818e1-H.pdf.

[24] *Id.*

[25] Ctrs. for Disease Control & Prevention, Infant Mortality Statistics From the 2013 Period Linked Birth/Infant Death Data Set 5 (Aug. 6, 2015), https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_09.pdf.

pronounced in obstetrics and gynecology. Only 69% of Native women have had prenatal care in the first trimester compared to 89% of white women.[26]

25. To this day, Native people are wary of IHS. The legacy of forced sterilizations and underfunded services contributes to our suspicion. Likewise, Native people continue to experience outright discrimination and implicit biases. A study found that 23% of Native people reported experiencing anti-Native discrimination when going to a doctor or health clinic, and 13% said they have avoided going to a doctor or seeking health care for themselves or someone in their family out of concern that they would be discriminated against or treated poorly because they are Native.[27] Likewise, 29% of Native women reported experiencing discrimination because they are women when going to a doctor or health clinic, and 27% of Native women avoided going to a doctor or seeking health care out of concern they would be discriminated against because they are women.[28] When looking around at their community, 24% of Native people said their neighborhood is in fair or poor health, and 30% reported that the quality of available doctors or health care services in their neighborhood is worse than in other places.[29]

Discrimination Against Native People Seeking Abortion Care

26. Because IHS is subject to the Hyde Amendment, it does not provide or pay for all medically necessary abortion care. As discussed above, due in part to inadequate resources, and in part to anti-abortion bias, this is true even in circumstances where the Hyde Amendment allows

[26] ACOG, Committee No. 649, Racial and Ethnic Disparities in Obstetrics and Gynecology (Dec. 2015), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/racial-and-ethnic-disparities-in-obstetrics-and-gynecology.
[27] NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, Discrimination in America: Experiences and Views of Native Americans 8, 12 (2017), https://legacy.npr.org/documents/2017/nov/NPR-discrimination-native-americans-final.pdf.
[28] NPR/Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, Discrimination in America: Experiences and Views of American Women 21 (2017), https://legacy.npr.org/assets/news/2017/12/discriminationpoll-women.pdf.
[29] NPR, Experiences and Views of Native Americans, *supra* note 27, at 19, 20.

funding, including cases of life endangerment, rape, and incest. Since many Native people rely on IHS for health care, restrictions on abortion care acutely impact their access. Federal policy thus forces many Native pregnant people to rely on an abortion fund like IWR or pay out-of-pocket, and to travel long distances to obtain abortion care. For some, these and other barriers to accessing abortion care are insurmountable and will force them to forgo abortion care altogether.

27. IHS also does not usually refer for abortions and often IHS facilities fail to provide information to patients about abortion care or counseling about pregnancy options. At the Fort Defiance Indian Hospital, for example, the health care providers are explicitly told not to talk about abortions. At the IHS facility I grew up using in New Mexico, patients seeking information about abortion were instructed to "Google it." On occasion, some providers will go against their facility's policy to care for their patient and refer them to IWR for abortion care.

28. As a result of these policies, Native pregnant people who are experiencing emergency pregnancy complications that may require pregnancy termination cannot rely on IHS for care. Some of those patients will turn to IWR for assistance in accessing abortion care, if their circumstance allows. IWR has received calls from pregnant people—usually in their late second or early third trimesters—whose pregnancies are no longer viable and who need assistance obtaining care. In situations involving an immediate threat to the patient's life or health, however, the patient will need to travel to a non-IHS hospital's emergency room to obtain emergency care. For example, people who live in my community in New Mexico must travel 30 miles to Grants, New Mexico, or 50 miles to Albuquerque for emergency abortion care at a non-IHS hospital. But there is still a real risk that they will be denied the care they need or receive substandard care due to hospital policies that forbid provision of abortion care, or personal objections to providing abortion care by individual physicians, nurses, or other health care workers.

29. I know this to be true from personal experience, unfortunately. In 2013, I learned that I was pregnant but that the fetus was not viable. My doctors told me the fetus would expel itself within a few weeks, and that I might experience back pain and bleeding. No one told me that removing the fetus was an option or explained the risks I faced by forgoing appropriate treatment. After some time, I started to bleed severely and could not stand up straight. When I experienced contractions, I traveled to the nearest hospital that took my insurance (Medicaid), which was located in Albuquerque. When I arrived with my husband and then one-year-old daughter, I was placed in a triage bed in the emergency room and given pain medication. No doctor came to see me, even though I started to feel the urge to push and lay in bed bleeding. The pain became so bad that I began to feel dizzy and my vision was blurry. After some time, my husband had to take our daughter to a family member's house for childcare. I was left alone, blood soaking through my sheets. The hospital staff refused to give me additional pain medication. Hours later, I finally saw a doctor, but they refused to treat me, saying—"I know what needs to be done, but I can't do that for you." The doctor said someone else would take care of me. I continued to lay there, untreated, and left abandoned in the most pain I have ever experienced in my life. Finally, another doctor arrived who performed a dilation and curettage to remove the tissue from my uterus. By then I had lost a significant amount of blood.

30. I survived this experience, but my mental health suffered. Because the hospital dismissed my concerns and refused to treat me with adequate care and dignity, my experience was painful and dehumanizing. I developed an addiction to oxycodone, a pain management medicine provided by the hospital. I also feared getting pregnant again. Though I eventually gave birth again, the next pregnancy took an emotional toll. Due to this experience, I decided, at age 25, to have a procedure to ensure that I would not become pregnant again.

Effect of the 2020 Rule

31. The Rollback Rule will harm the Native people that IWR serves by emboldening discriminatory refusals of reproductive health care, coverage, and information, and, in turn, will harm IWR by causing increased strain on the Abortion Fund and Midwifery Fund in a time when capacity is already strained due to the COVID-19 pandemic.

32. The Rollback Rule will cause more people to apply for assistance from IWR's Midwifery Fund to avoid experiencing discrimination when accessing pregnancy-related care. By deleting the 2016 Rule's explicit protections against discrimination on the basis of "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, [or] childbirth or related medical conditions" and incorporating an unlawful religious exemption into Section 1557, the Rule will allow and embolden discrimination in reproductive health care, including obstetrics and gynecological care. The Rule's consequences will be especially devastating to Indigenous people who already receive inconsistent, discriminatory, and substandard reproductive and pregnancy-related healthcare at IHS facilities—the primary source of health care for most IWR's clients. By removing the unitary standard, the Rule will also make it more difficult for Native people who can become pregnant to bring claims of intersectional discrimination, which is critical for the people we serve because they so often experience discrimination based on a combination of their sex and race. Finally, the Rollback Rule removes IHS entirely from the regulatory prohibitions by limiting the Rule's scope of application only to HHS programs administered under Title I of the ACA. By removing the threat of HHS enforcement and making it more difficult to obtain a judicial remedy, the Rule sends a signal that the law does not protect against pregnancy discrimination in IHS and opens the door to further discrimination against Native people. Already, Native people avoid going to the doctor out of fear of discrimination. This Rule will exacerbate the fear of discrimination,

substandard care, denials of care, and coercion, which will cause Native people who need pregnancy-related care to mistrust providers and turn to the Midwifery Fund for midwife or doula care. As a result, IWR will have to dedicate more funding and resources to its Midwifery Fund to support their needs. Ultimately, these layers upon layers of discrimination have devastating consequences for the reproductive health—and emotional health—of Native pregnant people.

33. The Rollback Rule stigmatizes abortion in particular and will embolden and encourage refusals of abortion care and coverage and information about abortion, even in emergency situations. Although the legal landscape governing provision of abortion care is complex, the 2016 Rule's explicit protections for "pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom" in the definition of "on the basis of sex" made clear that Section 1557 provides critical protection for access to abortion care. By deleting this regulatory definition of "on the basis of sex," unlawfully adding an abortion exemption and a religious exemption into Section 1557's nondiscrimination protections, singling out abortion in the preamble, and attempting to excise IHS from the scope of the Rule's application, the Rule signals to IHS facilities that they can refuse abortion care and information about abortion care without consequence, even in cases allowable under the Hyde Amendment, thus threatening to exacerbate refusals of care and information. Moreover, by stigmatizing abortion care and reinforcing the negative attitude the government holds toward abortion care, the Rollback Rule signals to healthcare providers and plan sponsors outside of IHS that they can refuse abortion care, coverage, and information without consequence.

34. The Rollback Rule will simultaneously aggravate clients' fears about being denied the abortion care, coverage, and information they need, even in cases of emergency. Again, many Native people already forgo obtaining health care for fear of discrimination. By giving the green

light to providers (both within and without IHS) to refuse abortion care based on personal or religiously motivated objections, as happened to me, the Rollback Rule will exacerbate this fear. Moreover, the Rule signals to our clients—who already express concern about sharing their abortion histories with health providers out of fear of discrimination—that they should keep their abortion histories private or forgo or delay care, with potentially serious adverse consequences for their health.

35. The Rollback Rule's attacks on abortion will increase costs for IWR's Abortion Fund. Again, our clients already face serious financial constraints, as well as geographic and linguistic barriers to accessing the care they need. For many Native people experiencing a miscarriage or other pregnancy complications, termination may be necessary. People seeking abortion care who are either denied appropriate care or fear that they will be denied such care from IHS or a non-IHS hospital may delay or forgo care altogether, with potentially deadly consequences. Others will turn directly to IWR for financial and logistical assistance in accessing the care they need rather than risk discrimination at a hospital or IHS facility, putting increased strain on our finances and operations. Still others may seek financial or other support from IWR after experiencing a denial of emergency abortion care similar to what I went through.

36. The Rollback Rule's attacks on abortion will increase demand for informational resources from IWR's Abortion Fund. The Abortion Fund provides critical information about pregnancy options and abortion care to clients because that information often is not provided by either IHS or other health care providers and hospitals upon which IWR's clients rely. Neither the Hyde Amendment nor other federal laws applicable to IHS restricting access to abortion care extend to provision of information about abortion, and so IHS should be providing information and counseling about all pregnancy options. Yet too many IHS facilities already fail to provide the

critical information necessary for patients to make informed decisions about their health and futures. By removing protections for abortion care and attempting to carve IHS out of the scope of the Rollback Rule's protections, the Rule threatens to exacerbate denials of information about abortion care by IHS facilities. This will cause more clients to turn to IWR as a trusted resource to supply the information they need, further straining IWR's already limited staff resources.

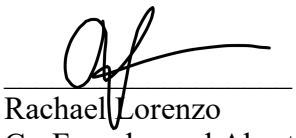
37. Denying care, coverage, and information about abortion care will also inhibit or delay access to abortion care. This will put a greater financial burden on the IWR Abortion Fund because the cost of abortion care increases when abortion care is delayed, and fewer clinics are able to provide abortion care later in pregnancy.

38. Thus, not only does the Rollback Rule threaten the life and health of IWR's clients who are denied the care, coverage, and information they need, it also will cause IWR's Abortion Fund to expend greater resources on increased demand for funding, on more expensive abortion care later in pregnancy, on clients' travel and related expenses to the few clinics that provide abortion care later in pregnancy, and on staff labor to provide information and resources to clients about abortion care. By straining IWR's finances and operations, the Rollback Rule undermines IWR's ability to achieve our broader mission of supporting culturally safe health options through our other programs, including our sexual and political education efforts.

39. Ultimately, my concern is for the Native people IWR serves. As my own experience illustrates, being denied reproductive and pregnancy-related health care can cause serious physical, mental, and emotional consequences. Yet the Rollback Rule encourages and will cause precisely this type of discrimination, harming the health of the very people HHS—and IHS—are charged with protecting.

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 17, 2020



Rachael Lorenzo
Co-Founder and Abortion Access Lead, Indigenous Women Rising

Exhibit G

Declaration of Alice Riener,

Chief of Staff of NO/AIDS Task Force, d/b/a CrescentCare

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services, ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services, SEEMA VERMA, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF ALICE RIENER

I, Alice Riener, declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

1. I am the Chief of Staff of Plaintiff NO/AIDS Task Force, d/b/a CrescentCare. I received a J.D. from American University's Washington College of Law. I joined CrescentCare in

2011 as Director of Housing, and have also held the position of Chief Legal Officer. As Chief of Staff, I provide legal advice, oversight of compliance and audit requirements, administrative support for grants, and guidance for human resources. I staff the Board Executive Committee along with the Chief Executive Officer, Noel Twilbeck, Jr. In my role, I track risk and compliance issues and advise on regulatory and legal concerns.

A. Introduction

2. CrescentCare is a federally qualified health center whose mission is to offer comprehensive health and wellness services to the community, to advocate empowerment, to safeguard the rights and dignity of individuals, and to provide for an enlightened public. CrescentCare aims to lead in quality-driven health and wellness care, and to meet existing and emerging need with active participation from the community we serve. We intend to pursue our mission of providing comprehensive health and wellness care with integrity, quality, respect, and compassion and ensure our care is safe, effective, patient-centered, timely and efficient, equitable and evidence-based.

3. Our services include primary care, dentistry, obstetrics and gynecology, pediatrics, psychiatry, specialty care, preventive health, and sexual health services. We also provide non-medical wraparound services, such as case management for people living with HIV, legal services, and outreach and education regarding discrimination and public benefits, to ensure our patients are empowered to lead healthy lives.

4. CrescentCare also operates research, training, education, and policy programs. CrescentCare collaborates with other community health centers and providers to advance clinical service strategies that result in higher engagement with medical care and better health outcomes for its patient population. For example, CrescentCare serves as a site for the Transgender Women

Engagement and Entry to Care Project, an evidence-informed intervention that links transgender women to HIV care that is part of a multi-site intervention led by Fenway Health. CrescentCare also works closely with community advocates to ensure that its patients' interests are represented across relevant policy areas, including housing, nutritional support, and nondiscrimination protections.

5. CrescentCare's patient population is incredibly diverse. Many of our patients identify as lesbian, gay, bisexual, transgender, queer, intersex, and gender non-conforming people ("LGBTQ+"), with around 40% reporting a sexual orientation other than heterosexual and over 7% identifying as transgender. Approximately 35% of our patients live with HIV. Many of our patients have limited resources, with around 48% of our patients having lived below the poverty line in 2019. Thirty-five percent of our patients ware uninsured and around 36% receive Medicaid. In 2019, 1,086 CrescentCare patients were best served in a language other than English.

6. CrescentCare has a diverse, experienced, and culturally-competent staff of almost 300 employees and 600 volunteers. Employees include medical and behavioral health providers, case managers, support staff, medical adherence and insurance navigation professionals, community health workers, lawyers, administrators, and professionals working in finance and human resources. CrescentCare recruits from the communities it serves to ensure that staff is representative of the greater New Orleans community. CrescentCare's employees represent many different races, ethnicities, sexual orientations, gender identities, religious and spiritual traditions, and life experiences. To better serve our patients, some of our trans-identified and allied staff serve on our Transgender Advisory Committee to advise on programming and procedures for CrescentCare.

7. CrescentCare receives various forms of federal funding from HHS and from institutions affiliated with or funded by the United States Department of Health and Human Services ("HHS"), including but not limited to funds under the Public Health Services Act, direct grants, funding under the Ryan White Comprehensive AIDS Resources Emergency Act of 1990, 42 U.S.C. § 300ff et seq., funds under the 340B Drug Discount Program, research grants from the Centers for Disease Control and Prevention and Medicaid and Medicare reimbursements. CrescentCare also receives funds from the Health Resources and Service Administration ("HRSA") and is designated as a federally qualified heath center. In 2019, CrescentCare's federally funded research contracts totaled more than $14 million.

8. I am aware that HHS issued a Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act on June 14, 2019. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) (to be codified at 42 C.F.R. pts 438, 440, 460) ("2019 Proposed Rule").

9. I understand that on June 19, 2020, HHS published a final rule that adopts, with only minor or technical alterations, the entirety of the 2019 Proposed Rule. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that thousands of commenters raised.

10. I understand CrescentCare to be subject to Section 1557 and its regulations as we are a health entity that receives federal financial assistance.

B. The Rollback Rule Will Cause CrescentCare to Divert Crucial Resources

11. The Rollback Rule will cause CrescentCare to expend resources associated with training staff to address the confusion about the requirements of federal law. For example, CrescentCare's Transgender Advisory Committee held a training for our staff members about the 2019 Proposed Rule and potential changes that could occur for our patients. We expect to require further training for our employees, specifically regarding the final Rollback Rule and its incongruence with other federal non-discrimination protections such as Title VII, and how our staff can best support patients given the uneven application of non-discrimination protections.

12. The Rollback Rule will cause CrescentCare to expend resources associated with our responsibility to educate our patient community. For example, CrescentCare has regularly educated patients through our Transgender Women's Engagement and Entry to Care ("T.W.E.E.T.") program and during our Transgender Advisory Committee town halls about changes to policies that protect against discrimination on the basis of gender identity. Patients at these events have indicated that further education is needed regarding the final rule.

13. The Rollback Rule will also cause CrescentCare to expend resources associated with our patient navigation services. Patient navigation services include insurance verification, financial assistance, and Medicaid enrollment assistance. CrescentCare is required to provide Medicaid enrollment assistance to remain eligible for funding as a federally qualified health center. CrescentCare staff members have spent significant time helping patients determine what services are covered by their insurance plan and what prior authorization requirements may be applicable for specific services. Given the increasing concern over the impact the Rule will have on benefit coverage, we will need to dedicate additional staff time to identifying policy changes.

For example, UnitedHealthcare Community Plan recently issued a policy bulletin announcing the retirement of a treatment policy for gender dysphoria in Louisiana as "treatment for gender dysphoria is not covered in the state of Louisiana." *See, e.g.*, UnitedHealthcare Community Plan, *Medical Policy Update Bulletin* 78 (Aug. 2020), https://perma.cc/445E-VCTZ; UnitedHealthcare Community Plan, *Gender Dysphoria Treatment (For Louisiana Only)* 13, previously available at https://perma.cc/M2KJ-5VH7, attached as Exhibit 1 (retired Aug. 1, 2020) ("Policy retired; treatment for gender dysphoria is not covered in the state of Louisiana."). One of our Medicaid Eligibility Specialists has sought out more information about this change from state officials and has been told no change has been made. Additional staff time is continuing to be spent determining the reason for and impact of this retired policy as Medicaid-eligible patients are currently in an open enrollment period and selecting a plan that does not provide coverage of gender affirming care could be detrimental to some of our patients' health and financial well-being.

