UNITED STATES DISTRICT COURT

DISTRICT COURT 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.

Motion for Leave to File Amicus Brief

Civil Action No. 1:20-CV-11297-PBS
Hon. Patti B. Saris

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Amici States California, Massachusetts, New York, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia respectfully move the Court for leave to file an amici curiae brief in this matter, attached hereto as Exhibit 1. In particular, Amici States seek leave to file a brief in support of Plaintiffs' motion for summary judgment. In this action, Plaintiffs seek declaratory and injunctive relief vacating a regulation issued pursuant to the Patient Protection and Affordable Care Act (ACA) by Defendant U.S. Department of Health and Human Services (HHS), 85 Fed. Reg. 37,160 (June 19, 2020) (2020 Rule) under the Administrative Procedure Act (APA).

Amici States have a strong interest in supporting Plaintiffs' motion for summary judgment. Specifically, Amici States are responsible for protecting the health and welfare of their residents. When Congress enacted the ACA, it included Section 1557 (42 U.S.C. § 18116), a landmark civil rights provision that prohibits health programs and activities receiving federal financial assistance from discriminating against individuals on the basis of race, color, national origin, sex, age, or disability. In 2016, when the U.S. Department of Health & Human Services issued a final rule implementing Section 1557, it stressed the importance of comprehensive anti-

discrimination protections and noted that discrimination within the healthcare system contributes to poor health outcomes, exacerbates existing health disparities, and leads to ineffective distribution of healthcare resources. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (codified at 45 C.F.R. pt. 92) (2016 Rule).

Amici States are leading advocates for the Affordable Care Act and nondiscrimination in the provision of health care, including those protecting underserved populations, such as individuals with disabilities, women, and LGBTQ individuals. Amici seek to provide perspective on the application of federal nondiscrimination standards and the resulting harms if the 2020 final rule is permitted to stand. The 2020 final rule dismantles protections against discrimination intended by Section 1557 of the ACA, leading to decreased access to valuable preventive services that Amici States' citizens rely on. Amici's proposed brief supports Plaintiffs' argument and discusses the 2020 rule's unsupported and unjustified contradiction with the factual findings in the record that support the prior administrative policy behind the 2016 rule.

Plaintiffs consent to the filing of Amici States' amicus brief. Defendants take no position on the motion but note for the Court that each of the Amici States are plaintiffs in a separate challenge to the same rule in the

United States District Court for the Southern District of New York that has been stayed pending issuance of the new rule pursuant to the States' consent.

Dated: March 26, 2024

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that this document, filed through the Court's ECF system, will be sent electronically to registered participants and that copies will be sent to non-registered participants by email on March 26, 2024.

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Dated: March 26, 2024

EXHIBIT A

UNITED STATES DISTRICT COURT
DISTRICT COURT 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-PBS Hon. Patti B. Saris

AMICUS CURIAE BRIEF OF THE STATES OF CALIFORNIA, MASSACHUSETTS, NEW YORK AND OTHERS IN SUPPORT OF PLAINTIFFS

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INTRODUCTION AND INTERESTS OF AMICI CURIAE

Amici States California, Massachusetts, New York, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Michigan, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia have a vital interest in protecting the health and welfare of their residents, including ensuring equitable access to healthcare. Amici States submit this brief in support of Plaintiffs' motion for summary judgment.

Congress enacted the Patient Protection and Affordable Care Act (ACA) to address significant barriers to healthcare caused by an inadequate and discriminatory healthcare system. The ACA plays a crucial role in setting appropriate minimum standards for individuals' access to healthcare services across the country. In order to make healthcare more affordable and accessible, Congress created protections for patients from disparate charges based on their health status, guaranteed healthcare coverage for individuals, and increased affordability by creating subsidies for coverage in the private market and expanding the Medicaid program.

