UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

STATE OF WASHINGTON, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR, in his official capacity as the Secretary of the United States Department of Health and Human Services, Defendants.	NO. 2:20-cv-01105 DECLARATION OF JESSICA TODOROVICH

I, Jessica Todorovich declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct:

1. I am over the age of 18, have personal knowledge of the facts and circumstances in this Declaration, and competent testify in this matter.

My Background and Credentials

2. I currently served as the Chief of Staff at the Washington State Department of Health (DOH), and am responsible for the daily operations of the agency. I have been with DOH

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since 2012, and previously served as Human Resources Director and Deputy Secretary for Administrative Operations. I hold a bachelor's degree in Politics from Whitman College, and a master's degree in Science in Human Resources from Chapman University in California. I have been with the State of Washington for 18 years.

The Operations of the Department of Health

3. DOH is Washington's statewide public health agency. It is within the executive branch, with the Secretary of Health reporting directly to the governor. DOH programs and services help to prevent illness and injury, promote healthy places to live and work, provide information to help people make good health decisions, and ensure our state is prepared for emergencies.

4. As Chief of Staff for the Secretary of Health, I work directly with the Secretary of Health and members of the agency executive team on high-level policy and strategic issues. I am responsible for planning and directing all operational activities for DOH, as well as providing oversight and guidance for projects of high importance. DOH operations are split amongst five divisions, more than 1700 staff members, and a wide range of programs and projects. DOH oversees a broad portfolio of services and works extensively with state, local, tribal, and community partners to improve the health of all Washingtonians. The biennial budget for DOH is $1.3 billion, including $498 million in federal funding.

5. Based on the expansive impact of Final Rule and DOH's broad portfolio, I have received data and information from impacted staff across the agency, including program staff in (1) the Family Planning Program, (2) the Breast, Cervical, and the Colon Health Program, and (3) the Office of Infectious Disease.

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6. The Breast, Cervical, and Colon Health Program is a program within DOH that provides free breast, cervical, and colon cancer screening to eligible people in Washington State. This program, funded with a combination of state and federal funds, supports the health and well-being of Washingtonians by identifying cancer early when there is the greatest chance that medical intervention will be successful and save lives.

7. The Family Planning Program is a program within DOH that works to increase the ability of individuals of all genders to achieve optimal sexual and reproductive health. FPP provides funding for direct services, facilitates coordination between stakeholders, collaborates with other state agencies, and works toward state policies that are equitable and inclusive. Also, the program uses state funding to support 87 clinics that offer direct clinical services and education to help people choose if and when to have children and to plan healthy and well-timed pregnancies. In addition to contraception and preconception health, Family Planning Program funding supports testing and treatment sexually transmitted infections (STIs) and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). These clinics offer discounts based on family size and income, but serve all who want and need family planning services. Family Planning Program also covers abortion services for people with insurance when that insurance is regulated by Washington State and does not include coverage for abortion. Finally, this program provides sexual and reproductive health services because they reduce future costs to the state.[1] These include reducing costs associated with medical services provided by the State for prenatal care, labor and delivery, and postpartum care for unwanted pregnancies,

[1] Frost, et al., Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program, Milbank Quarterly Oct. 15, 2014.

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medical services provide for premature or low birth weight babies, and the decreased transmission of STIs as a result of more regular screening.

8. The Office of Infectious Disease is a program within DOH that provides services to prevent and control sexually transmitted diseases, HIV/AIDS, adult viral hepatitis and assesses the incidence and prevalence of these diseases. This program is responsible for HIV drug assistance programs which pay for medications, insurance premiums and limited medical, mental health and dental care for eligible individuals who are living with our at elevated risk for HIV. Also, the program includes prevention and linkage to care programs and partnerships with community organizations to serve populations who may be at elevated risk for HIV, Hepatitis C, and sexually transmitted infections due to substance use. In addition, this program provides support for people who cannot afford treatment and people who are disproportionately affected by HIV and Hepatitis C. The Office of Infectious Disease administers HIV drug assistance programs to provide financial assistance to eligible people who are prescribed HIV treatment or prevention medication but cannot afford it. Additionally, OID contracts with community based organizations to provide HIV Case managers and HIV prevention navigators to assess needs and support systems for people living with HIV or at risk for HIV and help them access services to improve and maintain their overall health.