14. CrescentCare's patient services also include navigating referral processes and making health care as seamless as possible. Because of the Rollback Rule, CrescentCare will need to expend additional resources to determine whether other providers will choose not to discriminate against our patient. For example, CrescentCare provides referrals to outside providers when we are unable to provide the needed medical services in our facilities. In June 2020, a gender non-binary patient required a specialized podiatry service and was referred to two separate providers who failed to provide non-discriminatory care. Our patient navigator spent significant time confirming with each referred-to provider that their office had LGBTQ+ friendly procedures and would treat our patient with respect. Despite several phone calls explicitly requesting otherwise, the patient was misgendered repeatedly and addressed publicly with their traditionally-

masculine birth name. Increased concern over the impact of the Rule, particularly on provider practices, has led CrescentCare to begin more systematic reviews of referral experiences.

15. The Rollback Rule will cause CrescentCare to expend resources associated with our legal services. Some of our funding streams require that we provide high-quality legal services to our patients. We currently have limited capacity to represent our patients in navigating or appealing discriminatory denials of coverage. The Rollback Rule's narrowing of the definition for "covered entity" and rescission of a uniform enforcement mechanism will require greater resources, particularly for patients who mistakenly assume their health care coverage does not need to comply with Section 1557 and for patients who experience intersectional discrimination, as it is unclear what legal standards will apply to those claims.

16. Based on the atmosphere of emboldened discrimination occasioned by the Rollback Rule, CrescentCare anticipates increased demand for our services, including gender affirming care and mental health services related to anxiety. As CrescentCare is already operating at close to full capacity, and our behavioral health services (known for being gender affirming) are only available to patients who receive their primary care from our providers, such increased demand will strain our resources. For example, some patients who receive services through the Gender Clinic have expressed an urgency to complete certain transition-related care before the end of the 2020 plan year due to anxiety that their insurance companies will modify the coverage of certain gender dysphoria services. The COVID-19 pandemic and weather-related emergencies have decreased the number of patients who can complete certain procedures in 2020 and consequently, our staff has had to expend additional resources addressing patients' fears.

17. As a result of the Rollback Rule, CrescentCare also anticipates increased demand for needles and syringes used by people injecting hormones as part of their gender affirming care.

Many of our patients have faced discrimination at their pharmacies and have been unable to obtain necessary supplies for their hormone injections, despite explicit inclusion of appropriately-sized needles and syringes on prescriptions. These experiences are shared by people across the country. *See* Ames Simmons, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019), https://perma.cc/S38F-LRKX ("After I eventually found an affirming osteopath, I still encountered pharmacists who refused to sell me needles for testosterone, even though a prescription is not required for needles in either state I lived in."); Isaac Crip, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019), https://perma.cc/S38F-LRKX ("I used to get my medications through CVS, including my injection needles and testosterone prescription. They would constantly forget to order them or order the wrong size/dose. A lab tech even openly glared at me and talked down to me whenever I came in. . . . I would end up taking shots late, or with too large needles, ones I was told were the only ones they had. It made my fear of needles worse. I stopped taking my injections because of those reasons, though I'm starting them again soon with a different pharmacy."). Without these supplies, our patients are unable to access their medication and turn to CrescentCare for appropriate needles and syringes. Thus, with an increased demand for these supplies, we will need to expend more resources ensuring our patients can get the care we prescribe for them.

18. The Rollback Rule will also cause CrescentCare to lose revenue. Maximizing third-party reimbursement for healthcare services that CrescentCare provides is central to its financial wellbeing. CrescentCare provides healthcare, including gender affirming care, regardless of insurance status and regardless of ability to pay. To remain eligible for certain federal funding and to keep CrescentCare designated as a federally qualified health center, we are required to reduce fees on a sliding scale for patients who are unable to pay and whose income is no greater than 200% of the Federal Poverty Level, even when the patient has insurance. CrescentCare currently

generates about 13% of its operating revenue from insurer reimbursement for patient services. Approximately 25% of that insurer reimbursement comes from commercial insurers. Some of those insurers are subject to limited or no state regulation. For example, one of our patients with Louisiana-sponsored health care coverage was unable to get coverage for gender affirming treatment because their plan, offered by the Louisiana Office of Group Benefits, had a categorical exclusion for treatment related to gender dysphoria. While many of our patients ultimately decline to file multiple appeals or claims against their insurer or employer when coverage continues to be denied, these regulatory changes directly harm CrescentCare, our patients, and our pool of potential patients that CrescentCare draws from, by diminishing the scope of third-party reimbursement for necessary health care and leaving CrescentCare to provide an increased quantity of uncompensated care and to spend significant administrative time associated with understanding, applying, and appealing associated coverage decisions.

19. The Rollback Rule will cause CrescentCare to expend resources ensuring that we are not excluded from insurance networks, as some insurance companies may now understand their products to be outside of the scope of Section 1557 and understand the Rollback Rule to no longer extend Section 1557 protections to associational discrimination. In the last two years, CrescentCare has been dropped abruptly from a major insurer's network. We believe that this insurer cancelled our contract partly because one-third of our patients insured by the company were HIV positive and may have high pharmaceutical and medical costs. The termination of this contract brought financial harm to CrescentCare, as we lost out on a significant source of third-party reimbursement and diverted resources to ensuring patients did not experience an interruption in care and services. The Rollback Rule's elimination of protections against associational discrimination and its narrower definition of "covered entities" will create the conditions for such

an incident to occur again, especially as many of CrescentCare's services have grown in size and reputation, including services for people living with HIV and people who are LGBTQ+.

20. The Rollback Rule will cause CrescentCare financial harm through an increase in non-reimbursable costs. An increase in patient volume, whether insured or uninsured, will lead to an increased demand in non-medical services. Our current funding streams either would not cover or would not adjust to cover these additional services in a timely manner. Additionally, several of these services, such as patient outreach and Medicaid enrollment assistance, are required for federally qualified health centers but are not billable to insurance. Based on CrescentCare's obligation to provide such services to all patients who need them, an increased demand would require additional expenditure of our resources.

21. CrescentCare has finite financial resources to dedicate to its healthcare services, and it does not anticipate an increase in funding that will match the increase in need for services. Our funding streams do not rapidly account for increases in uncompensated services and will not offset expected cost increases in a timely manner. For example, federal funding from HRSA will very likely not offset the costs associated with a rapid increase in demand and a decrease in covered services. CrescentCare's annual HRSA grants are not immediately increased based on an increased patient population. As an FQHC, CrescentCare is also eligible for the Community Health Center Fund ("CHCF"), which provides supplemental federal grants to respond to emerging priorities. While the amount of CHCF funding CrescentCare receives generally depends on patient volume, the funding calculation is not based on current patient volume. For example, COVID-19 supplemental funding provided in the Spring of 2020 was calculated using 2018 patient volume. A rapid increase in patient volume will not be accounted for immediately through federal funding, and thus will not offset CrescentCare's expected cost increase.

C. The Rollback Rule Will Frustrate CrescentCare's Mission

22. As recounted above, CrescentCare's mission places particular emphasis on providing the highest quality of healthcare to the LGBTQ+ and broader community, and ensuring general access to healthcare for our patients through education, research, and advocacy.

23. The Rollback Rule will frustrate CrescentCare's mission by making it more difficult for our patients to access healthcare, both care related to gender dysphoria and care that is not. As part of our routine healthcare practice, CrescentCare refers and counsels patients, especially in connection with healthcare services that we do not offer. For example, CrescentCare maintains and updates a network of providers who will accept referrals for reproductive care and gender affirming surgery, including hysterectomy, oophorectomy, orchiectomy, breast reconstruction, and mastectomy, among other procedures and who will provide high-quality, non-discriminatory care and support services to our patients. In the past, CrescentCare has had to adjust certain referral procedures to avoid discriminatory care, such as not indicating when an imaging request is related to post-abortion care.

24. The Rollback Rule will frustrate CrescentCare's mission by making it more difficult for CrescentCare to ensure the non-discriminatory practices of those with whom we partner or do business. In order to safeguard CrescentCare's reputation as a beacon of inclusive healthcare, it is important that the contractors, vendors, and providers we partner or work with adhere to a strict policy of non-discrimination. The Rollback Rule will require CrescentCare to review each of these relationships anew to assess whether ongoing relationships are warranted. For example, due to increasing concern about provider discrimination, some employees who provide patient navigation services have begun following up with patients after their referral visits to ensure the outside provider did not provide services in a discriminatory way.

25. The Rollback Rule will frustrate CrescentCare's mission by making it more difficult to advocate for the coverage of medically necessary care. CrescentCare furthers its mission by guiding and supporting our patients as they appeal discriminatory insurance decisions. By diminishing the scope of compliant insurance coverage and eliminating protections meant to explicitly protect patients from discrimination, the Rollback Rule will make such advocacy significantly more difficult. Our providers, patient navigators, and legal services teams have limited capacity for assisting in these cases, and an increased need for this support would impede our ability to provide the highest quality of care to our patients.

Dated: November 17, 2020 at New Orleans, Louisiana.

/s/ Alice Riener
Alice Riener
Chief of Staff
CrescentCare

EXHIBIT 1

UnitedHealthcare® Community Plan

GENDER DYSPHORIA TREATMENT (FOR LOUISIANA ONLY)

Retired August 1, 2020

Policy Number: CS145LA.D **Effective Date**: November 1, 2018

Table of Contents **Page**

APPLICATION 1
INSTRUCTIONS FOR USE 1
BENEFIT CONSIDERATIONS 1
COVERAGE RATIONALE 2
DEFINITIONS 3
APPLICABLE CODES 4
DESCRIPTION OF SERVICES 8
CLINICAL EVIDENCE 8
U.S. FOOD AND DRUG ADMINISTRATION 12
CENTERS FOR MEDICARE AND MEDICAID SERVICES 12
REFERENCES 12
POLICY HISTORY/REVISION INFORMATION 13

Related Community Plan Policies

- Blepharoplasty, Blepharoptosis and Brow Ptosis Repair
- Botulinum Toxins A and B
- Cosmetic and Reconstructive Procedures
- Gonadotropin Releasing Hormone Analogs
- Panniculectomy and Body Contouring Procedures
- Rhinoplasty and Other Nasal Surgeries
- Speech Language Pathology Services

Commercial Policy

- Gender Dysphoria Treatment

APPLICATION

This Medical Policy only applies to the state of Louisiana.

INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Medical Policy is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersede this Medical Policy. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this policy, please check the federal, state or contractual requirements for benefit coverage.

Coverage Information

Unless otherwise specified, if a plan covers treatment for gender dysphoria, coverage includes psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. This benefit also includes certain surgical treatments listed in the Coverage Rationale section below. See the Medical Benefit Drug Policy titled *Gonadotropin Releasing Hormone Analogs*.

Limitations and Exclusions

Certain treatments and services are not covered. Examples include, but are not limited to:

- Treatment received outside of the United States.
- Reproduction services, including, but not limited to, sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor

eggs, donor sperm and host uterus (please check the federal, state or contractual requirements for benefit coverage).
- Transportation, meals, lodging or similar expenses.
- Cosmetic procedures (see Coverage Determination Guideline titled *Cosmetic and Reconstructive Procedures* and the Coverage Rationale section below).
- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.

Benefits are limited to one sex transformation reassignment per lifetime which may include several staged procedures.

Coverage does not apply to members who do not meet the indications listed in the Coverage Rationale section below.

COVERAGE RATIONALE

Note: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development.

Gender reassignment surgery may be indicated for individuals who provide the following documentation:
- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria is needed for breast surgery. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age (age of majority)
  - If significant medical or mental health concerns are present, they must be reasonably well controlled
- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the individual, are required for genital surgery. The assessment must document that an individual meets **all** of the following criteria:
  - Persistent, well-documented Gender Dysphoria
  - Capacity to make a fully informed decision and to consent for treatment
  - Must be at least 18 years of age (age of majority)
  - If significant medical or mental health concerns are present, they must be reasonably well controlled
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated)
- Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating Gender Dysphoria.

When the above criteria are met, the following gender reassignment surgical procedures are medically necessary and covered as a proven benefit:
- Male-to-Female (MtF):
  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)
  - Vaginoplasty (creation of vagina)
- Female-to-Male (FtM):
  - Bilateral mastectomy or breast reduction*
  - Hysterectomy (removal of uterus)
  - Metoidioplasty (creation of penis, using clitoris)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prostheses
  - Urethroplasty (reconstruction of male urethra)
  - Vaginectomy (removal of vagina)
  - Vulvectomy (removal of vulva)

*Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary when performed as part of gender reassignment:

- Abdominoplasty (also see the Coverage Determination Guideline titled *Panniculectomy and Body Contouring Procedures*)
- Blepharoplasty (also see the Coverage Determination Guideline titled *Blepharoplasty, Blepharoptosis and Brow Ptosis Repair*)
- Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also see the Coverage Determination Guideline titled *Panniculectomy and Body Contouring Procedures*)
- Breast enlargement, including augmentation mammaplasty and breast implants
- Brow lift
- Calf implants
- Cheek, chin and nose implants
- Face/forehead lift and/or neck tightening
- Facial bone remodeling for facial feminization
- Hair removal (e.g., electrolysis or laser)
- Hair transplantation
- Injection of fillers or neurotoxins (also see the Medical Benefit Drug Policy titled *Botulinum Toxins A and B*)
- Lip augmentation
- Lip reduction
- Liposuction (suction-assisted lipectomy) (also see the Coverage Determination Guideline titled *Panniculectomy and Body Contouring Procedures*)
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty (also see the Coverage Determination Guideline titled *Rhinoplasty and Other Nasal Surgeries*)
- Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
- Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple)
- Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords)
- Voice lessons and voice therapy

DEFINITIONS

Gender Dysphoria in Adolescents and Adults: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least two** of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Gender Dysphoria in Children: A disorder characterized by the following diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders, 5th edition [DSM-5]):

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by **at least six** of the following (**one of which must be criterion A1**):
   1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
   2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
   3. A strong preference for cross-gender roles in make-believe play or fantasy play
   4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
   5. A strong preference for playmates of the other gender

6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities
7. A strong dislike of one's sexual anatomy
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender

B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

CPT Code	Description
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15750	Flap; neurovascular pedicle
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap

CPT Code	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	Mammaplasty, augmentation; with prosthetic implant
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
20926	Tissue grafts, other (e.g., paratenon, fat, dermis)
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)

CPT Code	Description
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
21899	Unlisted procedure, neck or thorax
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53430	Urethroplasty, reconstruction of female urethra
54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female
55980	Intersex surgery; female to male

CPT Code	Description
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57110	Vaginectomy, complete removal of vaginal wall
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral;
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64896	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

ICD-10 Diagnosis Code	Description
F64.0	Transsexualism

ICD-10 Diagnosis Code	Description
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

DESCRIPTION OF SERVICES

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed gender and assigned gender (DSM-5). Treatment options include behavioral therapy, psychotherapy, hormone therapy and surgery for gender reassignment, which can involve genital reconstruction surgery and breast/chest surgery. For the FtM patient, surgical procedures may include mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, vulvectomy, scrotoplasty, urethroplasty, placement of testicular and/or penile prostheses and phalloplasty or metoidioplasty (alternative to phalloplasty). For the MtF patient, surgical procedures may include penectomy, vaginoplasty, clitoroplasty, labiaplasty, orchiectomy and urethroplasty.

Other terms used to describe surgery for Gender Dysphoria include sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery and sex reassignment.

CLINICAL EVIDENCE

An ECRI special report systematically reviewed the clinical literature to assess the efficacy of treatments for gender dysphoria. The authors identified limited evidence from mostly low-quality retrospective studies. Evidence on gender reassignment surgery was mostly limited to evaluations of MtF individuals undergoing vaginoplasty, facial feminization surgery and breast augmentation. Outcomes included mortality, patient satisfaction, physical well-being, psychological-related outcomes, quality of life, sexual-related outcomes, suicide and adverse events. Concluding remarks included the need for standardized protocols and prospective studies using standardized measures for correct interpretation and comparability of data (ECRI, 2016).

A Hayes report concluded that, overall, the quality of the evidence on gender reassignment surgery for gender dysphoria was very low (Hayes, 2014a; updated 2018). The evidence suggests positive benefits, but because of serious limitations, permits only weak conclusions. Limitations include small sample sizes, retrospective data, lack of randomization and control and a lack of objective and validated outcome measures.

- Patients who underwent chest/breast or genital surgery were generally pleased with the aesthetic results.
- Following gender reassignment surgery, patients reported decreased gender dysphoria, depression and anxiety and increased quality of life.
- The majority of gender reassignment surgery patients were sexually active, but the ability to orgasm varied across studies.
- Complications of surgery following gender reassignment surgery were common and could be serious.
- Rates of regret of surgery and suicide were very low following gender reassignment surgery.
- Data were too sparse to draw conclusions regarding whether gender reassignment surgery conferred additional benefits to hormone therapy alone.
- Data were too sparse to draw conclusions regarding whether outcomes vary according to which surgeries were performed.

A separate Hayes report concluded that, overall, the quality of the evidence on ancillary procedures for the treatment of gender dysphoria was very low (Hayes, 2014b; updated 2018). There is some evidence that transgender patients are satisfied with the results of rhinoplasty and facial feminization surgery, but patient satisfaction with vocal cord surgery and voice training was mixed. The evidence has serious limitations, and the effect of these procedures on overall individual well-being is unknown.

- Patients who had rhinoplasty or facial feminization surgery were generally pleased with the results.
- Vocal cord procedures and voice training had variable outcomes. Although the fundamental frequency was reduced by all treatment methods, patient satisfaction with the outcome was mixed.
- Most of the studies did not report complications; however, there was a low rate of bone nonunion following facial surgery, and moderate rates of dysphagia or throat pain following cricothyroid approximation.