Along with this wide range of reforms, Congress included in the ACA a landmark civil rights provision that prohibits discrimination in healthcare, known as Section 1557. Section 1557 prohibits health programs and activities receiving federal financial assistance from discriminating against individuals on the basis of their race, color, national origin, sex, age, or disability. It is designed to work together with the other provisions of the ACA to reduce the health disparities that made healthcare unequal for

disadvantaged groups.[1] In 2016, the U.S. Department of Health & Human Services (HHS), when promulgating a final rule to implement Section 1557, stressed the importance of comprehensive anti-discrimination protections and noted that discrimination within the healthcare system contributes to poor health outcomes, exacerbates existing health disparities, and leads to ineffective distribution of healthcare resources. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (codified at 45 C.F.R. pt. 92) (2016 Rule).

Upon a change in federal administration, HHS promulgated a Final Rule rejecting the prior approach. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority, 85 Fed. Reg. 37,160 (June 19, 2020) (amending 45 C.F.R. pt. 92) (2020 Rule). The 2020 Rule removed critical nondiscrimination protections for transgender and gender-nonconforming individuals, persons seeking reproductive health care or with pregnancy-related conditions, limited-English-proficiency individuals, and all persons facing discrimination by certain health insurers and HHS programs that the Rule now excludes from its scope. The Rule's changes are at odds with the central purpose of the ACA to increase access to quality, affordable health care and to eradicate arbitrary barriers to such access, including discrimination. Because the 2020 Rule contravenes both the ACA and the Administrative Procedure Act (APA), the Amici States support Plaintiffs' motion for summary judgment.

[1] Specifically, Section 1557 prohibits discrimination on the basis of any protected classification covered under Title VI of the Civil Rights Act (race, color, and national origin), Section 504 of the Rehabilitation Act of 1973 (disability), Title IX of the Education Amendments (sex), and the Age Discrimination Act of 1975 (age).

DISCUSSION

I. SECTION 1557 IS A LANDMARK CIVIL RIGHTS LAW THAT FULFILLS THE ACA'S GOALS BY PROHIBITING DISCRIMINATION IN HEALTHCARE AND HEALTH INSURANCE.

Section 1557 was the first federal civil rights law to comprehensively prohibit discrimination in healthcare and to expressly extend prohibitions on sex discrimination to healthcare programs and services. *See, e.g.*, Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C.J.L. & Soc. Just. 235, 236 (2016) (describing Section 1557 as "the first healthcare-specific civil right, the first civil right to extend gender protections to healthcare (including protections for gender identity and sexual orientation discrimination), and the first civil right to broadly capture the private health insurance market"); Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 How. L.J. 855, 871-73, 880 (2012) ("For the first time, federally funded health programs will be prohibited from discriminating on the basis of sex."). To enforce its anti-discriminatory mandate, Section 1557 offers "a far-reaching new civil rights remedy," which allows individuals harmed by discrimination to redress that harm through a private right of action. *Id.*; *see also, e.g.*, *Cummings v. Premier Rehab Keller, P.L.L.C.,* 596 U.S. 212, 218 (2022) (observing that it is "beyond dispute" that private individuals may sue to enforce Section 1557); and *Doe v. BlueCross BlueShield of Tennessee, Inc.*, 926 F.3d 235, 239 (6th Cir. 2019) (joining numerous courts in holding that a plaintiff may enforce Section 1557 through a private right of action).

Before Congress enacted the ACA, individual States played a leading role in regulating healthcare and health insurance, but there was a dearth of leadership or

consistency at the federal level. As a result, there was "considerable geographic variation in insurance coverage, access to care, health status, quality of care, and cost of care." Sara R. Collins & Jeanne M. Lambrew, *Federalism, the Affordable Care Act, and Health Reform in the 2020 Election*, The Commonwealth Fund (Jul. 29, 2019).[2] And while "[p]rior to the ACA, federal and state law included some nondiscrimination protections," they "had only a limited effect in ensuring that coverage m[et] the needs of all consumers." Katie Keith et al., *Nondiscrimination Under the Affordable Care Act*, Georgetown Univ. Health Policy Inst., SSRN 4 (2013).[3] The net result of this patchwork system—along with "the skyrocketing cost of healthcare and health insurance" nationwide—was to leave "nearly 47 million uninsured people in th[e] country" with "worse health outcomes" and trouble affording and accessing care. *The Instability of Health Coverage in America: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 110th Cong. 50, at 2, 4 (Apr. 15, 2008)[4]; *see also, e.g.*, Inst. of Med. Comm. on Health Ins. Status and Its Consequences, *America's Uninsured Crisis: Consequences for Health and Health Care* 95-96, 108-09 (2009) (describing the "tremendous variation in uninsurance rates across the United States," which had "grave implications for the quality and timeliness of care").