U.S. Department of Health and Human Services Final Rule

9. I understand the U.S. Department of Health and Human Services has issued a new regulation entitled "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 81 Fed. Reg. 31375-473 (the "Final Rule"), which was published in the Federal Register on June 19, 2020. As I understand it, the new regulation will

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remove protections against healthcare discrimination for sexual orientation, transgender status or gender identity, and women with respect to pregnancy termination. The new Final Rule also removes requirements for notices of non-discrimination and taglines and communications about the availability of language access for persons with Limited English Proficiency (LEP), narrows the scope of entities to which the anti-discrimination provision applies, and expands the institutions that may refuse to provide care based on a conscience objection. As a result of these changes, the new regulation will allow health care providers and insurers to discriminate against LGBTQ people and women. This will create chilling effect on LGBTQ enrollment and participation in preventative health programs, health care services, and mental health services.

10. As HHS found in the previous version of the regulation, prohibiting discrimination against LGBTQ people and women with a history of pregnancy termination results in more LGBTQ people and women "obtaining coverage and accessing services." 81 Fed. Reg. 31460. And, as HHS admits in the new regulation, removing these protections will result in at least some healthcare entities declining to provide coverage consistent with the previous version of the regulation. 85 Fed. Reg. 37181.

11. HHS also found in the previous version of the regulation that greater healthcare coverage for LGBTQ people and women would result in reduced violence against affected individuals, reduced depression and suicide, and declines in substance abuse, smoking, and alcohol abuse rates. 81 Fed. Reg. 31460. The reverse is also true, and if the new regulation is allowed to take effect, Washington State will bear the cost of these negative health outcomes for Washingtonians who are turned away by clinics, hospitals, and insurance providers, as well as

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in the form of paying for subsidized healthcare services for marginalized and lower income Washingtonians.

12. HHS also previously found that transgender individuals who have experienced healthcare discrimination often postpone or do not seek needed healthcare, which may lead to negative health outcomes. 81 Fed. Reg. 31460. Concerns over discrimination in healthcare is one of the major barriers to transgender individuals seeking healthcare services. *Id.* If allowed to take effect, the new regulation will result in Washingtonians who are transgender or women with a history of pregnancy termination delaying or choosing not to seek preventative healthcare services and other medical services, which will have disastrous long term effects. These include, but are not limited to, delays in preventative screenings and necessary medical treatment leading to more acute health problems and outcomes, cancer, HIV, obesity, mental health, tobacco use, and more. In other words, LGBTQ people, who are disproportionately likely to need a wide range of routine medical care, already have reason to fear, and often do fear, negative consequences of "coming out" to health care providers about their sexual orientation, history of sexual conduct, gender identity, transgender status, history of gender-affirming medical treatment, and related medical histories.

Populations Affected by the Final Rule and their Risk Factors

13. According to the Washington State Office of Financial Management (OFM), the population of Washington State is approximately 7,656,200 people as of April 1, 2020.[2] Declaration of Thea Mounts, ¶ 5.

[2] Press Release, Washington State Office of Financial Management, Washington tops 7.6 million residents in 2020, *available at* https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_press_release.pdf (last visited July 3, 2020).

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14. As of 2018, the Washington State Office of Financial Management (OFM) estimates that 1,385,380 people in Washington State receive healthcare coverage under a private-sector employer's self-insured or self-funded group health plan, and 198,301 Washingtonians receive healthcare coverage through a healthcare plan that is part of the Federal Employees Health Benefits Program. Declaration of Thea Mounts, ¶¶ 7, 9.

15. I understand that, because of provisions of law in the Employee Retirement Income Security Act of 1974 (ERISA) and the Federal Employees Health Care Protection Act of 1998, Washington State laws that prohibit discrimination in healthcare on the basis of pregnancy termination, sexual orientation, and transgender status or gender identity do not apply to these plans. Declaration of Mike Kreidler, ¶¶ 10-14.

16. Because of ERISA and the law applicable to the FEHBP, the healthcare coverage plans of approximately 1,583,681 Washingtonians will not be prevented by Washington State law from discriminating on the basis of pregnancy termination, sexual orientation or transgender status or gender identity. *Id.* at ¶ 14.