Dreher et al. (2018) conducted a systematic review and meta-analysis to evaluate the epidemiology, presentation, management, and outcomes of neovaginal complications in the MtF transgender reassignment surgery patients. Selected studies reported on 1,684 patients with an overall complication rate of 32.5% and a reoperation rate of 21.7% for non-esthetic reasons. The most common complication was stenosis of the neo-meatus (14.4%). Wound infection was associated with an increased risk of all tissue-healing complications. Use of sacrospinous ligament

fixation (SSL) was associated with a significantly decreased risk of prolapse of the neovagina. The authors concluded that gender-affirmation surgery is important in the treatment of gender dysphoric patients, but there is a high complication rate in the reported literature. Variability in technique and complication reporting standards makes it difficult to assess the accurately the current state of MtF gender reassignment surgery. Further research and implementation of standards is necessary to improve patient outcomes.

Manrique et al (2018) conducted a systematic review of retrospective studies on the outcomes of MtF vaginoplasty to minimize surgical complications and improve patient outcomes for transgender patients. Forty-six studies met the authors eligibility criteria. A total of 3716 cases were analyzed. The results showed the overall incidence of complications as follows: 2% fistula, 14% stenosis and strictures, 1% tissue necrosis, and 4% prolapse. Patient-reported outcomes included a satisfaction rate of 93% with overall results, 87% with functional outcomes, and 90% with esthetic outcomes. Ability to have orgasm was reported in 70% of patients. The regret rate was 1%. The authors concluded that multiple surgical techniques have demonstrated safe and reliable means of MtF vaginoplasty with low overall complication rates and with a significant improvement in the patient's quality of life. Studies using different techniques in a similar population and standardized patient-reported outcomes are required to further analyze outcomes among the different procedures and to establish best-practice guidelines.

Van Damme et al. (2017) conducted a systematic review of the effectiveness of pitch-raising surgery performed in MtF transsexuals. Twenty studies were included: eight using cricothyroid approximation, six using anterior glottal web formation and six using other surgery types or a combination of surgical techniques. A substantial rise in postoperative frequency was identified. The majority of patients seemed satisfied with the outcome. However, none of the studies used a control group and randomization process. Further investigation regarding long-term results using a stronger study design is necessary.

Morrison et al. (2016) conducted a systematic review of the facial feminization surgery literature. Fifteen studies were included, all of which were either retrospective or case series/reports. The studies covered a variety of facial feminization procedures. A total of 1121 patients underwent facial feminization surgery, with seven complications reported, although many studies did not explicitly comment on complications. Satisfaction was high, although most studies did not use validated or quantified approaches to address satisfaction. The authors noted that further studies are needed to better compare different techniques to more robustly establish best practices. Prospective studies and patient-reported outcomes are needed to establish quality of life outcomes for patients.

Frey et al. (2016) conducted a systematic review of metoidioplasty and radial forearm flap phalloplasty (RFFP) in FtM transgender genital reconstruction. Eighteen studies were included: 7 for metoidioplasty and 11 for RFFP. The quality of evidence was low to very low for all included studies. In studies examining metoidioplasty, the average study size and length of follow-up were 54 patients and 4.6 years, respectively (1 study did not report [NR]). Eighty-eight percent underwent a single-stage reconstruction, 87% reported an aesthetic neophallus (3 NR) and 100% reported erogenous sensation (2 NR). Fifty-one percent of patients reported successful intercourse (3 NR) and 89% of patients achieved standing micturition (3 NR). In studies examining RFFP, the average study size and follow-up were 60.4 patients and 6.23 years, respectively (6 NR). No patients underwent single-stage reconstructions (8 NR). Seventy percent of patients reported a satisfactorily aesthetic neophallus (4 NR) and 69% reported erogenous sensation (6 NR). Forty-three percent reported successful penetration of partner during intercourse (6 NR) and 89% achieved standing micturition (6 NR). Compared with RFFP, metoidioplasty was significantly more likely to be completed in a single stage, have an aesthetic result, maintain erogenous sensation, achieve standing micturition and have a lower overall complication rate. The authors reported that, although the current literature suggests that metoidioplasty is more likely to yield an "ideal" neophallus compared with RFFP, any conclusion is severely limited by the low quality of available evidence.

Using a retrospective chart review, Buncamper et al. (2016) assessed surgical outcome after penile inversion vaginoplasty. Outcome measures were intraoperative and postoperative complications, reoperations, secondary surgical procedures and possible risk factors. Of 475 patients who underwent the procedure, 405 did not have additional full-thickness skin grafts while 70 did have grafts. Median follow-up was 7.8 years. The most frequently observed intraoperative complication was rectal injury (2.3 percent). Short-term postoperative bleeding that required transfusion (4.8 percent), reoperation (1.5 percent) or both (0.4 percent) occurred in some cases. Major complications were three (0.6 percent) rectoneovaginal fistulas, which were successfully treated. Revision vaginoplasty was performed in 14 patients (2.9 percent). Comorbid diabetes was associated with a higher risk of local infection, and use of psychotropic medication predisposed to postoperative urinary retention. Successful vaginal construction without the need for secondary functional reoperations was achieved in the majority of patients.

Bouman et al. (2016) prospectively assessed surgical outcomes of primary total laparoscopic sigmoid vaginoplasty in 42 transgender women with penoscrotal hypoplasia. Mean follow-up time was 3.2 ± 2.1 years. The mean operative duration was 210 ± 44 minutes. There were no conversions to laparotomy. One rectal perforation was recognized during surgery and immediately oversewn without long-term consequences. The mean length of hospitalization was

5.7 ± 1.1 days. One patient died as a result of an extended-spectrum beta-lactamase-positive necrotizing fasciitis leading to septic shock, with multiorgan failure. Direct postoperative complications that needed laparoscopic reoperation occurred in three cases (7.1 percent). In seven cases (17.1 percent), long-term complications needed a secondary correction. After 1 year, all patients had a functional neovagina with a mean depth of 16.3 ± 1.5 cm.

Gaither et al. (2017) retrospectively reviewed the records of 330 MtF patients from 2011 to 2015, to assess surgical complications related to primary penile inversion vaginoplasty. Complications included granulation tissue, vaginal pain, wound separation, labial asymmetry, vaginal stenosis, fistula formation, urinary symptoms including spraying stream or dribbling, infection, vaginal fissure or vaginal bleeding. Median age at surgery was 35 years, and median followup in all patients was 3 months. The results showed that 95 of the patients presented with a postoperative complication with the median time to a complication being 4.4 months. Rectoneovaginal fistulas developed in 3 patients, and 30 patients required a second operation. Age, body mass index and hormone replacement therapy were not associated with complications. The authors concluded that penile inversion vaginoplasty is a relatively safe procedure. Most complications due to this surgery develop within the first 4 months postoperatively. Age, body mass index and hormone replacement therapy are not associated with complications and, thus, they should not dictate the timing of surgery.

Horbach et al. (2015) conducted a systematic review of vaginoplasty techniques in MtF individuals with gender dysphoria. Twenty-six studies were included (mostly retrospective case series of low to intermediate quality). Outcome of the penile skin inversion technique was reported in 1,461 patients and bowel vaginoplasty in 102 patients. Neovaginal stenosis was the most frequent complication in both techniques. Sexual function and patient satisfaction were overall acceptable, but many different outcome measures were used. Quality of life was only reported in one study. Comparison between techniques was difficult due to the lack of standardization. The authors concluded that the penile skin inversion technique is the most researched surgical procedure. Outcome of bowel vaginoplasty has been reported less frequently but does not seem to be inferior. The available literature is heterogeneous in patient groups, surgical procedure, outcome measurement tools and follow-up. There is a need for prospective studies with standardized surgical procedures, larger patient groups and longer follow-up periods. Uniformity in outcome measurement tools such as validated questionnaires and scores for sexual function and quality of life is mandatory for correct interpretation and comparability of data.

Bouman et al. (2014) conducted a systematic review of surgical techniques and clinical outcomes of intestinal vaginoplasty. Twenty-one studies were included (n=894). All studies had a retrospective design and were of low quality. Prevalence and severity of procedure-related complications were low. The main postoperative complication was introital stenosis, necessitating surgical correction in 4.1% of sigmoid-derived and 1.2% of ileum-derived vaginoplasties. Neither diversion colitis nor cancer was reported. Sexual satisfaction rate was high, but standardized questionnaires were rarely used. Quality of life was not reported. The authors concluded that prospective studies, using standardized measures and questionnaires, are warranted to assess functional outcomes and quality of life.

Murad et al. (2010) conducted a systematic review to evaluate the effects of hormone therapy on patients undergoing gender reassignment surgery. The authors identified 28 eligible studies, all of which were observational and most lacked controls. These studies enrolled 1833 participants with gender dysphoria (1093 MtF; 801 FtM). After gender reassignment surgery, individuals reported improvement in gender dysphoria (80%), psychological symptoms (78%), sexual function (72%) and quality of life (80%). The authors concluded that very low quality evidence suggests that gender reassignment, that includes hormonal interventions, is likely to improve gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life.

Sutcliffe et al. (2009) systematically reviewed five individual procedures for MtF gender reassignment surgery: clitoroplasty, labiaplasty, orchiectomy, penectomy and vaginoplasty. Further evaluations were made of eight surgical procedures for FtM gender reassignment surgery: hysterectomy, mastectomy, metoidioplasty, phalloplasty, salpingo-oophorectomy, scrotoplasty/placement of testicular prostheses, urethroplasty and vaginectomy. Eighty-two published studies (38 MtF; 44 FtM) were included in the review. For MtF procedures, the authors found no evidence that met the inclusion criteria concerning labiaplasty, penectomy or orchiectomy. A large amount of evidence was available concerning vaginoplasty and clitoroplasty procedures. The authors reported that the evidence concerning gender reassignment surgery in both MtF and FtM individuals with gender dysphoria has several limitations including lack of controlled studies, lack of prospective data, high loss to follow- up and lack of validated assessment measures. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence.

Djordjevic et al. (2013) evaluated 207 patients who underwent single-stage metoidioplasty, comparing two different surgical techniques of urethral lengthening. The procedure included lengthening and straightening of the clitoris, urethral reconstruction and scrotoplasty with implantation of testicular prostheses. Buccal mucosa graft was used in all cases for dorsal urethral plate formation and joined with one of the two different flaps: longitudinal dorsal clitoral skin flap (n=49) (group 1) and labia minora flap (n=158) (group 2). The median follow-up was 39 months. The total

length of reconstructed urethra ranged from 9.1 to 12.3 cm in group 1 and from 9.4 to 14.2 cm in group 2. Voiding while standing was significantly better in group 2 (93%) than in group 1 (87.82%). Urethral fistula occurred in 16 patients in both groups. Overall satisfaction was noted in 193 patients. The authors concluded that combined buccal mucosa graft and labia minora flap was the method of choice for urethroplasty in metoidioplasty, minimizing postoperative complications.

A single-arm study by Weigert et al. (2013) evaluated patient satisfaction with breasts and psychosocial, sexual and physical well-being after breast augmentation in MtF individuals with gender dysphoria. Thirty-five patients were asked to complete the BREAST-Q Augmentation module questionnaire before surgery, at 4 months and later after surgery. A prospective cohort study was designed and postoperative scores were compared with baseline scores. Responses indicated significant improvements in satisfaction with surgery (+59 points), psychosocial well-being (+48 points) and sexual well-being (+34 points). No significant changes were reported for physical well-being. This study has several limitations including lack of a control group and subjective measures.

In a non-randomized study, Dhejne et al. (2011) evaluated mortality, morbidity and criminal rates after gender reassignment surgery in 324 individuals (MtF n=191; FtM n=133). Random population controls (10:1) were matched by birth year and birth sex or reassigned final sex. The authors reported substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts and psychiatric hospitalizations in sex-reassigned individuals (both MtF/FtM) compared to a healthy control population. FtMs had a higher risk for criminal convictions.

In a case control study, Kuhn et al. (2009) evaluated quality of life and general satisfaction in patients following gender reassignment surgery compared with healthy controls. Fifty-five individuals with gender dysphoria (52 MtF; 3 FtM) participated in the questionnaire-based study. Fifteen years after gender reassignment surgery, quality of life was lower in the domains of general health, role limitation, physical limitation and personal limitation. Overall satisfaction was lower in individuals with gender dysphoria compared with controls.

Kanhai et al. (2000) conducted a retrospective survey evaluating the effects of augmentation mammaplasty on MtF individuals with gender dysphoria. Of 164 questionnaires sent, 107 (65%) were evaluated. Average clinical follow-up was 4.8 years. The average time lapse between mammaplasty and filling out the questionnaire was 5.5 years. Seventeen of the 107 patients had undergone further augmentation mammaplasty, on average 57 months after the initial mammaplasty. Eighty patients (75%) indicated satisfaction with the final outcome of the mammaplasty. The remaining 27 patients (25%) were unhappy with the results of mammaplasty. This study has several limitations including a retrospective design and subjective measures.

World Professional Association for Transgender Health (WPATH)

WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, is an advocacy group devoted to transgender health. WPATH guidelines (2012) present eligibility and readiness criteria for transition-related treatment, as well as competencies of health care providers.

WPATH describes the transition from one gender to another in the following three stages:
- Living in the gender role consistent with gender identity
- The use of cross-sex hormone therapy after living in the new gender role for a least three months
- Gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months

Professional Societies

American College of Obstetrics and Gynecology (ACOG)

An ACOG committee opinion (2017) provides guidance on health care for transgender adolescents. The document makes the following recommendations regarding surgery:
- Obstetrician-gynecologists should understand gender identity and be able to treat transgender patients or refer them appropriately for medical and surgical therapeutic options.
- Surgical management for transgender male patients is typically reserved for patients 18 years and older.
- For transgender male patients, phalloplasty may be performed when the patient reaches the age of majority.
- Transgender female patients who choose to undergo surgery for a neovagina may have vaginoplasty after the age of majority.
- Transgender patients should be counseled about fertility and fertility preservation prior to surgical treatment.

A separate ACOG committee opinion (2011) provides guidance on health care for transgender individuals. The document makes the following recommendations regarding surgery:
- Obstetrician-gynecologists should assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies.
- Hormonal and surgical therapies should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender persons.

Endocrine Society

Endocrine Society practice guidelines (Hembree et al., 2017) addressing endocrine treatment of gender-dysphoric/gender-incongruent persons makes the following recommendations regarding surgery for sex reassignment and gender confirmation:

- Suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country (Recommendation based on low quality evidence).
- A patient pursue genital gender-affirming surgery only after the mental health practitioner (MHP) and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being (Strong recommendation based on low quality evidence).
- Surgery is recommended only after completion of at least one year of consistent and compliant hormone treatment unless hormone therapy is not desired or medically contraindicated (Ungraded Good Practice Statement).
- The physician responsible for endocrine treatment medically clears individual for surgery and collaborates with the surgeon regarding hormone use during and after surgery (Ungraded Good Practice Statement).
- Recommend that clinicians refer hormone treated transgender individuals for genital surgery when (Strong recommendation based on very low quality evidence):
  - The individual has had a satisfactory social role change
  - The individual is satisfied about the hormonal effects
  - The individual desires definitive surgical changes
- Suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement (Recommendation based on very low quality evidence).

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Gender reassignment surgeries are procedures, and therefore, not subject to FDA regulation. However, medical devices, drugs, biologics or tests used as a part of these procedures may be subject to FDA regulation. See the following website to search by product name: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed June 5, 2018)

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does have a National Coverage Determination (NCD) for Gender Dysphoria and Gender Reassignment Surgery (140.9). Local Coverage Articles (LCAs) also exist; refer to the LCAs for Gender Reassignment Services for Gender Dysphoria.
(Accessed June 7, 2018)

REFERENCES

American College of Obstetricians and Gynecologists (ACOG). Committee Opinion #512. Health care for transgender individuals. Obstet Gynecol. 2011 Dec;118(6):1454-8.

American College of Obstetricians and Gynecologists (ACOG). Committee Opinion #685. Care for transgender adolescents. Obstet Gynecol. 2017 Jan;129(1):e11-e16.

American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. Am Psychol. 2015 Dec;70(9):832-64.

American Psychological Association. Report of the task force on appropriate therapeutic responses to sexual orientation. Washington, DC: 2009.

American Psychological Association. Report of the task force on gender identity and gender variance. Washington, DC: 2009.

Bouman MB, van der Sluis WB, Buncamper ME, et al. Primary total laparoscopic sigmoid vaginoplasty in transgender women with penoscrotal hypoplasia: a prospective cohort study of surgical outcomes and follow-up of 42 patients. Plast Reconstr Surg. 2016 Oct;138(4):614e-23e.

Bouman MB, van Zeijl MC, Buncamper ME, et al. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function. J Sex Med. 2014 Jul;11(7):1835-47.

Buncamper ME, van der Sluis WB, van der Pas RS, et al. Surgical outcome after penile inversion vaginoplasty: a retrospective study of 475 transgender women. Plast Reconstr Surg. 2016 Nov;138(5):999-1007.

Byne W, Bradley SJ, Coleman E, et al. Report of the American Psychiatric Association task force on treatment of gender identity disorder. Am J Psychiatry. 2012 Aug;169(8):875-6.

Dhejne C, Lichtenstein P, Boman M, et al. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. PLoS One. 2011 Feb 22;6(2):e16885.

Diagnostic and statistical manual of mental disorders (5th ed.). 2013. Washington, DC: American Psychiatric Association.

Dreher PC, Edwards D, Hager S, et al. Complications of the neovagina in male-to-female transgender surgery: A systematic review and meta-analysis with discussion of management. Clin Anat. 2018 Mar;31(2):191-199.

Djordjevic ML, Bizic MR. Comparison of two different methods for urethral lengthening in female to male (metoidioplasty) surgery. J Sex Med. 2013 May;10(5):1431-8.

ECRI Institute. Special Report. Gender dysphoria. January 2016.

Frey JD, Poudrier G, Chiodo MV, Hazen A. A systematic review of metoidioplasty and radial forearm flap phalloplasty in female-to-male transgender genital reconstruction: is the "ideal" neophallus an achievable goal? Plast Reconstr Surg Glob Open. 2016 Dec 23;4(12):e1131.