Through the ACA, Congress sought to "tear down the jurisdictional divides erected by state lines" that were inhibiting equal access to healthcare across the country.

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[2] Available at https://www.commonwealthfund.org/publications/fundreports/2019/jul/ federalism-affordable-care-act-health-reform-2020-election

[3] Available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2362942.

[4] Available at https://gop-waysandmeans.house.gov/event/hearing-on-the-instability-of-health-coverage-in-america/

John A. Cogan, Jr., *The Affordable Care Act's Preventive Services Mandate: Breaking Down the Barriers to Nationwide Access to Preventive Services*, 39 J. Law Med. Ethics 355, 355 (2011). The ACA did so by substantially reforming the federal regulation of private health insurance and by providing "new minimum federal standards" aimed at increasing access to health insurance and healthcare. Keith et al., *supra* at 9. The need for uniform minimum standards animated many of the ACA's most important reforms, including its requirement that insurers accept every individual that applies for coverage (the "guaranteed issue" requirement), its prohibition on charging individuals more based on their pre-existing health conditions (the "community rating" requirement), its prohibition on limiting or excluding coverage for individuals with preexisting conditions, its new gender-rating standards, and its minimum essential health benefits requirements—"the nation's first federal benefits standard." Nat'l Ass'n of Ins. Comm'rs, *Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers* (2012).

The ACA also sought to eliminate the deeply entrenched healthcare disparities facing disadvantaged groups across the country, including LGBTQIA+ individuals. *See, e.g.*, Kaiser Family Foundation, *The Affordable Care Act and Insurance Coverage Changes by Sexual Orientation* (Jan. 2018). LGBT individuals "often face challenges and barriers to accessing needed health services and, as a result, can experience worse health outcomes." Kaiser Family Foundation, *Issue Brief: Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.* (May

2018).[5] That disparity is especially heightened for transgender people, who are "more likely to live in poverty and less likely to have health insurance than the general population," and who face harassment and discrimination "when seeking routine health care." *Id.* at 14; *see also* 81 Fed. Reg. at 31,460 (citing studies reflecting that 25% of transgender people report being denied needed health care or subjected to harassment in medical settings, which "often led those individuals to postpone or avoid needed healthcare").

Section 1557 was part of Congress's effort to eliminate these types of health disparities. Keith et al., *supra* at 16; *see also* Kellan Baker, *Open Doors for All: Sexual Orientation and Gender Identity Protections in Health Care*, Center for American Progress (Apr. 30, 2015) (describing the ACA's "nondiscrimination protections that are both nationwide in scope and clearly applicable throughout the health system").[6] HHS recognized as much in its initial regulations, emphasizing the importance of Section 1557 to improving the lives of transgender people. 81 Fed. Reg. at 31,460.

Complementing the ACA's minimum standards, Amici States have enacted their own statutory or regulatory protections against discrimination. For instance, many Amici "prohibit health insurers from excluding coverage for transgender health services." Am. Med. Ass'n, Issue Brief: Health Insurance Coverage for Gender-Affirming Care of Transgender Patients (2019), 2. Research shows that those efforts, together with the ACA's protections, have significantly increased access to healthcare for LGBT

[5] Available at https://www.kff.org/report-section/health-and-access-to-care-and-coverage-lgbt-individuals-in-the-us-the-lgbt-community/

[6] Available at https://www.americanprogress.org/issues/lgbtq-rights/reports/2015/04/30/112169/open-doors-for-all/

individuals and their families. *See* Kaiser Family Foundation, *Issue Brief* (May 2018), *supra.* Indeed, "since the implementation of the ACA, rates of uninsurance decreased significantly among LBG adults," and "there has been a five-fold increase in the number of businesses offering at least one health plan that includes coverage of transgender services." *Id.* at 15, 23. But the States cannot do it alone. Legally adequate and strong Section 1557 regulations are crucial to ensuring that the goals of the ACA are fulfilled.