17. A recent study confirms that approximately 0.35% to 1.08% of the Washington population identify as transgender.[3] Based on this, DOH estimates that between approximately 5,543 and 17,104 of the 1,583,681 Washingtonians have healthcare coverage to which the Washington State law prohibitions on transgender discrimination will not apply.

[3] Flores, et al., *How many Adults Identify as Transgender in the United States, Williams Institute, June 2016,* available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf.

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18. In addition, approximately 5.2% of the population in Washington is lesbian, gay, or bisexual, [4] so that an additional 82,351 such persons are expected to lose the protection of the anti-discrimination provisions of Washington law in healthcare if the Final Rule takes effect. Additionally, there were approximately 54,320 pregnancy terminations in 2014, 2015, and 2016,[5] and about 249,845 Washington women aged 15-44 in 2019,[6] so that DOH estimates that at least 20% of women in this age group have had a pregnancy termination, and therefore hundreds of thousands of women who have had a pregnancy termination will lose protection from healthcare discrimination on that basis if the Final Rule takes effect.

19. In 2017, the first year in which the previous version of the regulation was in effect, 95.1% of insurance companies had removed language excluding healthcare related to gender transition.[7] Because of this, DOH expects between 5,271 and 16,266 transgender Washingtonians to lose healthcare coverage for transgender healthcare services like hormone therapy and surgical gender transition procedures if the new regulation is allowed to take effect. This does not even include the loss of other healthcare treatment because of discrimination.

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[4] LGBT Demographic Data Interactive, January 2019, the Williams Institute of the UCLA School of Law, *available at* https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=53#demographic (last visited July 11, 2020).

[5] Jones RK, et al., Abortion Incidence and Service Availability in the United States, 2017, Guttmacher Institute, 2019, State Data Table at p. 15, *available at* https://www.guttmacher.org/sites/default/files/report_downloads/abortion-incidence-service-availability-us-2017-tables.pdf (last visited July 11, 2020).

[6] Washington State Office of Financial Management, 2019 Data Book, Population, *available at* https://www.ofm.wa.gov/sites/default/files/public/dataresearch/databook/pdf/population.pdf (last visited July 11, 2020).

[7] Out2Enroll, Summary of Findings: 2017 Marketplace Plan Compliance with Section 1557, *available at* https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2017-Marketplace-Plans.pdf (last visited July 3, 2020).

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20. According to the Centers for Disease Control and Prevention (CDC), inequality is associated with poor health outcomes and LGBTQ individuals are at an increased risk for numerous health issues.[8] To compound this issue, an abstract of a recent national study reported that LGBTQ individuals experienced discrimination in healthcare and one in six avoided seeking care due to this concern.[9] Due to this need, Washington was the first state in the nation to develop cross-sector healthcare recommendations to address health and healthcare equity for LGBTQ persons. Washington's LGBTQ Health Care Recommendations align healthcare delivery, coverage, and purchasing with existing evidence-based, culturally sensitive standard of care for LGBTQ people in Washington State. These recommendations are used to inform state-purchased healthcare (Medicaid, PEBB, SEBB), clinical practice, and standards and systems of care for LGBTQ people. These proposed changes from the Final Rule jeopardize our efforts to advance health and healthcare equity through partnerships and health policies outlined in the LGBTQ Health Care Recommendations.

21. Information gaps on cancer risk for transgender patients as well as overreliance on cisgender-centered paradigms of care mean little work on transgender populations and colorectal cancer has been published.[10, 11] The research that has been published indicates transgender patients are less likely to receive recommended colorectal cancer screening when

[8] Centers for Disease Control and Prevention. https://www.cdc.gov/lgbthealth/ (last visited July 11, 2020).

[9] Casey LS, Reisner SL, Findling MG et al. Discrimination in the United States: experiences of lesbian, gay, bisexual, transgender, and queer americans [abstract only] Health Serv Res. 2019; 54(2): 1454-1466

[10] Burkhalter JE, Margolies L, Sigurdsson HO, et al. The national LGBT cancer action plan: a white paper of the 2014 National Summit on Cancer in the LGBT Communities. LGBT Health. 2016;3(1):19–31

[11] Cahill S, Makadon H. Sexual orientation and gender identity data collection in clinical settings and in electronic health records: a key to ending LGBT health disparities. LGBT Health. 2013;1(1):34–41.