Gaither TW, Awad MA, Osterberg EC, et al. Postoperative Complications following Primary Penile Inversion Vaginoplasty among 330 Male-to-Female Transgender Patients. J Urol. 2017 Oct 12 pii: S0022-5347(17)77717-8. doi: 10.1016/j.juro.2017.10.013. [Epub ahead of print].

Gooren LJ. Clinical practice. Care of transsexual persons. N Engl J Med. 2011 Mar 31;364(13):1251-7.

Hayes, Inc. Hayes Directory Report. Ancillary procedures and services for the treatment of gender dysphoria. Lansdale, PA: Hayes, Inc.; May 2014b; updated April 2018.

Hayes, Inc. Hayes Directory Report. Sex reassignment surgery for the treatment of gender dysphoria. Lansdale, PA: Hayes, Inc.; May 2014a; updatedApril 2018.

Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2017 Nov 1;102(11):3869-3903. https://academic.oup.com/jcem/article/102/11/3869/4157558.

Horbach SE, Bouman MB, Smit JM, et al. Outcome of vaginoplasty in male-to-female transgenders: a systematic review of surgical techniques. J Sex Med. 2015 Jun;12(6):1499-512.

Kanhai RC, Hage JJ, Mulder JW. Long-term outcome of augmentation mammaplasty in male-to-female transsexuals: a questionnaire survey of 107 patients. Br J Plast Surg. 2000 Apr;53(3):209-11.

Kuhn A, Bodmer C, Stadlmayr W, Kuhn P, Mueller MD, Birkhäuser M. Quality of life 15 years after sex reassignment surgery for transsexualism. Fertil Steril. 2009 Nov;92(5):1685-1689.e3.

Manrique OJ, Adabi K, Martinez-Jorge J, et al. Complications and Patient-Reported Outcomes in Male-to-Female Vaginoplasty-Where We Are Today: A Systematic Review and Meta-Analysis. Ann Plast Surg. 2018 Jun;80(6):684-691.

Morrison SD, Vyas KS, Motakef S, et al. Facial feminization: systematic review of the literature. Plast Reconstr Surg. 2016 Jun;137(6):1759-70.

Murad MH, Elamin MB, Garcia MZ, et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. Clin Endocrinol (Oxf). 2010 Feb;72(2):214-31.

Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

Sutcliffe PA, Dixon S, Akehurst RL, et al. Evaluation of surgical procedures for sex reassignment: a systematic review. J Plast Reconstr Aesthet Surg. 2009 Mar;62(3):294-306; discussion 306-8.

Van Damme S, Cosyns M, Deman S, et al. The effectiveness of pitch-raising surgery in male-to-female transsexuals: a systematic review. J Voice. 2017 Mar;31(2):244.e1-244.e5.

Weigert R, Frison E, Sessiecq Q, et al. Patient satisfaction with breasts and psychosocial, sexual, and physical well-being after breast augmentation in male-to-female transsexuals. Plast Reconstr Surg. 2013 Dec;132(6):1421-9.

World Professional Association for Transgender Health (WPATH). Standards of care for the health of transsexual, transgender and gender nonconforming people. 7th edition. 2012.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2020	• Policy retired; treatment for gender dysphoria is not covered in the state of Louisiana

Exhibit H

Declaration of Galina Mae Smith,

Health Programs Manager at the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

Affidavit of Galina Mae Smith

1. I, Galina Mae Smith, swear that the following is true, correct and complete to the best of my knowledge under the laws of the United States:
2. I am the Health Programs Manager at the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth (BAGLY). BAGLY is a Plaintiff in this action, acting on behalf of itself, its patients, and other recipients of its services.

3. I started working at BAGLY in 2017 as the Health Programs Coordinator and have worked in the organization's health programs since. In my current role, I manage clinic operations, including patient intake, phlebotomy, risk assessment interviewing, patient harm reduction, and biological sample management. I hold a certificate in phlebotomy in addition to my undergraduate degree.
4. Prior to joining BAGLY, I worked for Planned Parenthood of Southern New England as a clinic assistant. My work there constituted direct patient care, including phlebotomy, contraceptive care, abortion support, counseling, and education. This position provides me with further perspective about the health needs of young people in New England.
5. During my tenure at BAGLY, I have worked with hundreds of young LGBTQ people, which has provided me with a perspective informed by a broad range of youth experiences.
6. Much of BAGLY's health care work takes place through the Clinic @ BAGLY, a program that provides screening for sexually transmitted infections; sexual healthcare services provided by a nurse and peer health education; health care navigation with health insurance enrollment; and referrals for other LGBTQ welcoming providers.
7. All of these services are free of cost for people ages 29 and younger, and no one is required to provide proof of insurance or identification to access them. We maintain these policies and practices to extend the reach of BAGLY's services to those who may otherwise be unable to access traditional care.
8. BAGLY acts as a "safety net" program for LGBTQ youth. If a young person requires additional services that The Clinic @ BAGLY ("the Clinic") cannot provide, we refer them out for additional services at institutions that are LGBTQ centered and/or have a

sliding fee scale, since 28% of clients report having no insurance, and 18% of clients refuse to use their health insurance, citing safety or confidentiality concerns.

9. BAGLY also provides free mental health services to LGBTQ youth under 25 including a drop-in therapy program, group therapy, peer-led, adult-supported discussion groups, and art therapy.

10. One of our most popular programs, Tea Time, is a program providing individual therapy, letters of support for gender affirming surgery after counseling, and referrals to long-term care providers for young transgender people. There is usually a waiting list to get into the Tea Time program as we are unable to currently accommodate all the young people who would like to participate.

11. Our group therapy programs also typically reach capacity quickly, and we unfortunately often have to turn away youth who wish to join. There is only one other LGBTQ group therapy program in Boston, Boston GLASS, a program based in the Justice Resource Institute providing services to LGBTQ youth of color.

12. BAGLY's services are so popular, in part, because we have a reputation for being LGBTQ affirming and many of our young people have had negative experiences with other providers. During Clinic BAGLY's youth often share with me about their histories of poor treatment including being denied care by health care providers. This is so common that it is a topic we often process together in group therapy sessions. As the Health Programs Manager, our patients' histories of discrimination motivate me to make BAGLY as accessible and affirming a space as possible, so that young people have somewhere safe to go to receive care.

13. To maintain this space, we have maintained operation of all of our mental health services, with the exception of closed group therapy sessions, during the COVID-19 pandemic. We use an online video program called DOXY that allows us to connect with young people who otherwise may lack access to any other affirming space. Keeping this lifeline of support for our clients has been a key priority for BAGLY throughout the pandemic.
14. BAGLY's free, confidential services are especially important to young people who receive health insurance through their parents and wish to keep their healthcare decisions private. In Massachusetts, the PATCH Act protects confidentiality, but about 12% of BAGLY's clients are on the insurance plans of parents who = live out of state. This means that clinics like ours, which do not require young people to use their parents' insurance, are an especially supportive resource for youth who may want to keep private STI testing or gender affirming care.
15. The fact that 28% of our clients' report having out of state insurance, parental insurance, or no insurance at all, makes the Rollback Rule more concerning because while Massachusetts has anti-discrimination protections on the basis of sexual orientation and gender identity, the same is not true for clients from other states.
16. Through my years at BAGLY, I have spoken with many youths who expressed fear and confusion about the Trump Administration's policies that target transgender people, including the Rollback Rule. BAGLY has already experienced an increase in clients using our online counseling services in the months following the announcement of the Rule. We have had to add three additional counseling slots and we are still finding that we are not able to see every client who is interested in remote counseling.

17. I would estimate that, in our group therapy programs, discrimination specifically from healthcare providers (as opposed to discrimination in public places, for example) is described or talked about 20-30% of the time. There are some groups in which discrimination comes up as a topic more readily than in others, such as Disabilities Meeting (a group for people with disabilities), Trans Meeting (a group for all trans and/or nonbinary folks), Girl's Room (a group for trans women), and occasionally Women's meeting (a group for all women).
18. These fears are especially salient for BAGLY's clients who face multiple barriers to care based on their gender identity, race, access to housing, and English proficiency. These young people are already at a greater risk of discrimination when accessing care, and the Rule only seems to affirm their worst fears.
19. I believe these fears, coupled with the negative experiences many young people at BAGLY have had with other health care providers, will lead LGBTQ youth to avoid seeking needed health care. I have already witnessed instances in which our young people have forgone medical care because they could not get an appointment at Fenway or other LGBTQ affirming organizations and were not comfortable scheduling appointments at other healthcare establishments that were not LGBTQ-specific. The fear of discrimination coupled with the limited resources of LGBTQ affirming providers has therefore already led young people to forgo care. Recently, one young person relayed her experience trying to access emergency mental health care where she felt the provider asked invasive irrelevant questions about her identity and did not take her complaints seriously because she is transgender.

20. Avoidance of care puts our youth's safety in jeopardy. The youth I work with at BAGLY have told me that they are afraid of even calling an ambulance in an emergency because of fear they will face discrimination. To think that this Rule would further jeopardize our most vulnerable young people, those who experience violence or sexual assault and may feel unable to seek aid, is particularly disturbing.
21. The young LGBTQ people of color that we serve are also at particular risk to experience negative health outcomes based on multiple kinds of discrimination they may face when seeking care, and further deterred from addressing their health care needs.
22. This is especially dangerous during the COVID-19 pandemic, when our young people are more likely to need emergency health care services, which are strained.
23. Based on my knowledge of the barriers our young people face I expect that the Rollback Rule will drive more youth to rely on BAGLY's services. As a "safety net" provider, BAGLY will try to meet the needs of young people who feel unsafe going elsewhere. However, our resources are limited, and an influx of young people would seriously strain our financial stability. We have already seen an increase of young people utilizing our virtual programming in the past months. With some of our programs already operating at capacity, it is unclear how we would be able to meet this demand without somehow raising substantial new funds to hire an additional therapist and rent expanded space.
24. I also believe this Rule will increase confusion for young people and providers. I have already spoken with youth who are confused about how the Rollback Rule will affect protections against discrimination that exist for transgender and gender-non-binary people.

25. There was even confusion among staff about what the Rollback Rule would mean for our young people when it was announced. When even our professional staff who are trained in LGBTQ issues are uncertain about the impact of this law, I am worried that providers without specialized knowledge will be even more confused about what their obligations are and how to meet them.
26. With so much confusion created by the Rollback Rule, I believe that providers who wish to discriminate will feel emboldened to do so. I have heard young people describe experiences of being misgendered or asked inappropriate or invasive questions from health care providers since the rule's passage. I believe this Rule will degrade a standard of care since LGBTQ individuals will not know if their EMT, nurse practitioner, or specialist will treat them with respect if at all until it is too late.
27. The fear and uncertainty bred by the announcement of the Rollback Rule is amplified for our young people because of how recently Massachusetts enacted gender identity protections in public accommodations. Gender identity was only added to our state's civil rights law in public accommodations in 2015 and was challenged by a popular vote in 2018. The fluctuation of our state's protections and the apparent hostility of many exacerbates some of our youth's feelings of precarity and fear.
28. Additionally, about one third of BAGLY's clients come from outside of Massachusetts or are on parents' insurance plans that are based outside of Massachusetts, including some localities that have no explicit state or local protections on the basis of gender identity.
29. This uncertainty will lead more young people to go where they feel safe, places like BAGLY. I have had so many young people tell me that the care they receive at BAGLY feels more affirming than the care they have had at general providers. While this is

wonderful for these youth, if there is a major increase in need for our services because of the Rollback Rule, we will be unable to provide this affirming care to the many young people who will need it. With only two fulltime and one part-time staff members on our healthcare team, we cannot meet the health care needs of all young LGBTQ people in Boston.

30. My understanding of the Rollback Rule is that, among other things, it has changed the scope of entities that are subject to the protections of 1557. Namely, HHS now exempts many insurers from complying with them. Providing care will be even more difficult if the insurers of our young people, especially the one third of insurers of our young people outside of Massachusetts, restrict reimbursements. While we do not require insurance information, we do collect it when possible, and it is used to pay for lab fees and other costs. If more insurers dropped coverage for transition related care, our budget would have to be shifted to find ways to make up this gap or to take on fewer patients. This would seriously harm and limit our ability to serve young LGBTQ people.
31. BAGLY may also need to spend time revamping its referral system in light of the Rollback Rule. If some insurers will no longer cover gender affirming care, we must make sure that the places where we are referring our young people will provide affordable care. This is already a problem for specialists like endocrinologists who are needed for gender affirming care.
32. In response to the recent influx of questions about the Rollback Rule from our young people BAGLY staff are considering developing a medical Know-Your-Rights training for young LGBTQ people as a way to combat their confusion and fear. These responsive changes will put further strain on BAGLY's staff and resources.

Dated: 11/17/20
Boston, Massachusetts

/S/ Galina Smith
Galina Smith

Exhibit I

Declaration of Wendy Stark,

Executive Director of Callen-Lorde Community Health Center

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH, et al.,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF WENDY STARK, EXECUTIVE DIRECTOR OF CALLEN-LORDE COMMUNITY HEALTH CENTER

I, Wendy Stark, declare under penalty of perjury that:

1. I am the Executive Director of Plaintiff Callen-Lorde Community Health Center ("Callen-Lorde"). In this capacity, I am responsible for overall organizational performance, including clinical, administrative, finance, and governance functions to ensure the mission of the organization is maintained as per the strategic direction-setting of the Board of Directors.

2. Callen-Lorde is a federally qualified health center whose mission is to provide sensitive, quality health care and related services primarily to New York's lesbian, gay, bisexual, and transgender communities—in all their diversity—regardless of ability to pay; and in furtherance of that goal, to promote health education and wellness and to advocate for gay, lesbian, bisexual, and transgender (LGBTQ+) health issues.

3. Callen-Lorde provides primary care, dental care, behavioral health care, care coordination and case management, as well as health education services, to a primary care patient base of nearly 18,000 people at four locations in New York City.

4. Primary care is the provision of preventive healthcare and treatment throughout a person's life cycle, which serves as the centralized foundation for the management of comprehensive clinical needs. All of our patients are enrolled in our primary care services; they are the foundation through which we provide our other healthcare services as well as our referrals to others' services. For our population, primary care includes the provision of gender-affirming care, such as hormone replacement therapy, as treatment for gender dysphoria. It also includes other care focused specifically on LBGTQ+ populations, such as sexual and reproductive healthcare, pregnancy testing, and contraceptive counseling. We also offer referral services for patients who need care we do not provide. Most of our surgical referrals are for gender-affirming surgical procedures, such as top and bottom surgery or facial feminization surgery. We also refer for prenatal care and assisted reproductive technology.

5. Callen-Lorde's primary patient population is almost entirely LGBTQ+: about four-fifths identify as lesbian, gay, bisexual, or having a sexual orientation other than heterosexual; and over 4,000 are transgender or gender non-conforming—to our knowledge, the largest such outpatient practice in the US and likely the world. Callen-Lorde's patients also have limited financial resources. At least 23% of the patient population lives at or below 150% of the federal poverty line, and about 14% of the patient population is homeless or unstably housed. Many patients also lack or have limited health insurance coverage. We subsidize the patients' care through providing services on a sliding-fee scale based on ability to pay; many patients pay nothing. About 26% of Callen-Lorde's patient population is uninsured, and about 29% receive Medicaid or other income-based public insurance. The remainder have insurance through private and public sector employment, the marketplace, or Medicare. A significant proportion of

our patients have a criminal history. About 2.4% of our patients report that English is their second language. Some of our patients are undocumented.

6. Through its telehealth program, Callen-Lorde also provides direct health services to patients outside of the New York City area. Telehealth services encompasses episodic, medical, mental, and dental healthcare. Our primary telehealth services encompass most forms of primary care that don't require physical examinations, including chronic condition management and hormone replacement therapy management.

7. About seven percent of our patients visit us from out-of-state. We have at least one or two patients from almost every state. Larger numbers come from several distant states, such as Texas, Florida, and Georgia. These patients come to us largely because they have been unable to find adequate healthcare in their communities.

8. Callen-Lorde also provides an eConsult service to assist other clinicians with providing competent healthcare to transgender and gender non-binary people around the nation. The clinicians served through Callen-Lorde Community Health Center's eConsult service are largely in community health centers, correctional facilities, or rural areas. This program improves patient care quality and avoids unnecessary procedures and referrals as well as referrals to the wrong specialty.

9. Callen-Lorde also undertakes and participates in federally- and privately-funded research into improving healthcare outcomes among LGBTQ+ communities.

10. On June 14, 2019, the United States Department of Health and Human Services (HHS) issued a Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) ("2019 Proposed Rule"). In response

to the 2019 Proposed Rule, Callen-Lorde submitted a Comment Letter to HHS. *See* Callen-Lorde, Comment Letter on 2019 Proposed Rule (Aug. 7, 2019), https://bit.ly/38s6rVf. The Comment Letter succinctly expressed that the 2019 Proposed Rule:

> would severely threaten LGBT patients' access to all forms of health care, create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBT people, and enable insurance companies to deny transgender people coverage for health care services that they cover for non-transgender people. The rule would also make it harder for other people experiencing discrimination in health care to know and exercise their rights . . . .

11. On June 19, 2020, HHS published a final rule that adopts the entirety of the 2019 Proposed Rule, with only a few minor changes that do not affect its impact on LGBTQ+ people. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that we raised.

12. Most of Callen-Lorde's work is related in some way to addressing discrimination and its effects. The LGBTQ+ patient population that we serve suffers severely from discrimination, which in turn leads to disparities in health care access and outcomes. Patients, especially our transgender ones, come to us having been regularly treated with skepticism, contempt, judgment, ignorance, or fear by many in the healthcare system. Often they have been unable to obtain necessary care, or been unwilling even to seek it due to past bad experiences. Only recently has the healthcare system at large begun to demonstrate increased awareness of the need to provide affirming healthcare services to the LGBTQ+ population and to combat discrimination against them—a change that has been driven in great part by legal developments such the Affordable Care Act and its implementing regulations, which the Administration is now

attempting to roll back. We have seen the change in our patients' attitudes and their ability to access healthcare as these developments chip away at discrimination and its legacy. But this development is still incipient and incomplete, and it is still subject to reversal.