II. THE 2020 RULE CONTRAVENES THE TEXT AND PURPOSE OF THE ACA.

The APA requires courts to "hold unlawful and set aside agency action" that is "not in accordance with law." 5 U.S.C. § 706(2)(A). The 2020 Rule is contrary to Section 1557's text and controlling case law because it narrows the scope of covered health programs and activities by improperly excluding many private health insurers and many of HHS's own programs; excludes discrimination based on gender identity from the scope of discrimination "on the basis of sex," a position at odds with the Supreme Court's decision in *Bostock v. Clayton County,* 140 S.Ct. 1731 (2020); eliminates protections for transgender people; and incorporates exemptions not authorized by Congress. Further, its adoption was arbitrary and capricious.

A. The 2020 Rule Drastically Narrows the Scope of Section 1557.

Through Section 1557, Congress expressly prohibits discrimination by "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 this title (or amendments)." 42 U.S.C. § 18116(a). The 2020 Rule adopted by HHS unduly narrows

the application of Section 1557 by excluding: (1) all insurance plans offered by private health insurers that receive federal funding, except for the specific plans that receive such funding, and (2) all HHS health programs and activities, except for those administered under Title I of the ACA. 85 Fed. Reg. at 37,244-45 (45 C.F.R. §92.3). Specifically, the 2020 Rule limits Section 1557's application to "all of the operations of entities principally engaged in the business of providing healthcare that receive Federal financial assistance," 85 Fed. Reg. at 37,244 (§ 92.3(b)), but adds that "an entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be considered to be principally engaged in the business of providing healthcare." *Id*. at 36,244-45 (45 C.F.R. §92.3(c)). In doing so, HHS unlawfully rewrites the statute and adopts an interpretation at odds with Section 1557's text and the ACA's objective of eliminating barriers to health insurance coverage in the United States. The statutory language of Section 1557 is unambiguous: Section 1557 applies to all aspects of a covered health program or activity, not just those aspects that receive federal assistance. And a health insurer plainly qualifies as a "health program" under the statute. *See Schmitt v. Kaiser Found. Health Plan of Wash.*, 965 F.3d 945, 948, 954-55 (9th Cir. 2020).

As noted, the plain language of the ACA also applies Section 1557's nondiscrimination protections to "any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." 42 U.S.C. § 18116(a). Yet in the 2020 Rule, HHS unlawfully narrows this category of entities to "[a]ny program or activity administered by the Department [of Health and Human Services] under Title I" or "[a]ny program or activity administered by any entity established under such Title." 85 Fed. Reg. at 37,244-45 (§ 92.3). This approach excludes

HHS health programs and activities administered by the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention, the Indian Health Service, the Health Resources and Services Administration, and the Substance Abuse and Mental Health Services Administration, among others. *See* 81 Fed. Reg. at 31,446; *see also Whitman-Walker Clinic, Inc., et al. v. U.S. Dep't of Health and Human Servs.*, 485 F.Supp.3d 1, 15 (D.D.C. 2020). Excluding health programs and activities from Section 1557's ambit is incongruous with the ACA's plain language and broad purpose of eliminating barriers to health coverage and care.

B. The Removal of Protections for Transgender Individuals Conflicts with Section 1557.

The 2020 Rule improperly eliminated (i) the preexisting regulatory definition of "on the basis of sex," which included discrimination on the basis of gender identity, 81 Fed. Reg. at 31,467 (former 45 C.F.R. § 92.4), and (ii) express regulatory prohibitions on discrimination against transgender people. *Id.* at 31,471-72 (former §§ 92.206, 92.207). Both aspects of the 2020 Rule are contrary to law because they conflict with Section 1557's statutory prohibition against discrimination "on the basis of sex." HHS justified these changes based on its misconception that Section 1557 does not extend to transgender people, 85 Fed. Reg. at 37,168, 37,177-80, 37,183-97, and its concomitant and mistaken desire "to restore[] the rule of law by confining regulation within the scope of the Department's legal authority." *Id*. at 37,163. Yet, it is the 2020 Rule that is contrary to law. For example, the 2020 Rule does not address or consider the U.S. Supreme Court's decision in *Bostock*, which held that under Title VII, "it is impossible to discriminate against a person for being . . . transgender without discriminating against

that individual based on sex," because "transgender status [is] inextricably bound up with sex." 140 S. Ct. at 1742. As such, the removal of the definition and express protections for transgender individuals is contrary to law. *See Walker v. Azar*, 480 F.Supp.3d 417, 429 (E.D.N.Y. Aug. 17, 2020) (rejecting HHS's argument that the definition's removal is "inconsequential" since "the premise of the repeal was a disagreement with a concept of sex discrimination later embraced by the Supreme Court").