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compared to cisgender individuals; 55% vs 70% respectively.[12] A literature review of transgender men receiving cervical health services found they are not receiving the same level of services as cis women and are less likely to be up to date on cervical cancer screening.[13] Cervical cancer screening uptake among transgender men was significantly lower (49.5%) compared to the overall US population (69.4%).[14] Trans women report the lowest proportion of up-to-date colorectal cancer screening while trans men report levels comparable to cisgendered individuals.[15]

22. In a 2010 report analyzing discrimination against LGBT people and people living with HIV, researchers found that over 20% of transgender and gender-nonconforming respondents reported being blamed for their own health conditions. Inequalities can be magnified when LGBTQ persons are also part of a racial or ethnic minority. 39% of LGBTQ adults identify as people of color, including 15% who identify as Latinx, 11% as Black, 2% as Asian Pacific Islander, and 1% as Native American. This is more diverse than the overall U.S. adult population, which is 65% white. LGBTQ people of color often face stark disparities:

a. Gay and bisexual men of color continue to make up the majority of new HIV/AIDS infections in the U.S., with Black men accounting for 39% of

[12] Kiran, T., Davie, S., Singh, D., Hranilovic, S., Pinto, A., Abramovich, A., & Lofters, A. Cancer screening rates among transgender adults: Cross-sectional analysis of primary care data. Canadian Familt Physician. 2019;65(1), e30 - e37.

[13] Gatos KC. A Literature Review of Cervical Cancer Screening in Transgender Men. Nursing for Women's Health; 22(1).

[14] Tabaac AR, et al. Gender Identity Disparities in Cancer Screening Behaviors. Am J Prev Med 2018; 54(3): 385-393.

[15] Tabaac AR, Sutter ME, Wall CSJ, Baker KE. Gender identity disparities in cancer screening behaviors. Am J Prev Med. 2018;54:385–393

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HIV diagnoses among men who have sex with men, and Latinos accounting for 24%.

b. 59% of syphilis, 30% of gonorrhea, and 7% of chlamydia cases were reported in MSM patients in Washington in 2019.

c. Men who have sex with men (MSM) are disproportionately impacted by these infections in Washington and across the United States. We have seen continuing increases in reported diagnoses of these conditions across the last 5 years in the general population and in MSM.

23. Among MSM, failure to seek medical care for sexually transmitted conditions will lead to continuing transmission of disease, leading to further increases in reported diagnoses. This can also lead to potentially disabling sequelae of syphilis such as ocular or otosyphilis (which can damage the ability to see or hear), or neurosyphilis, which can affect a variety of things such as mental health, balance, and mobility.

24. Untreated bacterial STDs increase the risk of HIV acquisition, so if MSM patients do not seek testing and treatment, HIV diagnoses in this population will likely increase.

25. Some MSM patients are also in relationships with women. Undiagnosed syphilis and HIV infections in patients who do not disclose their MSM sexual activity to medical providers or public health workers because they fear discrimination may unknowingly transmit these infections to female partners. If these female partners become pregnant, cases of congenital syphilis or perinatal HIV infection may also occur. OID expects continued spread of gonorrhea due to failure to diagnose and properly treat pharyngeal gonorrhea or cases when gonorrhea is

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not fully treated for patients who are mistreated, discriminated against, or refused care due to their sexual orientation or gender identify.

26. An additional risk of patient nondisclosure of sexual history to a provider and the resulting failure to test at all sites of infection for gonorrhea. Providers sometimes use oral (pill) medications to treat urethral gonorrhea, and those medications do not always reach sufficient concentration in pharyngeal tissue to cure gonorrhea.

27. Unintended medical consequences and harm can occur when care is accessed outside of traditional medical and behavioral health care systems. If a provider misgenders or traumatizes a patient during medical care, this could lead transgender, non-binary, and genderqueer people to seek gender affirming care outside of the traditional medical care system. According to one study, just over 10% of LGB respondents reported that health care professionals used harsh language toward them; 11% reported that health professionals refused to touch them or used excessive precautions; and more than 12% of LGB respondents reported being blamed for their health status. If the care they seek includes hormones or body modification, that may lead to infections or other medical consequences that add cost to both patient and medical system, and further damage the physical and mental health of the person seeking care. Almost 36% of respondents living with HIV reported that health care professionals refused to touch them or used excessive precautions and nearly 26% were blamed for their own health status. Nearly 21% of transgender and gender non-conforming respondents reported being subjected to harsh or abusive language from a health care professional.