13. A study released by the Institute of Medicine in 2011 found that 56% of lesbian, gay or bisexual respondents and 70% of transgender respondents had experienced discrimination in healthcare settings. A 2001 study by the Gay and Lesbian Medical Association also found that a lack of culturally competent providers is a major barrier to healthcare, with 40% of respondents reporting a lack of adequately trained healthcare professionals.

14. Due in great part to many providers' substandard treatment of transgender patients, transgender patients are often reluctant to seek care. Before Section 1557's implementing regulations first came out, twenty-eight percent of transgender New Yorkers reported not having a regular health care provider and therefore utilizing fewer preventative services (Porsch et al., *An Exploratory Study of Transgender New Yorkers' Use of Sexual Health Services and Interest in Receiving Services at Planned Parenthood of New York City*, 1 Transgender Health 1, 2016). Another pre-Section 1557 survey found that 23 percent respondents nationwide did not see a provider for needed health care because of fears of mistreatment or discrimination. Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 5 ("2015 Transgender Survey") (2016).

15. The enactment of Section 1557's implementing regulations and some state rules and laws about sex and gender identity discrimination has reduced but not eliminated these problems. When we recently surveyed a group of our own transgender patients, one-fifth reported having been denied care due to a provider's personal objections to caring for transgender patients. Structural barriers that have slowed progress include our patients'

difficulties finding an LGBTQ+-friendly medical or mental health care provider, and a lack of provider focus/knowledge of health issues specific to the LGBTQ+ community. Short provider visits may compromise building of trust between an LGBTQ+ patient and provider. These barriers continue to exist in part because rules against discrimination against LGBTQ+ patients are new and incomplete, and many providers have not yet developed competency in treating patients that they perceive as difficult or have long sought to avoid; or they are still unaware of what these rules require.

16. As an example of this second problem, Callen-Lorde's own research has shown that many health insurance plans do not yet comply with regulations protecting transgender and gender non-conforming people, such as New York State's requirement that they not withhold coverage of medically-necessary healthcare related to treating gender dysphoria (Ray Edwards, *Barriers to Accessing Gender Affirming Care: Insurance Coverage in New York State*, Dec. 2019) ("Trans Health Advocacy Working Group Report"). Moreover, New York law does not mandate coverage for gender dysphoria treatments that many insurers erroneously deem "cosmetic," and such denials are the reason many transgender patients' gender dysphoria and related conditions are untreated or undertreated. (Trans Health Advocacy Working Group Report). As of 2018, approximately 16% of Callen-Lorde's patients seeking support for gender affirming care or surgeries were denied coverage, resulting in hundreds of hours of staff time and delayed or no care for patients.

17. These barriers to accessing care can lead LGBTQ+ individuals to delay or avoid seeking treatment for medical needs or mental health/substance abuse issues. Delays in treatment can result in further exacerbation of medical/behavioral health issues. This in turn means that Callen-Lorde needs to work harder to address our patients' needs.

18. Because of the discrimination and delays they have faced, Callen-Lorde's patients often come to us sicker, and with greater healthcare and supportive service needs. Our patients' more acute conditions therefore also require more treatment and medication to stabilize their conditions. Likewise, our nurses' chronic disease management care, our dental care, and our healthcare also require greater commitment of staff time and training to build trust and overcome the effects of discrimination. For example, over the past decade, almost all demographic groups in New York people have seen significant decline in new HIV diagnoses, with the exception of transgender persons (HIV Surveillance Annual Report, 2017). Transgender people living with HIV are also more likely than the general population of people living with HIV/AIDS to have a history of one or more co-occurring challenges such as substance use (30%), incarceration (23%), sex work (6%), homelessness (6%) and sexual abuse (2%) (NYCDOHMH, 2018 report).

19. Among our transgender patients, too many (especially those from distant states) have to come to us because they were unable to obtain coverage for hormone replacement therapy or gender affirming surgery, and so obtained them through underground means. Often, this meant obtaining hormone treatments from providers who were not operating in safe environments, or who provided harmful substances, which damaged our patient's health.

20. In order to improve health outcomes and effectively engage our patients in ongoing primary care, Callen-Lorde knows that we must meet them where they are, and that includes addressing their health needs and barriers to healthcare access comprehensively. We have learned through experience that effective healthcare interventions must be centered around resiliency and relationship-building, earning the trust of each patient through trauma-informed care and a non-judgmental, harm-reduction approach. The more discrimination is permitted, or practiced, the harder this becomes. Callen-Lorde's healthcare services are aimed to address the

health disparities faced by people who live with the stress of discrimination and actual or threatened violence in their day-to-day lives. In addition to understanding the clinical needs of our patients and striving to provide an affirming environment (including inclusive intake forms, inclusive sexual health history questionnaires, etc.) for people to be able to disclose and discuss sensitive psycho-social concerns as well as physical health needs, we strive to provide an environment of care that counteracts the devaluation of lives that many of our patients encounter outside of our doors.

21. For example, our clinical spaces include photographs of our own community members, as patients rarely see images of folks who look like them portrayed as beautiful, strong, or happy. As part of new staff orientation, all our new hires receive transgender and gender-non-binary (TGNB) competency training, and anti-racism training. We provide periodic training regarding the LGBTQ+ community's specific health needs. including how to provide clinically and culturally competent care, such as trainings on cultural humility, and on undoing racism in the context of intersecting identities. We have grand rounds on topics like Black LGBTQ+ health and on racism with in the LGBTQ+ community. We have detailed policies on correct pronoun and gender marker usage and other ways to ensure that appropriate care is a part of our employees' work performance.

22. We also have to have detailed procedures and exhaustively train our staff to aid patients who've been denied care or coverage for care for discriminatory reasons. Callen-Lorde has spent considerable time, effort, and organizational resources over the last several years in assisting individual patients in filing complaints or legal actions against health plans refusing to cover gender affirming services. We have a transgender care coordination team and a robust gender affirming surgery education and preparation program for our transgender and non-binary

patients, staffed with surgical doulas, in which patients can opt in to group sessions about surgery options and how to prepare for them. We have worked to identify the gaps throughout the medical system that tend to fail our low-income transgender patients most often, and created carefully curated programming that includes medical and behavioral health support as well as specialized case management and patient navigation services. We operate a specialized clinic to serve transgender patients engaged in sex work and the street economy, in close coordination with community partners. Our TGNB patients receive pre and post-operative care planning, medical education, and insurance navigation to support their transition more fully. The catalyst for this work began with providing health policy education for our patients who struggled to navigate the complexities of their health plans.

23. In our care coordination programs, we work with patients who are wrongfully denied coverage by their insurance provider. We work with our patients directly to help them assemble and present their appeals when they are denied coverage for the care we provide them. We also do the same with many patients whom we refer to other providers for care, and whose coverage is denied, because many providers lack the requisite expertise or ability to assist. We also have a referral service for patients to obtain counsel should their appeals fail. Our medical providers also regularly conduct peer-to-peer reviews with insurance carriers, to advocate on behalf of their patients.

24. We also have to work with patients who are all to often unwilling to go to emergency rooms or even leave emergency rooms because of discrimination. Two recent cases (out of many) are illustrative. We had a patient come to our practice for an urgent appointment with possible stroke symptoms, and initially refused to go to an emergency room due to past experiences with discrimination. Another of our patients, needing inpatient care for an infected

and blocked central line, left an emergency room bleeding and without treatment because the hospital tried to force him to be admitted and treated as a woman; he took an Uber to a different hospital. As a result of incidents like these, we have created a special program called HEALS (Hospital Escort Advocacy Liaison Support) where highly trained volunteers accompany transgender patients to emergency rooms. Thus, we were able to persuade our stroke symptom patient to obtain emergency care by sending a HEALS volunteer to accompany her to the ER; the volunteer was able to intervene when, at one point, some of the nurses began behaving inappropriately, such as touching her face while asking, "You're transgender? But how? You're so pretty!" The HEALS volunteer stepped in to advocate for the patient, redirecting hospital staff to the medical emergency at hand. Each HEALS volunteer requires 50 hours of initial training and 30 hours of annual renewal training by our staff.

25. The Rollback Rule will exacerbate these challenges. It will roll back much of the incipient progress we have seen in recent years in assisting our patients to overcome barriers brought about by discrimination. It will contradict the message we have been trying to inculcate throughout the healthcare system that discrimination is harmful, wrong, and impermissible. It will require a robust response from us.

26. Our patients who are Medicare beneficiaries often face difficulties obtaining coverage for gender-affirming healthcare. Because these health plans are part of the federal government, I expect that they will follow the Rollback Rule to the letter and cease addressing these coverage denials as sex discrimination. They will deny more care and be less responsive to appeals.

27. I also expect private insurers will understand the Rollback Rule to mean that they are no longer constrained from offering plans that categorically exclude gender-affirming care or

other sex-based treatment that HHS incorrectly asserts to be exempt from Section 1557's scope. This includes both care related to gender transition and sex-based care—things like preventative mammograms for transgender women, which may be denied coverage on the erroneous basis that the patient is "male" and does not need such care. For example, members of our transgender care coordination team recently communicated extensively with a patient's employer to ensure coverage for a gender-affirming procedure that should not have been excluded from the patient's health plan under Section 1557; and yet they were unable to resolve the situation and get coverage for the patient.

28. I also expect employers who say that their religion prohibits their covering their employees for medically-necessary gender-affirming care, like hormone replacement therapy, will also cease to cover such care. For example, our surgical doula has been unable to obtain coverage for a gender-affirming procedure for a patient whose employer offers a health plan through Fidelis Care, which is a plan originally founded under the auspices of the Catholic dioceses of New York City that may still be using legacy practices despite a recent change in ownership.

29. The Rollback Rule's resulting reduction in health insurance coverage will require us to devote even more staff time and resources to assisting patients with obtaining approval. Callen-Lorde will also necessarily increase efforts to facilitate referral to legal services.

30. Increased denials of coverage will result in our patients having more un- and under-treated conditions, further exacerbating existing health disparities and taxing an already over-burdened safety-net system for behavioral health and primary care needs. One-third (33%) of transgender people in a recent survey reported that there was at least one time in the past year when they needed to see a doctor or other health care provider but did not because of cost (2015

Transgender Survey). When insurers do not cover transgender health care costs, it causes an enormous health problem for an economically-disadvantaged population.

31. Increased insurance denials also affect Callen-Lorde's financial ability to provide care. All of Callen-Lorde's services are provided regardless of a patient's ability to pay and accessible on a sliding fee scale. In the face of widespread challenges resulting from the coronavirus pandemic, Callen-Lorde's financial position is not sufficiently strong to subsidize the expected increase in uncompensated care that would result from the Rollback Rule. We have no reason to expect additional state, federal, and local government support to help us to respond to the expected increase in community need from under and uninsured patients without significant reduction in spending on other services.

32. I also expect healthcare providers and facilities will understand the Rollback Rule to mean that they are no longer constrained by federal law from misgendering transgender patients, treating them as a curiosity or problem, or refusing to provide medically-necessary gender affirming care. For example, we have a patient who is currently seeking coverage for a hysterectomy; the surgeon who was slated to provide this care ceased returning the patient's communications after learning that the purpose of the surgery was to treat gender dysphoria, and we have been unable to rectify this situation, although we understand it to be illegal sex discrimination.

33. Callen-Lorde devotes also time and effort to maintaining our preferred providers list for providers to whom to refer patients for care we do not provide; and ensuring that providers who discriminate against LGBTQ+ people. The Rollback Rule will require us to undertake greater efforts to ensure providers emboldened by the Rule are kept off of it.

34. Likewise, increased discrimination by providers and facilities will exacerbate the already significant problems faced by our patients in obtaining care and protecting their health, placing further strain on the fraying safety net systems available for this care, including Callen-Lorde. This will require us to provide more care, and to more people.

35. We expect to see especially great increases in patient numbers, and decreased insurance coverage, among patients coming to us from out of state. People travel great distances to us because the care they need is unavailable due to discrimination—for example, health plans that refuse to cover gender-affirming care, or providers who refuse to provide gender-affirming care or even properly care for TGNB patients at all. This may not even be illegal under the laws of many states, and so they come to us. The Rollback Rule will increase the number of such patients we must care for.

36. Our patients have expressed that the Rollback Rule is a barrier to seeking and access healthcare for them, and we anticipate that it will require us to respond to increased demand for services, like our HEALS program, that assist our patients overcoming such barriers to care. One patient recently told us, "Having been born an FtM [i.e. a man assigned a female sex at birth] transgender individual, prior to access to all forms of medical care was fraught with huge financial and access related obstacles prior to Section 1557 of the Patient Protection and Affordable Care Act. For example, I was forced to leave the United States and go to Serbia for life saving and affirming gender corrective surgeries because my insurance would not cover the procedures. The Rollback Rule would reinstate insecurities and uncertainties concerning even basic treatment coverage going forward for me as a post-operative FtM individual, including a fear of rejection from health related services such as a stress test, eye exam, yearly physical examinations, and dental work based on a doctor refusing service to transgender patients and the

concern that medications, such as needed hormones, will no longer be covered by insurance." Another patient recently told us about the Rollback Rule, "I've always been an optimist. But for the first time ever I'm troubled about the future of protection for me and all LGBT. My family and I are seriously considering moving to another country." Another patient said simply, "As a trans person I have experienced discrimination in health care that has negatively impacted my health. The rollback has exacerbated these struggles by creating a patchwork of rules and protections that has sowed fear and confusion in my community."

37. We have had to address all of the numerous inquiries from our patients about whether they still have rights to healthcare and how the Rollback Rule will affect them, and try to calm their fears.

38. In sum, the Rollback Rule is already resulting in our patients becoming more fearful of seeking care and coming to us with greater needs. Our ability to educate providers and insurers about the need to cease discriminating for legal and community health outcome reasons and to provide care and coverage is already being hampered. We are preparing for reduced health insurance coverage of our patients' needs, and for increased difficulties in referring patients for care we do not provide, including increased denials of care. We anticipate a decrease in our ability to fund our provision of primary care, while simultaneously increasing the demand for that care.

Dated: November 17, 2020.

/s/ Wendy Stark
Wendy Stark
Executive Director
Callen-Lorde Community Health Center

Exhibit J

Declaration of Grace Sterling Stowell,

Executive Director of the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; and Transgender Emergency Fund of Massachusetts, Plaintiffs, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-11297

Affidavit of Grace Sterling Stowell

1. I, Grace Sterling Stowell, swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:
2. I am the Executive Director of the Boston Alliance of Lesbian, Gay, Bisexual, Transgender, Queer Youth (BAGLY). Our organization is a nationally recognized model of lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth leadership and services and has worked with over 40,000 young people since its founding in 1980. BAGLY is a

Plaintiff in this action, acting on behalf of itself, its patients, and other recipients of its services.

3. I joined BAGLY shortly after it was founded in 1980 and served as a volunteer leader until I was hired as its first paid Executive Director in 1995. Now, with a graduate degree in Counseling Psychology, and 40 years' experience working on behalf of LGBTQ youth, I have developed significant expertise and understanding of their needs and best practices to address those needs.

4. During these past four decades, I have led the expansion of BAGLY from an all-volunteer, grassroots social support group in Boston, to an established, nonprofit youth leadership, health promotion, and advocacy organization serving several thousand LGBTQ youth annually throughout Massachusetts.

5. I am also an active leader in local and national movements to expand community organizing, political advocacy, and resources for LGBTQ youth programs and services. I am a founding member of the Healthy Boston Coalition for GLBT Youth, the Massachusetts Governor's Commission on Gay and Lesbian Youth, and the National Youth Advocacy Coalition in Washington, D.C. I also currently serve as a member of the Massachusetts Commission on Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth, and as a steering committee member of the Massachusetts Transgender Political Coalition.

6. My work has been recognized by The International Court Council and the National Gay & Lesbian Task Force's "Stonewall Trans Heroes 40," and I was the recipient of the 2010 Susan J. Hyde Activism Award for Longevity in the Movement, in recognition of more than 35 years of leadership in the social justice and GLBT communities

7. Supporting LGBTQ youth's health is one of BAGLY's top priorities. We have two full time staff members and one part-time consultant dedicated to health care work for our youth. We are one of only three providers in the Boston area focused on serving LGBTQ youth, the other two being Boston GLASS, a program for LGBTQ youth of color at the Justice Resource Institute, and the Sidney Borum, Jr. Health Center at Fenway Health.
8. The Clinic @ BAGLY ("the Clinic"), a partnership with Fenway Health, is one of the ways we meet young LGBTQ people's health care needs. The Clinic provides screening for sexually transmitted infections, sexual healthcare services provided by a nurse and a peer health educator, assistance enrolling in health insurance, and referrals to other LGBTQ welcoming providers.
9. BAGLY also holds monthly workshops to teach young people about health topics such as HIV prevention, transgender healthcare, and healthy relationships.
10. To make our services as accessible as possible, the Clinic provides all of these services free of cost for LGBTQ people who are 29 or younger.
11. In addition to the work we do through the Clinic, BAGLY also provides mental health services to LGBTQ+ youth under 25. We offer a drop-in therapy program, group therapy, peer-led, adult-supported discussion groups, and art therapy for our clients.
12. Tea Time is one of our mental health programs that specifically focuses on providing services to transgender youth. We are able to do this thanks to funding provided by a block grant from Boston Children's Hospital. A licensed independent clinical social worker (LICSW) runs Tea Time, and provides individual therapy, evaluations for gender affirming surgery, and referrals to long-term care providers for transgender young people.

13. Tea Time is a popular program at BAGLY, and consistently has a waiting list for young people to join. If, the Rollback Rule results in fewer trans-affirming providers in the area or if transgender young people become more afraid to approach other providers, demand for services like Tea Time that are a well-known resource for this community will undoubtedly increase. BAGLY has already seen an increase in young people using our remote counseling services over the summer. A continued increase in demand would further strain our ability to serve our clients and increase the unmet needs of the population.
14. BAGLY serves over 2500 youth annually, and of those, over 98% are LGBTQ, over 60% are transgender and/or non binary (over 1500 youth annually), and over 35% are homeless, unstably housed, or financially struggling.
15. BAGLY's Sexual Health Clinic and Behavioral Health Services serve over 350 youth annually, and of those, over 45 % are transgender and/or nonbinary (over 158 youth annually), and over 23% are homeless/unstably housed/financially struggling.
16. Financial accessibility is not the only concern for BAGLY's clients. 3% of the young people who access our services also have limited English proficiency, further complicating health care access.
17. Because of the barriers to accessing health care for LGBTQ youth, I am greatly concerned about the effect of the Rollback Rule on BAGLY's young people. Over my four decades of experience working with LGBTQ youth, I have seen discriminatory laws and policies cut vulnerable young people off from vital services and support, and the devastating impacts of this. I have also seen such laws provoke confusion and fear for LGBTQ community members and embolden those who wish to discriminate against us. I

believe that this Rollback Rule will be another such policy, encouraging discrimination, cutting off access to care, and harming the young people with whom BAGLY works.