C. The 2020 Rule's Incorporation of Title IX's Religious Exemption and "Abortion Neutrality" Provision Exceeds HHS's Statutory Authority.

Because neither Section 1557 nor any other provision of the ACA authorizes the 2020 Rule's incorporation of Title IX's broad religious exemption (20 U.S.C. §§ 1681(a)(3)) and "abortion neutrality" provision (20 U.S.C. § 1688), 85 Fed. Reg. at 37,245 (§ 92.6), those provisions were adopted in excess of HHS's statutory authority and must be set aside. 5 U.S.C. § 706(2)(C). An agency's authority to promulgate regulations "is limited to the authority delegated by Congress." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). "[T]he question . . . is always whether the agency has gone beyond what Congress has permitted it to do[.]" *City of Arlington v. FCC*, 569 U.S. 290, 297-98 (2013). Section 1557 does not include a religious exemption, nor does it provide HHS authority to invent one. *See Andrus v. Glover Constr. Co.*, 446 U.S. 608, 616-17 (1980) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent."). To the contrary, Section 1557 makes clear that its nondiscrimination prohibitions apply broadly to all covered entities, "except as otherwise

provided for in [Title I of the ACA].” 42 U.S.C. § 18116(a). Like Section 1557, Title I has no religious exemption or abortion exception.

D. The 2020 Rule is Arbitrary and Capricious.

Agency action is arbitrary and capricious if the agency “entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or [made a decision that] is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.” *Motor Vehicle Mfrs. Ass’n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

First, HHS failed to consider the harms to individuals’ health and well-being and the associated public health costs that would result from its rescission of the regulatory provisions defining “on the basis of sex” and extending express nondiscrimination protections to transgender people. Listing a regulation’s benefits without also considering its costs is insufficient. *Michigan v. EPA*, 576 U.S. 743, 753 (2015). Because HHS did not meaningfully consider evidence in the record and its prior findings about these and other harms, the Rule is arbitrary and capricious. *See Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 932 (D.C. Cir. 2017); *Kern v. U.S. Bureau of Land Mgmt.*, 284 F.3d 1062, 1072 (9th Cir. 2002).

The 2020 Rule’s administrative record reflects many examples of transgender individuals being subjected to denial of health care treatment and coverage, and

inappropriate and humiliating comments from providers.[7] HHS knew about this evidence but failed to adequately address it. Rather, HHS claims it lacks data to evaluate how the Rule will impact transgender people and other members of the LGBTQ community. 85 Fed. Reg. at 37,225. HHS also claims it "lacks data or methods enabling it to provide quantitative estimates of any alleged economic impacts related to termination of pregnancy provisions" and refuses to calculate costs that would result from adopting Title IX's religious exemption. *Id*. at 37,239. But uncertainty as to the magnitude of harm is no excuse for disregarding a known harmful effect of the Rule, particularly where the record contains ample evidence of harm. *See Ctr. for Biological Diversity v. Zinke*, 900 F.3d 1053, 1075 (9th Cir. 2018); *Pub. Citizen v. Fed. Motor Carrier Safety Admin*., 374 F.3d 1209, 1219 (D.C. Cir. 2004); *New York v. Scalia*, 490 F.Supp.3d 748, 795 (S.D.N.Y. 2020). Under those circumstances, the agency's effort to rely on speculative benefits—while failing to adequately "consider cost"—demonstrates unreasonable decision-making. *Michigan*, 576 U.S. at 747.