28. Homophobia, HIV-related stigma, and discrimination in clinical settings are significant barriers in preventing Washington healthcare providers from meeting their duty to

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screen and test for infectious diseases. Implicit bias, of which the holder is unaware, and explicit bias (discrimination), can both influence what treatments are offered to which patients. Bias can lead the same physician to provide substandard care to some of patients compared to others with same clinical condition. Overcoming the impact of implicit or unconscious bias can prove to be the greater challenge because of a lack of cultural implications that it is even present. Research suggests that implicit bias may contribute to health care disparities by shaping physician behavior and producing differences in medical treatment along the lines of sexual orientation, gender identity/expression race, ethnicity, gender or other characteristics. Implicit or explicit bias impacts the physician client relationships resulting. Clinicians exhibiting bias spend less time with patients, tend to view patient behaviors more negatively, are typically unaware of cultural considerations and are perceived by patients to be less engaged.

29. In 2013, 67% of all new HIV diagnoses in the U.S. occurred in gay and bisexual men and other MSM, a group that includes approximately 2% of the U.S. population. In Washington State, over 70% of persons living with HIV/AIDS are gay and bisexual men. However, the current health care system is ill equipped to adequately meet the needs of these men. A national survey conducted by the Kaiser Family Foundation in 2014 found that 47% of gay and bisexual men had never revealed their sexual orientation to a physician; 57% of gay and bisexual men reported that a medical provider had never suggested that they test for HIV. Among 164 gay and bisexual men who responded to a Washington State internet-based survey, only 43% reported that they had a primary care medical provider who knew that they were a man who has sex with men.

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30. The state and local public health systems in Washington do not have resources, capacity or infrastructure to meet the unique needs of LGBT populations in non-clinical settings.

31. Additionally, if the Final Rule takes effect, it will dramatically affect LEP individuals by decreasing access to health care, severely limiting the ability of LEP individuals to communicate with the health care system and their providers, and overall compounding the inequities already experienced by this population.

32. Based upon US Census data from 2009-2013, the Migration Policy Institute estimated that there were over 500,000 living in Washington State who have Limited English Proficiency (LEP).[16] Currently, covered healthcare entities must post their non-discrimination policies and taglines that describe the ability for individuals to receive free language assistance services. The taglines must be posted in the covered entity's top 15 languages. The new revisions aim to eliminate the tagline and non-discrimination posting requirements. This will decrease access to health care because LEP individuals will not know they are entitled to interpretation at a medical visit. There is a cost to a patient for not being able to communicate fully within the medical system (e.g. missed appointments, delayed care, "non-compliant" self-care). This would negatively impact the information available to individuals with limited English proficiency receive regarding their language access rights in a healthcare setting and utilization of health care.

33. The proposed rule replaces the requirements for video interpreting services with audio-based services. This would negatively impact access for hearing impaired individuals. It

[16] See Migration Policy Institute tabulations from the U.S. Census Bureau's pooled 2009-2013 American Community Survey, Table B16001 "Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over," available through the U.S. Census Bureau's American FactFinder at https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states/

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would also negatively impact LEP individuals in scenarios where a video is key to the interpretation process (for example, during demonstration of how to use a medical device appropriately).

Costs to the DOH from the Final Rule

34. The Final Rule will have several significant and harmful impacts on the State of Washington, including but not limited to: (1) increased outreach costs for DOH to people who will be affected in order to mitigate harm; (2) increased administrative costs for referring people who have been denied care because of protected status or conscience of the scope issue to providers who can provide the services; and (3) increased costs for the State to actually provide some of those services.

35. If the Final Rule takes effect, DOH programs will be required engage in outreach to connect LGBTQ and other impacted people with needed services. DOH works to improve the health of all people in Washington, including the populations directly impacted by the Final Rule. Transgender individuals, as well as women who have had pregnancies terminated in the past and gay, lesbian, and bisexual people, will be subject to discrimination not only in health plans governed by FEHBP or ERISA, but also in health programs and activities that are outside of the Affordable Care Act marketplace, those funded or administered by an agency other than HHS, or short-term plans. To mitigate the impact from the Final Rule, DOH will incur significant expenses to develop communication tools and other outreach to connect LGBTQ and other impacted people with needed services that will not discriminate against them. This is not an option for DOH—if these efforts are not undertaken, DOH and Washington will pay the cost anyway because they will have to pay for increased subsidized sexual health and reproductive

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health services, increased mental health services for individuals affected by healthcare discrimination and lack of access to healthcare services (particularly transgender individuals who are denied gender affirming healthcare and services), and other down-the-road costs.