18. As Massachusetts and federal laws have changed over the last five years, we have also seen an increase in LGBTQ-friendly providers for our young people. I believe this is due, in part, to the strong support for transgender health care access by the Federal Government in the Obama administration's 2016 rule. This rule helped to make providers aware of their obligation to care for all patients, and opened doors to more options for our youth. This has given BAGLY more referral options and places where we can send young people to share the burden of their care.
19. The Rollback Rule will likely reverse this trend, creating new burdens on BAGLY's resources. I expect BAGLY will see an increase in demand for our services if the Rollback Rule goes into effect. BAGLY staff have already told me about youth who are concerned about safely accessing care from other providers because of the hostility of the presidential administration towards LGBTQ people apparent from their attempts to eliminate protections including the Rollback Rule. In response, more people will go to providers like us that explicitly welcome LGBTQ people. This will put a strain on our limited financial resources as we struggle to meet this increased need.
20. As BAGLY has served LGBTQ youth in the Boston area for decades, we are well-known as a "safety-net" provider of services. Fear of discrimination will drive more young people to BAGLY, both to receive services and to be referred to other providers who we can vouch for as safe and affirming.
21. As certain programs like Tea Time are already operating at capacity and have a waiting list, I expect the Rollback Rule will likely increase unmet need for LGBTQ youth as well

as straining BAGLY's resources. To expand our mental health services, BAGLY would need to hire an additional therapist and rent a larger space to accommodate more sessions, both of which would be major, unanticipated expenses for BAGLY.

22. BAGLY has limited financial resources to dedicate to its healthcare services, and it does not anticipate an increase in funding that will match the increase in need for services. BAGLY's 2020 annual operating budget is $1,557,299.00, and of this, $933,732.00 is health related contracts through a combination of city, state and foundation grants. $635,232.00 is granted to BAGLY from the Massachusetts Department of Public Health specifically for HIV/AIDS, sexual health services including the BAGLY Clinic. An additional $100,000.00 is granted to BAGLY from The Boston Children's Hospital Collaborative to support mental health services. This grant is not tied to the number of clients and is procured for several years at a time. Therefore, in the event that BAGLY receives an influx of patients seeking mental health support, we would struggle to serve an increased patient base without additional funding. All of this funding is time limited and several grants are subject to renewal. Based on my decades of experience as an Executive Director, times of economic downturn like the one we are entering, due to the impact of the COVID-19 pandemic, make fundraising for new initiatives or expansion of services particularly difficult.

23. Because of this, the Rollback Rule is a danger to BAGLY's financial stability, ability to meet the needs of our young people, and to the health of young LGBTQ people in Massachusetts. This Rule would put BAGLY under enormous strain and, more importantly, risk the wellbeing and lives of the young LGBTQ people who BAGLY serves.

Dated: November 18, 2020
Boston, Massachusetts

/S/ Grace Sterling Stowell
Grace Sterling Stowell

Exhibit K

Declaration of Stephe Thayer Koontz,

Member of Campaign for Southern Equality

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts, v. United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*, Defendants.	Civil Action No. 1:20-cv-11297

Affidavit of Stephe Thayer Koontz

I, Stephe Thayer Koontz, swear that the following is true, accurate and complete to the best of my knowledge under the laws of the United States:

1. I am a city council member of Doraville, Georgia and a member of Campaign for Southern Equality ("CSE"). I have donated money to CSE and engaged with their content on their website as well.
2. I have faced many barriers to access health care and have experienced poor treatment by medical providers throughout my life simply because I am a transgender woman.

3. Before the Affordable Care Act ("ACA") was enacted, I was unable to obtain health insurance simply because I am transgender. When I began my medical transition in order to obtain hormone replacement therapy ("HRT") I was required to meet with a psychiatrist to receive a diagnosis for what was known as "gender identity disorder" at the time.[1] Without it, I would not have been able to obtain medically necessary hormone treatment. However, this diagnosis was considered a pre-existing condition making me ineligible for health insurance. Every time I talked to an insurance agent I was told that, because of this diagnosis, very few policies were available to me and the monthly estimates of the few plans I did qualify for cost more than my income. I was trapped in a catch-22: in order to get the care I needed, I was required to receive a diagnosis that made me ineligible to obtain health insurance coverage. For this reason, I was only able to obtain health insurance after the ACA went into effect because of the law's prohibition against refusing coverage due to pre-existing conditions.
4. I paid out of pocket for my care for over 5 years, including a bilateral orchiectomy that cost me $4000, as well as thousands of dollars of regular doctors' visits and all of my transition related care including short term psychiatric care for my gender identity disorder diagnosis and my subsequent HRT.
5. I have also, on numerous occasions, faced very poor treatment by medical professionals. Most recently, one morning around 11am in late February of 2018, I went to the Emory Hospital's Emergency Department located at 1364 Clifton Rd, Atlanta, GA 30322

[1] "Gender dysphoria" previously known as "gender identity disorder" under the 5th edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") is a condition recognized as a marked, persistent difference between a person's assumed gender at birth and their actual gender identity. Gender Dysphoria is characterized as "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)." Am. Pyschiatric Ass'n Diagnostic and Statistical Manual 5th Ed. (2018).

because I had a splitting headache unlike any I had experienced before. The headache was so severe it caused me unbearable pain and made my right eye droopy. I was concerned the headache was caused by a blood clot or a stroke since I was receiving HRT, which increases the risk of blood clots.

6. The treating doctor was very friendly and cordial with me at first, smiling and exchanging pleasantries, as I described my symptoms to him. When I disclosed that I am transgender, including that I was on HRT and had undergone an orchiectomy—which I believed were relevant given my concern about blood clots—his entire demeanor immediately changed. He became very short with me and said, "we're done for now" and abruptly left the room and never returned.
7. There was another person also in the room who had been taking notes. When the doctor left the room, she appeared very confused and surprised. She hesitated, appearing unsure of how to proceed, and after about 20 seconds she followed the doctor out of the room. Her reaction led me to believe that the doctor was not, in fact, done with the examination. I was in pain the entire time I was in the emergency room.
8. Radiological imaging revealed that I had a dissected carotid artery—a very dangerous, life-threatening condition. I learned this because the radiologist told me. I asked the nurse conducting rounds on the floor what a dissected carotid artery was because the treating doctor was nowhere to be found. She responded words to the effect of "well it's not good. It's a very serious condition."
9. I was in excruciating pain but because the hospital could not locate the doctor I initially saw, I was provided with no answers or treatment for several hours. At around 5pm I was in such excruciating pain I was balling and begging hospital personnel for pain

medication, but because they could not locate the treating doctor, I was not given any for several hours. My right eye was drooping, and I was scared I had undergone a stroke but no doctor was present to explain what was likely happening to me. My understanding is that there is only a short period of time that treatment of a stroke can reverse any of the effects. I was terrified I might have missed out on that treatment because the doctor refused to see me or respond to the nurses.

10. Throughout the ordeal I was terrified for my life because of the absence of care at Emory. I had heard news reports about Tyra Hunter, a transgender woman who was injured in a car accident who died because the EMTs refused to treat her when they discovered she was transgender.
11. I refused to leave the hospital until I received medical advice. After the hospital could not locate the treating doctor who had conducted the initial exam and left abruptly, an on-call doctor came in around 7 or 8pm who finally explained my condition to me. I know this because this on-call doctor told me that is what happened. I never saw the first doctor or the other person taking notes with him again.
12. I later learned that a dissected carotid artery is a very dangerous condition that can block blood flow to the brain and in approximately 20% of the cases is immediately fatal, and left untreated, has an even higher incidence of death. The hospital kept me overnight for observation and eventually gave me aspirin for the pain and as part of the blood thinning treatment. I believe my treatment for this life threatening condition and pain management would have been started hours earlier if I had been a cisgender patient.
13. The next morning my brother, who had worked for a hospital in the past, came to advocate for me. With his advice I asked to speak with the hospital's risk management

team and made an internal complaint about what had happened. It was my understanding that the doctor who disappeared would be disciplined in some manner. The head of the neurology department came to speak with me as well. He was not apologetic and appeared exasperated. My brother was with me and witnessed this conversation.

14. Emory hospital is the closest hospital to where I live. After this nightmarish experience, I feared having to return in the event of another emergency. The only reason I went on this regrettable occasion was because I feared I was experiencing a life-threatening condition. Unfortunately, I did have to return to the hospital on a couple other occasions since—twice for follow up appointments with the hospital's neurology department to monitor my carotid artery, and another time to meet with a urologist to perform corrective surgery because I continued to experience constant pain after I underwent an orchiectomy. Thankfully those visits were not in the emergency department, but I was still very apprehensive about going there. My age and weight make me more vulnerable to COVID-19 infection and I still fear having to return to any doctor's office or emergency department to this day.

15. Suing in court to challenge the treatment I received at Emory Hospital's Emergency Department was not a realistic option for me at the time. I had neither the financial resources nor did I even know where to start, knowing that transgender people are so regularly discriminated against. I spent three years cold-calling surgeons to find one who would investigate the cause of my chronic pain after my botched bilateral orchiectomy; it seemed a foregone conclusion that I would never find a lawyer to fight for me in court, let alone the finances to pay for one.

16. I originally sought a bilateral orchiectomy, a common procedure for male to female transgender people, at the recommendation of the doctor who prescribed me HRT in order to lower the amount of HRT I needed to take. The hormones and hormone blockers that many transgender women take increases the risk of blood clots. My doctor was concerned that the high levels of HRT he prescribed to me to be effective, increased my risk of having a blood clot. This surgical procedure is normally done under general anesthesia and typically does not produce complications like those I experienced.
17. When I called surgeons' offices to schedule a consultation, providers refused to see me when I disclosed that I am transgender. Many providers outright told me "we don't treat people like you."
18. I finally was able to meet a surgeon by not disclosing my transgender status and only did so once I met with him face to face. Regrettably this surgeon misdiagnosed the problem as a hernia, of which the surgical repair did not resolve my chronic pain. While I had insurance at the time through the ACA the procedure still cost me thousands of dollars in co-pays and deductibles.
19. A year later I found a sympathetic doctor who was willing to perform an exploratory surgery and found the real problem: namely that the surgeon who performed the initial bilateral orchiectomy failed to remove sufficient tissue. Again, this cost me several more thousands of dollars in co-pay/deductibles. This final doctor conducted a revision surgery removed sufficient tissue to finally stop the chronic pain.
20. The original bilateral orchiectomy surgery was conducted as an outpatient procedure to reduce costs because I had to pay for it outright without any insurance coverage. For the same reason the surgeon only used local anesthesia as a cost saving measure while three

medical students observed. I believe that these circumstances were a part of the reasons the surgeon botched the procedure and failed to remove sufficient tissue.

21. The surgeon dismissed my post-surgical pain and told me it was likely "phantom pain" which can occur when patients "lose something they are emotionally attached to,"—a highly offensive and inaccurate response to provide to a transgender woman like myself for whom her statement could not be farther from the truth. My pain ceased after I underwent revision surgery where the surgeon removed some additional tissue.

22. While these experiences stand out in my memory as particularly egregious, I routinely face other microaggressions and incompetence that I would not if I was cisgender. For example, I have had to explain to multiple doctors why I do not need to be tested for pregnancy before undergoing an x-ray or a CT scan, and after I disclose my transgender status, I have suddenly been called "Sir" or "Mr. Koontz" by providers and otherwise treated in a disrespectful manner.

23. This kind of treatment is what I have experienced ever since I began living authentically and undergoing medical transition. As a result of these experiences and my knowledge of discrimination experienced by other transgender people seeking medical care, I am wary of medical professionals and experience emotional distress when I must be seen by providers I have never met. The last time I underwent a mammogram to screen for breast cancer, approximately three years ago I became terrified because the facility posted a sign that read "females only." I was scared that if my transgender status was discovered by the provider's staff that they would refuse to perform the mammogram or subject me to humiliating treatment such as questioning my gender and right to be there. I have not sought a mammogram since because I fear facing discrimination yet again.

24. Since transitioning, I have not sought out a primary care doctor or preventative care for these reasons, and instead try to only see the doctor who is responsible for my transition-related care because I know he is competent to treat me as a transgender person.

25. I know my experiences are not unique. Transgender people face pervasive and systemic discrimination when seeking medical care. No one should experience this kind of devastating treatment especially when in the vulnerable position of entrusting one's life and well-being in the hands of medical professionals.

26. Based on my understanding from reading articles, the 2016 regulations HHS issued provided critically important guidance to healthcare providers and the public alike about what types of conduct constitute unlawful discrimination under the ACA, as well as a more accessible ways of enforcing patients' rights. The Rollback Rule cruelly attempts to gut the protections provided by the ACA, confuses rather than clarifies the rights of patients, and selectively eliminates the administrative complaint process to redress discrimination for transgender people, by making clear that the agency does not consider such forms of discrimination to constitute discrimination. Undoubtedly the Rollback Rule will embolden providers and insurers, especially in localities that do not have explicit state or local protections on the basis of gender identity, to discriminate against transgender people like myself. I fear for my life because politicians have decided that I do not deserve the same health care and medical emergency intervention as I would if I was a cisgender woman. Regrettably this fear is far from hypothetical as my experiences have taught me.

Dated: November 17, 2020
Doraville, Georgia

/S/ Stephe Thayer Koontz
Stephe Thayer Koontz

Exhibit L

Declaration of Noel Twilbeck,

Chief Executive Officer of NO/AIDS Task Force, d/b/a CrescentCare

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

BOSTON ALLIANCE OF GAY, LESBIAN, BISEXUAL AND TRANSGENDER YOUTH (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services, ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services, SEEMA VERMA, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF NOEL TWILBECK, JR.

I, Noel Twilbeck, Jr., declare under penalty of perjury and in accordance with the laws of the United States and of Massachusetts that:

1. I am the Chief Executive Officer of Plaintiff NO/AIDS Task Force, d/b/a CrescentCare. I received an M.B.A. degree from the University of New Orleans. I have been

employed at CrescentCare since 1989, and was appointed Executive Director (later Chief Executive Officer) in 1999. As Chief Executive Officer, I am responsible for the operation and administration of CrescentCare. I oversee day-to-day agency functioning, including our programs, services, facilities, and resources, and implementation of policies and procedures as established by the Board of Trustees.

A. Introduction

2. CrescentCare is a federally qualified health center located in New Orleans, Louisiana that offers comprehensive health and wellness services to a diverse range of patients, regardless of ability to pay. CrescentCare's mission is to offer comprehensive health and wellness services to the community, to advocate empowerment, to safeguard the rights and dignity of individuals, and to provide for an enlightened public.

3. CrescentCare's patient population is incredibly diverse and reflects our commitment to being a health care home for individuals and families that have experienced stigma and discrimination, or have otherwise encountered challenges in obtaining affordable, high-quality health care. CrescentCare provides culturally humble care to all individuals, without regard to race, creed, color, age, sex, gender, gender identity, marital or parental status, sexual orientation, religion, ancestry, national origin, physical or mental handicap (including substance abuse), immigration status, unfavorable military discharge, membership in an activist organization, HIV status, or any basis prohibited by law. We are particularly focused on our Greater New Orleans neighbors who come from traditionally medically underserved communities: the service industry, the LGBTQ+ community, the uninsured and the underinsured, immigrants, and communities of color. CrescentCare aims to increase access to care for existing and new patients and to work towards greater racial and ethnic health equity within its community.

4. In 2019, CrescentCare cared for almost 14,000 patients annually at two New Orleans clinic locations. We served over 20,000 individuals through our testing and prevention programs and more than 3,500 individuals through supportive services programs.

5. Our patients travel from significant distances for care because of our reputation as a safe place for LGBTQ+ people to receive care. In 2019, CrescentCare served patients from states including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, and Texas.

6. CrescentCare (as NO/AIDS Task Force) has historically provided HIV/AIDS services throughout southeast Louisiana in response to the HIV/AIDS epidemic. Upon becoming a federally qualified health center in 2013, CrescentCare began providing medical and supportive services to a broader community of low-income patients beyond people living with HIV.

7. Today, CrescentCare provides a number of health and wellness services. In addition to providing comprehensive adult primary care, CrescentCare provides dentistry, obstetrics and gynecology, pediatrics, psychiatry, specialty care (including HIV, diabetes, and hepatitis C), preventive health, and sexual health services.

8. CrescentCare provides a number of reproductive health and wellness services. We offer mammograms, contraception, and obstetric and gynecological care, including Pap smears and pre- and post-natal care. We provide sexual health services, such as testing and treatment for sexually transmitted infections, including HIV and hepatitis C. We also provide medical case management for patients living with HIV who may have more complex medical issues, such as pregnancy, medication and treatment-adherence problems, or comorbidities.

9. CrescentCare also provides support services. These programs include insurance enrollment, case management, legal services, health education, outreach and education regarding

discrimination and public benefits, food & nutrition services, housing assistance, and peer counseling. CrescentCare runs a number of support groups for people living with HIV.

10. CrescentCare has a reputation across the southeast United States for being a welcoming healthcare provider for the LGBTQ+ community, people seeking reproductive care, and people with limited English proficiency. I use the term LGBTQ+ to refer to lesbian, gay, bisexual, transgender, queer, intersex, and gender non-conforming people.

11. CrescentCare designs services to be inclusive to LGBTQ+ people and families and has programs that specifically address the needs of LGBTQ+ patients. For example, the Gender Clinic provides gender-affirming primary care, hormone therapy, mental health services, and peer and group activities for over 1,200 transgender and gender non-conforming people. Our patients have often traveled great distances to receive care from the Gender Clinic, with some having moved to Louisiana for easier access to our care. As another example, CrescentCare also operates the Community Awareness Network Project, a prevention program that provides HIV testing, sexually transmitted disease screenings, rapid hepatitis C testing and care coordination, and other services to the LGBTQ+ community.