Second, HHS's decision to weaken, and in one case eliminate, the 2016 Rule's provisions relating to language access is arbitrary and capricious. Specifically, the 2020

[7] For only a few examples, see National Center for Transgender Equality, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs and Activities (August 13, 2019) https://www.regulations.gov/comment/HHS-OCR-2019-0007-153312; Boulder County Public Health, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs and Activities (August 13, 2019) https://www.regulations.gov/comment/HHS-OCR-2019-0007-145054; and Transgender Legal Defense & Education Fund, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs and Activities (August 13, 2019) https://www.regulations.gov/comment/HHS-OCR-2019-0007-149238. See also 85 Fed. Reg. 37238 (recognizing the record includes "data about the percent of transgender persons who forgo care due to fears or experiences of discrimination, and a calculation of the costs to the healthcare system resulting from such occurrences").

Rule dilutes the earlier requirement that covered entities provide meaningful access to "each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities," *id*. at 31,470 (former § 92.201(a)-(b)), requiring instead that covered entities provide such access to "[their] programs or activities by limited English proficient individuals" as an undifferentiated group. 85 Fed. Reg. at 37,245 (§ 92.101(a)). HHS also removed the 2016 Rule's patient-centered test for compliance, replacing it with a generic, four-factor test imported from other federal guidance. *See* 85 Fed. Reg. at 37,245 (§ 92.101(b)(1)-(4)); 67 Fed. Reg. 41,455 (June 18, 2002); 68 Fed. Reg. 47,314 (Aug. 8, 2003). This switch leaves it to each covered entity to apply the four-factor analysis and determine, on its own, whether it is obligated to offer *any* of the language access services listed in the Rule. 85 Fed. Reg. at 37,245 (§ 92.101(b)(1)-(4)). Through that change, HHS disregarded its prior factual findings demonstrating the necessity of robust language assistance requirements to ensure meaningful access to healthcare for limited-English-proficiency individuals and ignored the weight of the evidence in the records that these requirements are still necessary.[8]

[8] See, among many others, Migration Policy Institute, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs (November 16, 2015) https://www.regulations.gov/comment/HHS-OCR-2015-0006-1732; National Council of Asian Pacific Americans, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs and Activities (November 12, 2015) https://www.regulations.gov/comment/HHS-OCR-2015-0006-0855; and National Language Access Advocates Network, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs and Activities (November 12, 2015) https://www.regulations.gov/comment/HHS-OCR-2015-0006-1834. See also, The Children's Defense Fund New York, Comment Letter on Proposed Rule regarding Nondiscrimination in Health Programs and Activities (August 13, 2019), https://www.regulations.gov/comment/HHS-OCR-2019-0007-138914; National Alliance for Hispanic Health (September 6, 2019) https://www.regulations.gov/comment/HHS-OCR-2019-0007-147427.

While an agency "need not always provide a more detailed justification than what would suffice for a new policy created on a blank slate," it must do so "when . . . its new policy rests upon factual findings that contradict those which underlay its prior policy" since "a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009).

Third and finally, the 2020 Rule's incorporation of Title IX's broad religious exemption and "abortion neutrality" provision is arbitrary and capricious because HHS failed to consider the harms to individuals who will be denied health treatments, services, and insurance coverage because of these provisions, as well as the attendant public health costs. *See* 81 Fed. Reg. at 31,330 (HHS findings from 2016 about impact of religious exemptions on healthcare consumers' access and choices, particularly in rural areas); *State Farm*, 463 U.S. at 43. HHS also failed to reconcile the incorporation of those provisions in the 2020 Rule with its rejection of the same provisions in the 2016 Rule, where it expressly recognized that "a blanket religious exemption could result in a denial or delay in the provision of health care to individuals and in discouraging individuals from seeking necessary care, with serious and, in some cases, life threatening results." 81 Fed. Reg. at 31,380. HHS's failure to provide a substantial justification for its policy reversal is arbitrary and capricious. *See Encino Motorcars, LLC v. Navarro,* 136 S. Ct. 2117, 2125-2126 (2016).

CONCLUSION

For the foregoing reasons and those set forth in Plaintiffs' Motion for Summary Judgment, the Court should vacate the 2020 Rule in its entirety.

Dated: March 26, 2024

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that this document, filed through the Court's ECF system, will be sent electronically to registered participants and that copies will be sent to non-registered participants by email on March 26, 2024.

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