36. DOH will therefore be forced to incur substantial mitigation costs. These costs will include analyzing the gaps in coverage and discrimination protections that affected Washingtonians will experience; determining the extent to which existing State-funded programs provide the coverage and services which the Final Rule will cause affected Washingtonians to lose, determining a comprehensive plan for communicating these alternatives to affected Washingtonians; conducting the necessary outreach to and communication with advocacy and non-profit organizations, other agencies, and the public; creating, producing, and disseminating publications to these entities concerning the changes and the identified alternatives; analyzing DOH's budget to identify cost-savings and funds from other programs that can be diverted to offset the increased demand for coverage and services previously provided by sources that will no longer provide them as a result of the Final Rule; and analyzing and recommending additional expenditures by the Legislature to address any remaining health disparities resulting from the Final Rule.

37. DOH will incur increased administrative costs for referring people who have been denied care because of protected status or conscience of the scope issue to providers who can provide the services. LGBTQ individuals and women who have had pregnancies terminated in the past will increase reliance in the Family Planning Program; the Breast, Cervical, and the Colon Health Program; and the Office of Infectious Disease. DOH staffing is already stretched to the limit with the public health response to the historic coronavirus pandemic, as well as the

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increased demand for public services for individuals who have become unemployed as a result of the economic downturn. DOH will have to deny services to people already requiring those services or to the new individuals who will need those services as a result of the Final Rule, or need to request additional resources to support administrative costs for increased demands on these services by both groups.

38. Increases to the cost of care for LGBTQ persons due to loss of benefits, narrower interpretation of coverage and benefits, and higher out-of-pocket costs create more barriers and will increase demand for services and support from the Family Planning Program; the Breast, Cervical, and the Colon Health Program; and the Office of Infectious Disease.

39. For example, the Office of Infectious Disease program services will need additional resources to expand capacity at community based testing settings to serve people who no longer feel safe accessing care at a healthcare facility due to stigma and discrimination harm or whom discontinue health insurance coverage due to benefit restrictions and/or higher out-of-pocket costs.[17] One large study of transgender people found that 28% had postponed necessary medical care when sick or injured, and 33% had delayed preventive care, or did not seek it out at all.[18] Community based programs can help address immediate needs for these populations and link to them to appropriate care which may reduce or avoid engagement in medically-unmonitored hormone use, potential for incorrect dosing, risk of side effects, and exposure to HIV or hepatitis from needles. OID programs are relied on to prevent and control disease

[17] Bonvicini K.A., & Perlin, M.J. (2003). The same but different: Clinician-patient communication with gay and lesbian patients. Patient Education and Counseling, 51(2), 115-122.

[18] Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Kiesling M. Injustice at every turn: a report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.

transmission by ensuring access to services that meet the needs of high risk populations. Additional funding will be needed to pay for testing services in the amount of $579 per person on average for each LGBTQ individual who no longer can rely on non-discriminatory insurance coverage. Based on DOH estimates of the number of transgender individuals who will lose healthcare coverage because of ERISA preemption and FEHBP preemptions (between 5,271 and 16,266 individuals), DOH expects to spend at least $3,000,000 and probably closer to $10,000,000 in additional testing of this kind over the next decade.

40. The Office of Infectious Disease expects to see an increase in the number of people who need help paying for HIV treatment and prevention medications due to loss of insurance and/or insurance coverage and care denial from practitioners. Some of those persons will have to come back onto the HIV drug assistance programs to help pay for services. Less coverage means more out-of-pocket costs and more need for financial assistance and support. When insured patients turn to financial assistance programs offered by drug manufacturers, (e.g. manufacturer co-pay cards and coupons), they may have difficulty meeting their deductible and out-of-pocket maximum cap due to copay accumulators. DOH HIV drug financial assistance programs may pay more when out-of-pocket maximum caps are not reached. As of July 2020, over 4,600 people were enrolled in the HIV treatment financial assistance program. Annual costs per person for medications only is $11,327 and the annual cost for health insurance premiums is $7,525. As of May 2020, 1,931 people were enrolled in the HIV prevention financial assistance program. Nearly two-thirds of enrollees use their health insurance (Insured enrollees numbered 1377 and uninsured enrollees numbered 536). Annual costs per person for co-pays is $3,996 and the annual cost for enrollees without insurance is $17,544. Program enrollment shifts that result

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in more uninsured client is estimated to cost $ 13,548 per person per year. Current enrollment trends indicate consistent program enrollment growth and that more uninsured people are enrolling in the program (21% enrollment growth and 3% growth rate of uninsured in 2019).