12. To better serve our transgender and gender non-conforming patients, some trans-identified and allied staff members at CrescentCare serve on our Transgender Advisory Committee. This Committee provides guidance and leadership to make our programming and procedures more welcoming to our patients and their needs.

13. A significant part of CrescentCare's patient population is LGBTQ+. About 40% of CrescentCare's patient population has a sexual orientation other than heterosexual; and over 7% of CrescentCare's patient population is transgender. Our patients live with many chronic illnesses and disabilities; approximately 20% of our patients live with HIV. Many of CrescentCare's

patients have limited resources. For example, in 2019, about 48% of our patients lived below the poverty line and 244 patients experienced homelessness. Many also lack or have limited insurance resources. About 35% of CrescentCare's patient population is uninsured, and about 36% receive Medicaid. Our patients also face other barriers to advocating on their own behalf. For example, in 2019, 1,086 CrescentCare patients were best served in a language other than English.

14. I am aware that the United States Department of Health and Human Services ("HHS") issued a Notice of Proposed Rulemaking related to the nondiscrimination provisions of the Affordable Care Act on June 14, 2019. *See* Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) (to be codified at 42 C.F.R. pts 438, 440, 460) ("2019 Proposed Rule").

15. It is my understanding that on June 19, 2020, HHS published a final rule that adopts, with only minor or technical alterations, the entirety of the 2019 Proposed Rule. *See* Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (to be codified at 42 C.F.R. pts 438, 440, 460) ("the Rollback Rule"). The Rollback Rule largely ignores or summarily dismisses the concerns that thousands of commenters raised.

16. As a health program or entity that receives federal financial assistance, I understand CrescentCare to be subject to Section 1557 and the Rollback Rule.

B. The Rollback Rule Will Embolden an Atmosphere of Discrimination Against CrescentCare Patients

17. CrescentCare's patients have historically been subject to discrimination. Since our founding in 1983 (then doing business as NO/AIDS Task Force), CrescentCare has served people who have been subject to discrimination, including many patients that have been refused medical care by other providers, simply because they are living with HIV, are LGBTQ+, or seek certain

reproductive health care. It is my understanding that the discrimination our patients have faced are similar to those reported by LGBTQ adults across the South. In 2017 and 2018, the LGBTQ Institute at The Center for Civil and Human Rights and Georgia State University conducted a survey of over 6,500 self-identified LGBTQ adults in fourteen states, including Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Eric R. Wright et al., The LGBTQ Inst. at The Ctr. for Civ. Rts. And Hum. Rts. & Ga. State Univ., *Southern Survey General Findings Report* (Nov. 2018), https://perma.cc/E3EZ-2X6C. The survey found that 19.7% of transgender respondents reported receiving unequal treatment by medical staff and 45.4% of transgender respondents were "misgendered or had a provider inappropriately use the name/gender the respondent was assigned at birth." *Id.* at 81.

18. I have reason to believe that many CrescentCare patients have encountered health care providers who are hostile or unaccepting of LGBTQ+ patients and people seeking reproductive health care. Patients have been routinely denied care or mistreated at other facilities. For example, one transgender patient reported that a provider had treated her like a "science project." Other patients have reported being misgendered, being rejected from certain health care facilities, and being asked invasive questions about their gender identity and anatomy when seeking unrelated medical care. This type of discriminatory treatment is commonly reported in Louisiana and surrounding states. *See, e.g.*, Reed Miller, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019), https://perma.cc/S38F-LRKX ("Once, I broke my ankle and visited a hospital in Louisiana. They asked several inappropriate questions about me as a transgender person as well as the transgender person who drove me there."); Transgender L. Ctr., Comment Letter on 2019 Proposed Rule at 8 (Aug. 13, 2019), perma.cc/GTS9-LDYM (incorporating an anonymized

comment from Victoria, a transgender woman, who attempted to get HIV care in rural Louisiana but left the doctor's office because the receptionist refused to use her preferred name and pronouns). Such discrimination and fear of discrimination leads many people to seek out non-discriminatory care with us despite living several hours outside of the Greater New Orleans area.

19. The Rollback Rule's repeal of HHS' prior interpretation of "on the basis of sex" applies to health care providers, insurers, and institutional actors who are fundamentally opposed to serving CrescentCare's patients in a non-discriminatory manner. Such individuals and entities will use the Rollback Rule to discriminate against CrescentCare's patients on the basis of their sexual orientation and gender identity, on the basis of sexual stereotype, on the basis of who our patients associate with, and on the basis of having previously sought pregnancy-related services.

20. Some health care providers have openly objected to the application of sex-based protections to extend to LGBTQ+ patients and people seeking reproductive healthcare and will be emboldened to discriminate by the Rollback Rule. *See, e.g.*, Seth Landry, Comment Letter on 2019 Proposed Rule (July 25, 2019), https://perma.cc/4WJL-NKDQ ("I am a Nurse Practitioner in Louisiana. I urge you to remove sexual identity as a form of healthcare discrimination. It is an affront to medicine and science."); Stephanie Curtin, Comment Letter on 2019 Proposed Rule (Aug. 1, 2019), https://perma.cc/N2MN-8GRJ ("As a Registered Nurse in the state of Louisiana . . . I strongly support the Office for Civil Rights' proposal to correct the existing regulations which, by the government's admission, wrongly construed sex to include abortion and gender identity."); Anita Harkrader, Comment Letter on 2019 Proposed Rule (Aug. 5, 2019), https://perma.cc/M4KJ-SHXX ("I am a nurse and it is uncomfortable to work with trans . . . ."); Mark Rollo, Comment Letter on 2019 Proposed Rule (Aug. 7, 2019), https://perma.cc/YD7R-UM6U ("As a physician I am appalled by the mutilation of 'gender reassignment' compelling doctors to participate in this

or in the slaughter of innocence in the womb. I will NEVER submit to such a horrific law . . .”); Kathleen Quinn, Comment Letter on 2019 Proposed Rule (Aug. 6, 2019), https://perma.cc/3NLP-6CP4 (“I am a Mother and an RN. Abortion and surgeries designed to alter a persons biological sexual characteristics are not things that would ever be acceptable to me.”); Amber Reid, Comment Letter on 2019 Proposed Rule (Aug. 3, 2019), https://perma.cc/SN9K-SPEZ (“I am a registered nurse with 40 years of experience. Transgender reassignment and abortion is a travesty to medical professionals who entered the profession to provide medical care!”); Thomas Nevins, Comment Letter on 2019 Proposed Rule (Aug. 10, 2019), https://perma.cc/2GNP-ET5C (“As a Pediatrician and medical researcher I am appalled by the ridiculous nonsense that is being forced on children and those who care for them. The crude ‘experiments’ with puberty blockers and hormones that are being carried out on children who are not capable of ‘informed consent’ are a disgrace. No research institution, NIH or anyone else would permit such an untried intervention to 'treat' a imagined ‘disease’!”). As another example, some pharmacies refuse to provide our patients with the necessary and appropriate needles and syringes used for their hormone injections, despite our providers explicitly including these products in the prescription. Without these needles and syringes, our patients are unable to safely inject their hormones and delay or compromise their medical care.

21. Many of our patients live in states where religious hospitals have publicly stated they align with entities and standards that refuse the provision of certain services to LGBTQ+ patients and people seeking reproductive care. For example, Ascension Health, a large Catholic health care system, operates facilities in Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, and Texas, where many of our patients come from for care. Ascension Health has publicly stated that “[a]s a ministry of the Catholic Church, Ascension adheres to the official

teaching of the Catholic Church, including the *Ethical and Religious Directives for Catholic Health Care Services*[.]" Ascension Health, Comment Letter on Proposed Rule for Nondiscrimination in Health Programs and Activities at 2 (Nov. 9, 2015), https://perma.cc/7MJJ-T8KZ. Furthermore, Ascension Health has noted, "[U]nder its obligations as a healing ministry of the Church, Ascension will only provide those procedures that are not 'judged morally wrong by the teaching authority of the Church.' Thus, the health ministries of Ascension will . . . only provide care and procedures consistent with the values that are constitutive of our organization and its facilities as ministries of the Catholic Church." *Id.* at 4 (internal citations omitted).[1] In New Orleans specifically, we have a number of patients who receive primary care from Ascension DePaul Services of New Orleans (operating as DePaul Community Health Centers), but are denied access to contraception there due to the institution's religious tenets. These patients have turned to CrescentCare to obtain this reproductive care.

22. The discrimination occasioned by the Rollback Rule and the fear that it has caused will limit access to care for CrescentCare's patients. Our patients may encounter such individual and institutional providers in their towns or home states and may receive care that worsens existing conditions (including trauma related to gender dysphoria), may be denied care, or may avoid seeking necessary care until they are able to access CrescentCare or another provider that does not

[1] Public documents produced by Catholic authority have rejected the acceptance of transgender and gender non-conforming people. *See, e.g.*, Congregation for Cath. Educ., *"Male and Female He Created Them": Towards a Path of Dialogue on the Question of Gender Theory in Education* 11-12 (2019), https://perma.cc/LCS4-U2P8 ("[T]he generic concept of 'non-discrimination' often hides an ideology that denies the difference as well as natural reciprocity that exists between men and women. 'Instead of combatting wrongful interpretations of sexual difference . . . the utopia of the 'neuter' eliminates both human dignity in sexual distinctiveness and the personal nature of the generation of new life.'") (citation omitted); *Post-synodal Apostolic Exhortation* Amoris Laetitia *of the Holy Father Francis to Bishops, Priests and Deacons, Consecrated Persons, Christian Married Couples, and All the Lay Faithful on Love in the* Family 45-46 (Mar. 19, 2016), https://perma.cc/KP7N-9S3X ("It needs to be emphasized that 'biological sex and the socio-cultural role of sex (gender) can be distinguished but not separated'. . . . Let us not fall into the sin of trying to replace the Creator. . . . Creation is prior to us and must be received as a gift. At the same time, we are called to protect our humanity, and this means, in the first place, accepting it and respecting it as it was created.") (citation omitted).

discriminate. In 2016, 16.3% of hospital beds in Louisiana, 22.6% of hospital beds in Arkansas, and 12.1% of hospital beds in Texas were located in Catholic health care facilities. American Civil Liberties Union, *Percentage of Hospital Beds in Catholic Hospitals, 2016*, https://perma.cc/FY4J-YK5W. These facilities often follow the Ethical and Religious Directives for Catholic Health Care Services, which are known to compromise patient health, including but not limited to miscarriage management and pregnancy termination, by directing facilities not to provide certain types of care. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 1, 19 (6th ed. 2018) ("Catholic health institutions may not promote or condone contraceptive practices . . .") ("Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution.").

C. The Rollback Rule Will Harm CrescentCare's Patients

23. CrescentCare is bringing this lawsuit on behalf of itself and its patients, with whom we work hard to forge and maintain close relationships. On issues related to nondiscrimination protections, the interests of CrescentCare are wholly aligned with its patients. On the basis of CrescentCare's records, provider and staff experiences in clinical, educational, community support and advocacy settings, CrescentCare is well-positioned to represent the interests of its patients. Moreover, based on these same records and experiences, CrescentCare's patients face significant obstacles to bringing these claims as individuals on their own behalf. As explained herein, the Rollback Rule gives rise to an environment of emboldened discrimination against our patients. The obstacles and stigma routinely faced by the communities that comprise CrescentCare's patients are reflected in countless news reports, surveys and, increasingly, judicial opinions. Indeed, the Rollback Rule itself was recently cited by the Unites States Court of Appeals for the Fourth Circuit as it catalogued historical discrimination against transgender people for the

purposes of constitutional scrutiny. *See Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 611–12 (4th Cir. 2020) (holding that transgender people qualify for the status of "quasi-suspect" class partly on the basis of historical discrimination, including the observation that "the Department of Health and Human Services recently issued a final rule redefining 'sex discrimination' for purposes of Section 1557 of the Affordable Care Act to encompass only biological sex, and not gender identity."). For all of these reasons, CrescentCare is compelled to bring these claims on behalf of its patients.

24. The Rollback Rule will harm CrescentCare's patients. As I have described herein, the Rollback Rule will give rise to an emboldened atmosphere of discrimination in the healthcare system generally, which constitutes harm in and of itself. The Rollback Rule will cause CrescentCare's patients to fear repeated and worsening instances of the discrimination they have historically experienced in accessing healthcare. But even beyond that, there are a litany of specific harms to CrescentCare's patients that will be caused by the Rollback Rule.

25. Most importantly, the Rollback Rule will cause CrescentCare's patients to experience significantly worse health outcomes. Patients facing an emboldened atmosphere of discrimination will delay, avoid, or be unable to access medically necessary care and support services. Whether it is out of fear of being made directly subject to discrimination, concern about coverage or cost, or an inability to access the resources needed to understand care and coverage, it is clear that avoiding, delaying, or being unable to access care produces significantly worse health outcomes. For example, a CrescentCare patient was a victim in a motor vehicle accident where attending emergency room staff became hostile towards her upon discovering she was transgender. When the patient was involved in a second motor vehicle accident earlier this year, the patient, fearful of continued discrimination by emergency room staff, delayed necessary care. When the

patient did seek out emergency care for neurological symptoms related to the accident, emergency room staff were again discriminatory upon learning she was transgender. In another example, a non-binary patient had obtained prior authorization from their parents' health care insurance for a double mastectomy scheduled to occur in spring of 2020. The surgery was later delayed due to the coronavirus 2019 (COVID-19) pandemic. This past summer, the patient aged off of their parent's plan (which was based in a state with protections against discrimination on the basis of gender identity) and enrolled into their employer's Louisiana-based health care coverage. Under their new health care plan, the patient has been denied their request for prior authorization repeatedly and as a result, is delaying necessary care.

26. The Rollback Rule will negatively affect the ability of our patients to pay for health care services. In particular, the Rollback Rule's provisions regarding health insurance plans will cause some of our patients to experience significantly less advantageous third-party reimbursement for the health care services that they need. This added expense for the patient can result in delayed healthcare and negative health outcomes. For example, many of our patients obtain health benefits through one of the five Bayou Health plans made available to low-income people in Louisiana. One Bayou Health plan has routinely denied all but one of CrescentCare-facilitated requests for double mastectomies related to gender affirming care, despite several patients utilizing the appeals process to review these denials. When patients come to CrescentCare enrolled in this plan in need of a double mastectomy as a treatment for their gender dysphoria, patients (with the assistance of our staff) must apply for and be denied coverage of the procedure and appeal that denial at least once before they are able to switch to one of the other four Bayou Health plans that do not employ this discriminatory practice. Switching plans can take up to three months and unnecessarily delays care and causes negative health outcomes, such as increased anxiety and depression. Further, the

Rollback Rule will undermine CrescentCare's efforts to advocate for its patients with this health insurance plan.

27. The Rollback Rule will cause CrescentCare's patients to have to travel greater distances to receive care. Given the atmosphere of emboldened discrimination, LGBTQ+ patients, patients with limited English proficiency, and patients seeking certain reproductive health services will seek out healthcare providers with strong reputations for providing inclusive care, such as CrescentCare. Due to the finite supply of such providers, we expect more patients from outside southeast Louisiana will be forced to expend the time and expense of traveling to CrescentCare to ensure that they receive care in a nondiscriminatory setting. For example, many of our patients have sought out care at CrescentCare due to a lack of non-discriminatory and knowledgeable providers in their home states. In some cases, patients have moved their families to Louisiana so they could more easily access gender-affirming care.

28. The Rollback Rule will increase anxiety among CrescentCare's patients concerning access to care. For example, many of our transgender and gender non-conforming patients have expressed apprehension to our staff about the rule and its effect on their access to non-discriminatory care for both transition-related care (e.g., availability and coverage of hormone therapy) and other services (e.g., access to fertility services). Some of our patients have expressed an urgency to complete transition-related surgeries before the end of 2020 for fear of changes in plan benefits related to the Rule. Concern about the Rollback Rule and its effect on non-discriminatory access to health care has regularly been raised during town halls led by our Transgender Advisory Committee, during behavioral health assessments, through our Gender Clinic's online portal, and in direct communication with our staff.

29. The Rollback Rule will affect the ability of CrescentCare's patients to adequately understand the nondiscrimination protections available to them when interacting with, obtaining services from, or using coverage provided by a covered entity. Since the Rollback Rule was published in the Federal Register, some CrescentCare patients have expressed concerns and confusion over whether certain entities, such as their insurance companies or women's health providers, must still comply with all federal nondiscrimination protections or not. The regulatory changes around covered entities, exemptions, and notice requirements will harm our patients by leading them to believe they do not have the protections guaranteed by the law. For example, I believe many of CrescentCare patients' third-party payors will stop sending nondiscrimination notices to members in significant communications, because the payors no longer believe the entirety of their products to be subject to Section 1557 enforcement and because of the elimination of notice requirements for covered entities. *See, e.g.*, BlueCross BlueShield Association, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019), https://perma.cc/DKT9-EBRM (supporting the elimination of notice requirements). Additionally, I believe that some of our patients' non-CrescentCare providers will stop posting or including nondiscrimination notices as well. *See, e.g.*, Louisiana Dental Association, Comment Letter on 2019 Proposed Rule (Aug. 9, 2019), https://perma.cc/FHM6-L4M9 (describing the requirement to post nondiscrimination notices dental practices, online, and in significant communications as challenging).