41. The Final Rule's personal religious or moral belief exemptions permits discrimination and refusal to treat LGBTQ individuals and women who have had pregnancies terminated. DOH's Family Planning Program will be required to redirect their staff and resources from providing their own services to assisting individuals in determining who among the health care providers in the region will serve LGBTQ patients and women who have had pregnancies terminated in a nondiscriminatory manner. The Final Rule will have significant near-term costs for DOH services. In addition, discrimination against LGBTQ and women who have had pregnancies terminated will increase demand for providers who provide inclusive services and this increased demand will place a strain on these resources, leaving them unable to fulfill their organizational missions, spend sufficient time on each patient or individual seeking services, and provide care and services to all individuals. For example, DOH contractor data shows DOH provided less contraception and sexual health services as the ACA was implemented, including after 2016. In 2019, the Family Planning program served 1,631 fewer clients than 2012. Some of those persons will have to come back onto the State services for this in the amount of $579 per person on average. The estimate is more than $900,000.

42. Infectious, chronic, and reproductive health care and services and medication can be very expensive. As described above, LGBTQ populations are at higher risk for infectious, chronic conditions, substance use disorders, and certain types of cancers. Care and treatment may be avoided or delayed due to fear of stigma, discrimination, and unaffordability,

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leading to more severe and costly care. In addition, because more LGBTQ patients will delay seeking health care, there will be demand for the Breast, Cervical, and the Colon Health Program to fund care for patients with more acute conditions, diseases that are more advanced at diagnosis, less responsive to treatment, or no longer treatable. These increased costs are often paid for by DOH and public health programs (e.g. Medicaid). This delay will strain the resources of the State of Washington.

43. The Final Rule also encourages LGBTQ people to remain closeted to the extent possible when seeking medical care. But remaining closeted to a health care provider may result in significant adverse health consequences. For instance, a patient who conceals or fails to disclose a same-sex sexual history may not be screened for HIV or other relevant infections or cancers, or may not be prescribed preventative medications such as Pre-Exposure Prophylaxis or PrEP, which is extremely effective at preventing HIV transmission. Patients who fail fully to disclose their gender identity and sex assigned at birth may not undergo medically indicated tests or screenings (such as tests for cervical or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women). The barriers to care are particularly high for transgender people, as noted above.

44. Health care providers need patients and individuals seeking services to fully disclose all aspects of their health history, sexual history, and gender identity to provide appropriate care for the patients' health. Without full disclosure, health care providers are not able to treat adequately their patients. For instance, health care providers need to know patients' sexual history to know whether to test them for HIV or other infections or cancers. And health care providers need to be aware of patients' gender identity and sex assigned at

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birth to order proper screenings and tests – like cervical or breast cancer for some transgender men, or testicular or prostate cancer for some transgender women. The Final Rule endangers the provider-patient relationship and will harm health care providers and their patients by discouraging full disclosure. This also means DOH's Breast, Cervical, and the Colon Health Program will serve patients in greater need of care because of delayed diagnosis.

45. The weakening of protections for LEP individuals will result not only in poorer health outcomes for LEP individuals, but also in increased costs for DOH and DOH grant supported health care service providers. For example, in 2018 108 DOH Women, Infant, and Children participants used American Sign Language services which must be provided through video interpreting services, yet the Final Rule replaces the requirements with audio-based services. The Final Rule will increase the likelihood that more people will turn to DOH and public support programs, rather than other covered health care providers. The weakening of LEP protections also will burden DOH programs and other public services because patients will come to them sicker due to inadequate care elsewhere, and more people may come to them because their LEP services will remain robust.

EXECUTED on this 12th day of July, 2020 in Seattle, Washington.

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