30. The Rollback Rule will affect the ability of CrescentCare's patients to adequately understand language access resources made available at or by a covered entity. For example, third-party payors will stop including taglines in significant communications to members, because they no longer believe themselves to be subject to Section 1557 enforcement and because of the elimination of tagline requirements for covered entities. *See, e.g.*, BlueCross BlueShield

Association, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019), https://perma.cc/DKT9-EBRM (sharing support of the elimination of tagline requirements). Additionally, I believe that some of our patients' non-CrescentCare providers will stop posting or including taglines as well. *See, e.g.*, Louisiana Dental Association, Comment Letter on 2019 Proposed Rule (Aug. 9, 2019), https://perma.cc/FHM6-L4M9 (describing the requirement to post taglines in dental practices, online, and in significant communications as challenging). Approximately 1 in 14 patients at CrescentCare use interpretative services when they receive care at our facilities. Knowledge of the availability of these services is an important part of ensuring patients with limited English proficiency can make informed decisions about their care and exercise their rights within our facilities, within facilities we refer patients to, and with their insurance providers. While some staff members or CrescentCare-contracted translators are able to follow patients to outside appointments or provide translation over the phone when patients see outside specialists, our resources are finite and we can only provide limited language access assistance outside of our facilities. The regulatory changes eliminating tagline requirements on significant communications with third-party payors and other covered entities will harm our patients by decreasing knowledge of interpretation services for information directly related to their health care coverage and to the nondiscrimination protections that such entities are required to provide.

31. The Rollback Rule will affect the ability of CrescentCare's patients to obtain effective interpretation services when interacting or receiving services by covered entities. This is especially true for our patients who are limited English proficient, patients who have trouble communicating with others but do not have a diagnosed disability or medical issue, and young children. For these patients, video-based or in-person interpretation services are often vital for obtaining and maintaining informed consent for medical care. Without effective language

interpretation services, our patients will receive substandard care or will be unable to access care at all.

32. The Rollback Rule will affect the ability of CrescentCare's patients to understand which health insurance plans provide nondiscriminatory protections when enrolling in advance of a new plan year. For example, some third-party payors that offer products to our patients will stop including nondiscrimination notices on materials related to plan benefits, because the payors no longer believe themselves to be subject to Section 1557 enforcement and because of the elimination of notice requirements for covered entities. *See, e.g.*, BlueCross BlueShield Association, Comment Letter on 2019 Proposed Rule (Aug. 12, 2019), https://perma.cc/DKT9-EBRM (sharing support of the elimination of notice requirements). Many of CrescentCare's patients have experienced discrimination when seeking coverage of medically necessary health care services and prefer to enroll in health insurance coverage that will comply with Section 1557. Since the Rollback Rule was published in the Federal Register, some CrescentCare patients have expressed concerns and confusion over whether insurance providers must still comply with federal nondiscrimination protections or not. The regulatory changes around covered entities and notice requirements will harm our patients by leading them to erroneously believe that certain health insurance plans do not need to comply with federal protections guaranteed by law.

33. The Rollback Rule will likely affect the ability of CrescentCare's patients to address prohibited discrimination by covered entities. For example, some CrescentCare patients have used Section 1557 to address discrimination in their health insurance, specifically coverage exclusions of treatment and services related to gender dysphoria. Since the Rollback Rule was published in the Federal Register, some individuals have expressed confusion regarding the new

regulations to CrescentCare staff and are unsure whether their care will be protected by HHS' enforcement of Section 1557.

34. CrescentCare's patients face a myriad of obstacles that would hamper or impede their ability to file a lawsuit against the federal government regarding the Rollback Rule. While some of our patients have reported harm from the Rollback Rule, many have not publicly disclosed their gender dysphoria, sexual orientation, or history of terminating a pregnancy to their families, employers, caretakers, and others. For example, some of our patients receive their health insurance from the state of Louisiana (which contains discriminatory exclusions for the treatment of gender dysphoria) and are fearful of the stigma, discrimination, and violence they would face if they were to be named plaintiffs given their public-facing employment.

Dated: November 17, 2020 at New Orleans, Louisiana.

/s/ Noel Twilbeck, Jr.
Noel Twilbeck, Jr.
Chief Executive Officer
CrescentCare

Exhibit M

Declaration of Rick Zbur,

Executive Director of Equality California

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth (BAGLY); Callen-Lorde Community Health Center; Campaign for Southern Equality; Darren Lazor; Equality California; Fenway Health; Indigenous Women Rising; NO/AIDS Task Force (d/b/a CrescentCare); and Transgender Emergency Fund of Massachusetts,

Plaintiffs,

v.

United States Department of Health and Human Services; Alex M. Azar II, *in his official capacity as secretary of the U.S. Department of Health and Human Services*; Roger Severino, *in his official capacity as Director, Office for Civil Rights, U.S. Department of Health and Human Services*; and Seema Verma, *in her official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services*,

Defendants.

Civil Action No. 1:20-cv-11297

DECLARATION OF RICK ZBUR,
EXECUTIVE DIRECTOR, EQUALITY CALIFORNIA

I, Rick Zbur, declare as follows:

1. I am the Executive Director of Equality California, the nation's largest statewide lesbian, gay, bisexual, transgender, and queer plus ("LGBTQ+") civil rights organization. I have served as the Executive Director since 2014. I have personal knowledge of the facts set forth in this declaration, and if required to testify, would and could competently do so.

2. Equality California is a nonprofit organization that advocates locally, statewide, and nationally on behalf of LGBTQ+ individuals and other marginalized groups to which LGBTQ+ people belong.

3. Originally founded in 1999 as the California Alliance for Pride and Equality (CAPE), we became Equality California in 2003 and then merged with Marriage Equality California in 2004. For over 20 years, Equality California has been fighting for LGBTQ+ civil rights and social justice.

4. The mission of Equality California is to bring the voices of LGBTQ+ people and allies to institutions of power in California and across the United States, striving to create a world that is healthy, just, and fully equal for all LGBTQ+ people. We advance civil rights and social justice by inspiring, advocating, and mobilizing through an inclusive movement that works tirelessly on behalf of those we serve.

5. In a post-marriage equality landscape, Equality California expanded our mission to include increasing access to quality, affordable healthcare for LGBTQ+ people—and the diverse communities to which LGBTQ+ people belong—through education, mobilization and advocacy. We have several programs to advance the health care of LGBTQ+ people in California and nationwide. For example, through the *Health Happens with Equality* program, Equality California has trained over 2,800 healthcare providers and health clinic staff across California, Nevada, and Arizona, empowering them to provide culturally competent quality care to LGBTQ+ patients. The curriculum includes educational context about basic LGBTQ+ terminology, data on health disparities that affect the LGBTQ+ community, what it means to be LGBTQ+, HIV/AIDS, Pre-Exposure Prophylaxis (PrEP), transgender health issues and how to create a welcoming environment as a healthcare provider. Through the *Take It: I'm PrEP'd*

campaign, Equality California works to educate the LGBTQ+ community and healthcare providers on the availability and benefits of pre-exposure prophylaxis (PrEP) and other forms of HIV treatment and prevention. Equality California also has recently launched a COVID-19 Online Help Center and Help Line to connect LGBTQ+ Californians impacted by the crisis with LGBTQ+ friendly resources and support services.

6. Equality California has more than 500,000 members. While most of our members reside in California, we have members throughout the nation. Equality California's members include individuals who have contributed to the organization financially and those who have otherwise supported or participated in Equality California's education, mobilization and advocacy work. Equality California regularly conducts surveys, holds town hall meetings, and hosts conferences to understand the needs of the broader LGBTQ+ community, including members of Equality California. Through their participation in such surveys, town hall meetings, and conferences, Equality California's members help inform and shape the mission and direction of Equality California and the organization's programs.

7. Equality California is dedicated to combating discrimination and injustice on the basis of sexual orientation and gender identity, and to protecting the fundamental rights of those within the LGBTQ+ community and the vulnerable communities of which they are a part.

The Rollback Rule's Harm to Equality California Members

8. The Rule "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 85 Fed. Reg. 37,160 (June 19, 2020) (the "Rollback Rule") will harm Equality California's members.

9. By eliminating explicit regulatory protections that were included in the previous rule implementing Section 1557, which was promulgated in May 2016 ("2016 Final Rule"), and

importing new exemptions into Section 1557, the Rollback Rule invites and emboldens healthcare entities to discriminate against Equality California members who identify as LGBTQ+, as well as Equality California members who have obtained or are seeking reproductive health care.

10. The Rollback Rule not only invites discrimination against Equality California members based on their sex, gender identity, sexual orientation, capacity for pregnancy, and reproductive health history, but also based upon their race, color, national origin, limited English proficiency ("LEP"), disability, age, or some combination of these characteristics.

11. By misgendering transgender individuals, the Rollback Rule fosters stigma and bias toward transgender people, affects their status within the broader community, and compromises their ability to receive equitable healthcare. The Rollback Rule sends a message to our members that they do not have a right to equal access to healthcare, which will cause our members to fear seeking healthcare. Many transgender and gender nonconforming people already forgo health care due to fear of discrimination, and some of our members are likely to avoid going to the doctor, avoid necessary treatments, or even avoid sharing their gender identity, sexual orientation, pregnancy status, or reproductive health histories with their doctor or other health care provider out of fear of discrimination, which will exacerbate health disparities.

12. Although the state of California protects against discrimination in healthcare, the Rollback Rule subjects our members who live or travel out-of-state to a new and increased threat of discrimination by health providers on the basis of their sex. For example, Equality California has over 20,000 members living in the states of Texas, Nebraska, Kentucky, Kansas, Louisiana, Arizona, and Mississippi. These states filed litigation in federal court challenging the 2016 Rule in which they represented that the 2016 Rule "forced" them to provide transition and abortion

care at state healthcare facilities, to post patient notices of non-discrimination encompassing the full scope of Section 1557's protections against sex discrimination, and to train employees not to discriminate in accordance with Section 1557. *See Franciscan Alliance*, Brief in Support of State Plaintiffs' Renewed Motion for Summary Judgment, Docket No. 133 at 50, 7:16-cv-00108-O (N.D. Tex. Feb. 4, 2019). Under the Rollback Rule, these states would require even public healthcare facilities to deny medically necessary treatment for transgender and gender non-conforming individuals and people seeking reproductive health care, and to remove other protections against discrimination.

13. Members of Equality California seeking care in Texas, Nebraska, Kentucky, Kansas, Louisiana, Arizona, Mississippi, as well as in other states without robust healthcare anti-discrimination protections, are at a substantial risk of experiencing discrimination or denials of medical care, including potentially in emergency situations, as a result of the Rollback Rule. If one of our members has a medical emergency in those states, a hospital could refuse to treat them because they are transgender, could misgender them when providing care, or could deny life-saving emergency abortion care. Although Equality California believes that Section 1557 prohibits this behavior, the Rollback Rule will encourage and embolden such discrimination, particularly since HHS announced in the Rollback Rule that it will no longer enforce the full scope of Section 1557's prohibitions against sex discrimination.

14. The harms from the Rollback Rule to Equality California's members will be compounded because HHS chose to finalize the Rule in the middle of a global pandemic, where thousands of individuals nationwide are losing their jobs and, in turn, their health insurance. The LGBTQ+ community has been hit hard by the COVID-19 crisis because of underlying health

disparities and economic vulnerabilities.[1] LGBTQ+ people face higher rates of comorbidities such as HIV and cancer, are less likely to have health insurance, and are less likely to access care when they are sick out of fear of discrimination compared to the general public.[2] Members of the LGBTQ+ community are also overrepresented in the industries hit hardest by economic fallout, such as the restaurant and food services industries.[3] And LGBTQ+ elders were already more likely to face isolation and were less likely to reach out for support before the crisis began.[4] For many LGBTQ+ individuals, especially those who live in areas with limited options for LGBTQ+ affirming health care services, finding inclusive health care options is already a struggle. The Rollback Rule exacerbates this struggle by emboldening discrimination in healthcare, which will result in even fewer options for inclusive health care.

15. Equality California counts among its members individuals and family members of individuals who have been discriminated against when seeking health care, including Darren Lazor, Lisa Middleton, Dr. Andrea Cubitt, Ebony Ava Harper, Hillary and Jeffrey Whittington, and two Parent Members.

16. Mr. Lazor, a named plaintiff, is a transgender man who lives in Ohio, a state without statewide protections against discrimination based on gender identity in health care. Mr. Lazor has experienced discrimination based on his gender identity in healthcare on multiple occasions. He has been denied treatment, misgendered, and mistreated by medical professionals. Mr. Lazor also has a recurring medical condition that causes shortness of breath, and for which he has previously sought emergency medical treatment. On one occasion when Mr. Lazor sought

---

[1] *See* Human Rights Campaign Found., The Lives and Livelihoods of Many in the LGBTQ Community Are at Risk Amidst COVID-19 Crisis, available at https://www.hrc.org/resources/the-lives-and-livelihoods-of-many-in-the-lgbtq-community-are-at-risk-amidst-covid-19-crisis.

[2] *E.g.*, Human Rights Campaign Found., *supra* at 3, 5; Nat'l LGBT Cancer Network, The LGBT Community's Disproportionate Cancer Burden, https://cancer-network.org/cancer-information/cancer-and-the-lgbt-community/the-lgbt-communitys-disproportionate-cancer-burden/.

[3] Human Rights Campaign Found., *supra* at 2.

[4] *Id.* at 4.

treatment for acute shortness of breath at the emergency room near his home—the emergency room to which he would be taken if he called an ambulance—the medical staff mistreated and discriminated against him based on his gender identity. Medical staff misgendered him, expressed disgust at the surgery scars from his mastectomy, stated "we don't know how to treat you," and then discharged him without any diagnosis or treatment plan, leaving him on his own to treat his acute shortness of breath. Because the Rollback Rule removes explicit regulatory prohibitions on such discrimination and recourse he previously had to redress such discrimination, and because this hospital is not subject to state or local laws prohibiting discrimination based on gender identity, Mr. Lazor fears that discrimination at this hospital, as well as at other healthcare facilities, will only worsen. Given his medical history and past experiences, he believes that as a result of the Rollback Rule, there is a substantial likelihood that he will be faced with a situation where he must either forgo obtaining emergency care or risk suffering discrimination or substandard care that could lead to severe health consequences or even death. Mr. Lazor is particularly concerned in light of the current COVID-19 pandemic, as his recurring condition may make him more susceptible to extreme respiratory COVID-19 symptoms.

17. Ms. Middleton is a 68-year-old transgender woman. Ms. Middleton has experienced healthcare discrimination as a result of her transgender status. Ms. Middleton serves on the Palm Springs City Council and the California Public Employees' Retirement System (CalPERS) Board of Administration. As a public official, Ms. Middleton often travels outside of California. Ms. Middleton and her wife also travel in their spare time with their two rescue dogs throughout the Western United States. Particularly given her age, Ms. Middleton fears requiring medical assistance while traveling outside of California for work. As a result of the Rollback

Rule, Ms. Middleton is afraid that she may be denied critical care by healthcare providers because of her gender identity or her sexual orientation when traveling outside of California.

18. Dr. Cubitt is a transgender woman. Dr. Cubitt regularly travels for work and attends scientific conferences in states outside of California that have limited protections for transgender individuals, including Texas, Nebraska, North Carolina, and South Carolina. As a 57-year-old transgender woman, Dr. Cubitt fears requiring medical assistance while traveling outside of California for work. As a result of the Rollback Rule, Dr. Cubitt is afraid that she may be denied critical care by healthcare providers because of her transgender status while she is traveling outside of California.

19. Ms. Harper is a transgender woman who lives in California and is receiving gender-affirming care. Ms. Harper's health insurance plan has covered her hormone therapy since around 2008, and it started covering laser treatment and other gender affirming treatments around 2016. Her insurance has, however, denied coverage for gender-affirming surgery, for years. She believes her health plan has arbitrary criteria for covering surgery. Recently, Ms. Harper's health insurance plan denied her coverage for a transition-related medical procedure that was recommended by her doctor as part of her gender-affirming care. Ms. Harper is still in the process of challenging that denial is now afraid that, as a result of the Rollback Rule, she will be prevented from pursuing her appeal. She also is afraid that it would be futile to file a complaint about the denial with OCR because of the enforcement policy announced in the Rule. Ms. Harper also fears that her insurance company will decide to stop covering hormone care or laser treatments.

20. Mr. and Mrs. Whittington have a minor son and a minor daughter, and their son is transgender. The Whittingtons live in California but travel outside of California frequently,

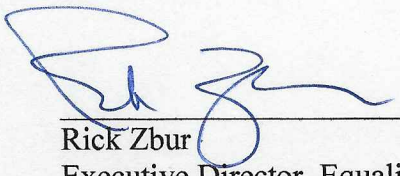
including an annual trip to Utah. They are concerned that, as a result of the Rollback Rule, their transgender son may experience discrimination if he needs healthcare while the family is in Utah or traveling to other states that do not have state laws that explicitly prohibit healthcare discrimination on the basis of gender identity.

21. Two Parent Members have two minor daughters, one of whom is transgender. Their family lives in California but travels outside of California frequently. In the past, they traveled 3 to 4 times per year, often taking their children to national parks such as Sedona National Park in Arizona. Their daughter is very active, and, like many children her age, has been prone to accidents during activities like skateboarding and biking. Their daughter is currently receiving healthcare at a gender-inclusive clinic, but that was not always the case. At a previous clinic, when Parent Members asked a pediatric endocrinologist about seeing their daughter, the doctor replied: "I don't do that." Parent Members now pay a higher copayment so that their daughter can receive pediatric endocrinological care at the gender-inclusive clinic. Parent Members expect that their daughter will need to begin hormone blockers within the next year but are concerned about their ability to obtain authorization from their insurance company for coverage of the treatment she needs. Just a few months ago, their insurance company, which is headquartered in Utah, rejected an authorization from their daughter's doctor for hormone blockers. The family was able to get approval only after going through an appeals process. The family believes it is a typical part of the process to get rejected the first time and have to appeal. Parent Members are concerned that, as a result of the Rollback Rule, both they and their transgender daughter will experience increased discrimination in the form of more denials of care, higher out of pocket costs for needed care, and lengthy and resource intensive battles with their insurance company for coverage of medical care. They fear that doctors and insurance

companies will take advantage of the confusion caused by the Rollback Rule to deny care to their daughter. They also fear that their daughter will not be able to access the hormone therapy that is best for her. Given their experiences with healthcare refusals in California—a state with LGBTQ+ protections in healthcare—they fear that their daughter may be discriminated against if she needs healthcare while on a family vacation to a state such as Arizona that lacks state-level protections against LGBTQ+ discrimination in healthcare.

I declare under the penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: November 17, 2020



Rick Zbur
Executive Director, Equality California